

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1336	Date: SEPTEMBER 14, 2007
	Change Request 5718

SUBJECT: October 2007 Update of the Hospital Outpatient Prospective Payment System (OPPS): Summary of Payment Policy Changes

I. SUMMARY OF CHANGES: This Recurring Update Notification describes changes to, and billing instructions for, various payment policies implemented in the October 2007 OPSS update. The October 2007 Integrated Code Editor (I/OCE) and OPSS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this notification. October 2007 revisions to I/OCE data files, instructions, and specifications are provided in Change Request (CR) 5723, "October 2007 Integrated Outpatient Code Editor (I/OCE) Specifications Version 8.3."

NEW / REVISED MATERIAL

EFFECTIVE DATE: *October 1, 2007

IMPLEMENTATION DATE: October 1, 2007

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	Chapter / Section / Subsection / Title
R	4/Table of Contents
R	4/60/Billing for Devices Eligible for Transitional Pass-Through Payments and Items Classified in "New Technology" APCs
R	4/60.1/Categories for Use in Coding Devices Eligible for Transitional Pass-Through Payments Under the Hospital OPSS
R	4/60.2/Roles of Hospitals, Manufacturers, and CMS in Billing for Transitional Pass-Through Items
R	4/60.3/Devices Eligible for Transitional Pass-Through Payments
R	4/60.4/General Coding and Billing Instructions and Explanations
R	4/60.5/Services Eligible for New Technology APC Assignment and Payments

D	4/60.6/Appropriate Revenue Codes to Report Medical Devices That Have Been Granted Pass-Through Status
R	4/61.2/Edits for Claims on Which Specified Procedures are to be Reported With Device Codes and For Which Specific Devices are to be Reported With Procedure Codes

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

**Manual Instruction
Recurring Update Notification**

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1336	Date: September 14, 2007	Change Request: 5718
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SUBJECT: October 2007 Update of the Hospital Outpatient Prospective Payment System (OPPS): Summary of Payment Policy Changes

EFFECTIVE DATE: October 1, 2007

IMPLEMENTATION DATE: October 1, 2007

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to, and billing instructions for, various payment policies implemented in the October 2007 OPSS update. The October 2007 Integrated Code Editor (I/OCE) and OPSS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this notification.

October 2007 revisions to I/OCE data files, instructions, and specifications are provided in Change Request (CR) 5723, "October 2007 Integrated Outpatient Code Editor (I/OCE) Specifications Version 8.3."

B. Policy:

1. Changes to Procedure to Device Edits

The effective dates for the previously existing procedure to device edits for the following procedures are changed from 1/01/2007 to 10/01/2005 in the October 2007 I/OCE:

19296 Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy.

19297 Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy concurrent with partial mastectomy (List in addition to code for primary procedure)

93651 Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connection or other atrial foci, singly or in combination.

2. Correction to the Offset Percentages for APCs 0315 and 0385

CMS reduces the payment for selected APCs when specified devices are furnished to the hospital without cost or with a full credit for the cost of the device being replaced. The tables that contain the devices and APCs to which the policy applies can be found on the CMS web at www.cms.hhs.gov/HospitalOutpatientPPS/HORD/ under supporting documentation for CMS-1506 FC. There were errors in the entries for two APCs in the table of adjustment percentages and adjustment amounts that was posted before October 1, 2007. The table containing the corrected amounts is now posted at www.cms.hhs.gov/HospitalOutpatientPPS/HORD/ under

supporting documentation for CMS-1506 FC and is titled: “2007 OPSS Without Cost or With Credit Device Information; corrected 10/01/2007”.

The table below shows both the incorrect and correct offset percentages and adjustment amounts for APC 0315 (Level II Implantation of Neurostimulator) and APC 0385 (Level I Prosthetic Urological Procedures). The OPSS PRICER for October 2007 contains the corrected amounts with an effective date of January 1, 2007.

Medicare contactors should adjust as appropriate claims brought to their attention that contain HCPCS codes for services assigned to APCs 0315 and 0385 where the FB modifier was reported on the line with a HCPCS code that is assigned to APC 0315 or 0385.

Table 1-Offset Percentages and Adjustment Amounts for APCs 0315 and 0385

APC	0315	0385
APC Group Title	Level II Implantation of Neurostimulator	Level I Prosthetic Urological Procedures
SI	T	S
CY 2007 Payment	\$14,932.81	\$4,868.83
Incorrect CY 2007 Adjustment Percent	76.03%	83.19%
Incorrect CY 2007 Adjustment Amount	\$11,353.42	\$4050.38
Correct CY 2007 Adjustment Percent	83.19%	46.86%
Correct CY 2007 Adjustment Amount	\$12,422.60	\$2,281.53

3. Billing for Drugs, Biologicals, and Radiopharmaceuticals

Hospitals are strongly encouraged to report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. It is also of great importance that hospitals billing for these products make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used in the care of the patient.

We remind hospitals that under the OPSS, if commercially available products are being mixed together to facilitate their concurrent administration, the hospital should report the quantity of each product (reported by HCPCS code) used in the care of the patient. Alternatively, if the hospital is compounding drugs that are not a mixture of commercially available products, but are a different product that has no applicable HCPCS code, then the hospital should report an appropriate unlisted drug code (J9999 or J3490). In these situations, we remind hospitals that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, Unclassified drug or biological, is for new drugs and biologicals that are approved by FDA on or after January 1, 2004, for which a HCPCS code has not been assigned.

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective October 1, 2007

In the CY 2007 OPSS final rule, it was stated that payments for separately payable drugs and biologicals based on average sale prices (ASPs) will be updated on a quarterly basis as later

quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, we will incorporate changes to the payment rates in the October 2007 release of the OPSS PRICER. The updated payment rates effective October 1, 2007, will be included in the October 2007 update of the OPSS Addendum A and Addendum B, which will be posted on the CMS Web site at the end of September.

b. Updated Payment Rate for HCPCS Code Q3025 Effective January 1, 2007 through March 31, 2007

The payment rate for HCPCS code Q3025 was incorrect in the January 2007 OPSS PRICER. The corrected payment rate is listed below and has been installed in the October 2007 OPSS PRICER, effective for services furnished on January 1, 2007, through implementation of the April 2007 update.

Table 2-Updated Payment Rate for HCPCS Code Q3025 Effective January 1, 2007 through March 31, 2007

HCPCS Code	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
Q3025	9022	IM inj interferon beta 1-a	\$115.13	\$23.03

c. Updated Payment Rates for Selected Drugs and Biologicals Effective April 1, 2007 through June 30, 2007

In the April 2007 OPSS PRICER, the payment rate for APC 9022 was incorrect and the payment rate for APC 0767 was not updated (as the APC 0767 rate did not change from the January rate). The corrected payment rates are listed below and have been installed in the October 2007 OPSS PRICER, effective for services furnished on April 1, 2007, through July 1, 2007.

Table 3-Updated Payment Rates for Selected Drugs and Biologicals Effective April 1, 2007 through June 30, 2007

HCPCS Code	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
Q3025	9022	IM inj interferon beta 1-a	\$114.50	\$22.90
J1324	0767	Enfuvirtide injection	\$0.38	\$0.08

d. New HCPCS Drug Code Separately Payable Under OPSS as of October 1, 2007

The following drug has been designated as eligible for separate payment under the OPSS effective October 1, 2007.

Table 4 - New Drug Separately Payable under OPSS as of October 1, 2007

HCPCS Code	APC	SI	Long Descriptor
C9236	9236	K	Injection, eculizumab, 10 mg

The payment rate for this drug can be found in the October 2007 update of OPPS Addendum A and Addendum B which will be posted on the CMS Web site at the end of September.

e. Correct Reporting of Drugs and Biologicals When Used As Implantable Devices

Hospitals are not to bill separately for drug and biological HCPCS codes, with the exception of drugs and biologicals with pass-through status, when using these items as implantable devices (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures. Under the OPPS, hospitals are provided a packaged APC payment for surgical procedures that includes the cost of supportive items, including implantable devices without pass-through status. When using drugs and biologicals during surgical procedures as implantable devices, hospitals may include the charges for these items in their charge for the procedure, report the charge on an uncoded revenue center line, or report the charge under a device HCPCS code (if one exists) so these costs would appropriately contribute to the future median setting for the associated surgical procedure.

f. Correct Reporting of Units for Drugs

Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor. For example, if the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be 1. As another example, if the description for the drug code is 50 mg but 200 mg of the drug was administered to the patient, the units billed should be 4. Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, bill 10 units, even though only 1 vial was administered. HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

4. Coverage Determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Fiscal intermediaries determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, fiscal intermediaries determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)							
		A	D	F	C	D	R	Shared-System Maintainers	OTHER
		/	M	I	A	M	H		

										F I S S	M C S	V M S	C W F	
5718.1	Medicare contractors shall install the October 2007 OPPS PRICER	X		X				X	X					
5718.2	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Contain HCPCS codes for services assigned to APCs 0315 and 0385; 2) FB modifier that was reported on the line with a HCPCS code that is assigned to APC 0315 or 0385; and 3) Were originally processed prior to the installation of the October 2007 OPPS PRICER.	X		X				X						
5718.3	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service that fall on or after January 1, 2007, but prior to April 1, 2007; 2) Contain HCPCS code listed in Table 2; and 3) Were originally processed prior to the installation of the October 2007 OPPS PRICER.	X		X				X						
5718.4	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service that fall on or after April 1, 2007, but prior to July 1, 2007; 2) Contain at least one of the HCPCS codes listed in Table 3; and 3) Were originally processed prior to the installation of the October 2007 OPPS PRICER.	X		X				X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)												
		A / B M A C	D M E M A C	F I	C A R R I E R	D M E R C	R H H I	Shared-System Maintainers				OTHER		
							F I S S	M C S	V M S	C W F				
5718.5	A provider education article related to this instruction will be available at	X		X				X						

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B	D M E	F I	C A R R I E R	D M E R C	R H I	Shared-System Maintainers				OTHER
								F I S S	M C S	V M S	C W F	
	http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.											

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Marina Kushnirova at: marina.kushnirova@cms.hhs.gov

Post-Implementation Contact(s): Regional Office

VI. FUNDING

A. For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC), use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. For Medicare Administrative Contractors (MAC), use the following statement:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual

Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS)

Table of Contents *(Rev. 1336, 09-14-07)*

60.2 - Roles of Hospitals, Manufacturers, and CMS *in* Billing for Transitional Pass-Through Items

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61.1 - Requirements that Hospitals Report Device Codes on Claims on Which They Report Specified Procedures

61.2 - Edits for Claims on Which Specified Procedures are to be Reported With Device Codes *and For Which Specified Devices are to be Reported With Procedure Codes*

60 - Billing for Devices Eligible for Transitional Pass-Through Payments and Items Classified in “New Technology” APCs

(Rev. 1336; Issued: 09-14-07; Effective/Implementation Dates: 10-01-07)

The list of *devices* eligible for *transitional* pass-through payments changes as new *device categories* are approved for pass-through *payment* status *on an ongoing basis*, and as *device categories expire from transitional pass-through payment and their costs* are included in APC rates *for associated surgical procedures*. *To view or download the latest complete list of currently payable and previously payable pass-through device categories, refer to*

http://www.cms.hhs.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage. Please note that this link may change depending on CMS web design requirements.

Hospitals are required to report device category codes that have expired from pass-through payment on claims when such devices are used in conjunction with procedures billed and paid for under the OPSS. In a Federal Register notice dated November 15, 2004 we summarized several provisions (69 FR 65762) related to the required reporting of HCPCS codes for devices.

The most recent information concerning applications *requesting CMS to establish coding and payment* and *eligibility* requirements for additional (*new*) device categories *for pass-through payment* is located on the CMS Web site at

http://www.cms.hhs.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage This web link may change from time to time, depending on CMS web design requirements.

60.1 - Categories for Use in Coding Devices Eligible for Transitional Pass-Through Payments Under the Hospital OPSS

(Rev. 1336; Issued: 09-14-07; Effective/Implementation Dates: 10-01-07)

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 requires establishing categories for purposes of determining transitional pass-through payment for devices, effective April 1, 2001. Each category is defined as a separate code in the C series *or occasionally a code in another series (e.g., certain codes in the L series)* of HCPCS. C-codes *are* assigned by CMS for this purpose *when other HCPCS codes for the eligible item do not exist*. Only devices specifically *described by* the long descriptions associated with the *currently payable pass-through category codes* *are* qualified for transitional pass-through payments. The *complete list of currently and previously payable pass-through category codes can be* viewed and/or downloaded from the CMS Web site, *currently* at

http://www.cms.hhs.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage.

Each item *that* qualifies for transitional pass-through payments fits in one of the *device categories currently active for pass-through payments*. *Devices* may be billed using the *currently active* category codes *for pass-through payments*, as long as they:

- Meet the definition of a device that qualifies for transitional pass-through payments and other requirements and definitions put forth below in [§60.3](#).

- Are described by the long descriptor associated with a *currently* active *pass-through device* category *HCPCS* code assigned by CMS and
- *Are described according to the* definitions of terms and other general explanations issued by CMS to accompany coding assignments in *program* instructions. *The current definitions and explanations are located with the latest complete list of currently payable and previously payable pass-through device categories, found at http://www.cms.hhs.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage. Please note that this link may change depending on CMS web design requirements.*

If a device does not meet the description and other coding instructions *for currently payable categories*, even though it appears to meet the other requirements in this section, it may not be billed *using one of the HCPCS codes for currently payable categories for transitional pass-through payments unless* an applicable category is established by CMS, *as discussed in section 60.3 below.*

Transitional pass-through payment for a device is based on the charge on the individual *provider's* bill, reduced to cost, and subject (in some instances) to a deduction that represents the cost of similar devices already included in the APC payment rate *of the APC billed with the device category* and, *possibly*, a pro-rata reduction (see chapter 17). The *PRICER* software determines the reduction to cost and the deduction for similar devices.

The *eligibility* of a device *category* for transitional pass-through payments is temporary, *lasting for at least 2 but no more than 3 years. (The initial categories expired on January 1, 2003 or on January 1, 2004. The underlying provision is permanent, and categories established later have expired or will expire in successive years.)* At the time of expiration, APC payment rates *are* adjusted to reflect the costs of devices (and drugs and biologicals) that received transitional pass-through payments. These adjustments *are* based on claims data that reflect the use of transitional pass-through devices, drugs and biologicals in conjunction with the associated procedures.

60.2 - Roles of Hospitals, Manufacturers, and CMS *in* Billing for Transitional Pass-Through Items

(Rev. 1336; Issued: 09-14-07; Effective/Implementation Dates: 10-01-07)

In general, hospitals are ultimately responsible for the content of the bills they present to Medicare. If hospitals have questions about appropriate coding that they cannot resolve on their own, the appropriate first step would be to review the *HCPCS codes* and/or the *regulation* governing payment for the year of service. CMS does not have to have qualified a particular device for transitional pass-through payment before a hospital can bill for the device. Hospitals are expected to make appropriate coding decisions based on these instructions and other information available to them.

Many device manufacturers routinely provide hospital customers with information about appropriate coding of their devices. This may be helpful but does not *supersede* Federal requirements.

60.3 - Devices Eligible for Transitional Pass-Through Payments

(Rev. 1336; Issued: 09-14-07; Effective/Implementation Dates: 10-01-07)

The definition *of and criteria for* devices *eligible for establishment of new categories for transitional pass-through payments* was *most recently discussed and defined in a final rule with comment period* published in the “Federal Register” on *November 1, 2002, (67 FR 66781)*. *Two of the criteria were also modified by means of a final rule with comment period published in the “Federal Register” on November 10, 2005 (70 FR 68628)*. The regulations regarding transitional pass-through payment for devices are compiled at [42 CFR 419.66](#). Additionally, the eligibility criteria for CMS to establish a new category for pass-through payment are discussed on the CMS web site at http://www.cms.hhs.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage.

60.4 - General Coding and Billing Instructions and Explanations

(Rev. 1336; Issued: 09-14-07; Effective/Implementation Dates: 10-01-07)

Explanations of Terms

Kits - Manufacturers frequently package a number of individual items used in a particular procedure in a kit. Generally, to avoid complicating the category list unnecessarily and to avoid the possibility of double coding, CMS has not established codes for such kits. However, hospitals are free to purchase and use such kits. If the kits contain individual items that separately qualify for transitional pass-through payments, these items may be separately billed using applicable codes. Hospitals may not bill for transitional pass-through payments for supplies that may be contained in kits. **Multiple units** - Hospitals must bill for multiple units of items that qualify for transitional pass-through payments when such items are used with a single procedure by entering the number of units used on the bill.

Reporting of multiple categories - For items with multiple component devices that fall in more than one category (e.g., kits or systems other than those explicitly identified in the long descriptors), hospitals should code the appropriate category separately for each component. For example, the “Rotablator Rotational Angioplasty System (with catheter and advancer)” consists of both a catheter and an advancer/sheath. Hospitals should report category C1724 for the catheter and C1894 for the advancer/sheath.

Also, for items packaged as kits that contain a catheter and an introducer, *hospitals should* report both appropriate categories. For example, the “Clinicath 16G Peripherally Inserted Central Catheter (PICC) Dual-Lumen PolyFlow Polyurethane” contains a catheter and an introducer. To appropriately bill for this item, hospitals *should* report category C1751 for the catheter and C1894 for the introducer. *(Please note that the device categories C1724, C1894 and C1751 are no longer eligible for pass-through payments, but are used here for illustrative purposes for reporting multiple categories. However, hospitals should continue to report devices on claims in this manner even after the category is no longer eligible for pass-through payment.)*

Reprocessed devices - Hospitals may bill for transitional pass-through payments only for those devices that are “single use.” Reprocessed devices may be considered “single use” if

they are reprocessed in compliance with enforcement guidance of the Food and Drug Administration (FDA) relating to the reprocessing of devices applicable at the time the service is delivered. The FDA phased in new enforcement guidance relating to reprocessing during 2001 and 2002. For further information, see FDA's guidance document entitled "Enforcement Priorities for Single-Use Devices Reprocessed by Third Parties and Hospitals," published August 14, 2000, *or any later FDA guidance or enforcement documents currently in effect. For a complete list of currently and previously payable device categories related to pass-through payments and specific definitions of such device categories, refer to*

http://www.cms.hhs.gov/HospitalOutpatientPPS/Downloads/DeviceCats_OPPSUpdate.pdf.

60.5 – *Services Eligible for New Technology APC Assignment and Payments*

(Rev. 1336; Issued: 09-14-07; Effective/Implementation Dates: 10-01-07)

Under OPPS, *services eligible for payment through New Technology APCs* are those codes that are *assigned to the series of New Technology APCs published in Addendum B of the latest OPPS update*. OPPS considers any HCPCS *code* assigned to these APCs to be a "new technology procedure *or* service." *Procedures for applying for assignment of new services to New Technology APCs may be found on the CMS Web site, currently at http://www.cms.hhs.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage. Please note that this link may change depending on CMS web design requirements.*

The list of HCPCS codes indicating the APCs to which each is assigned can be found in *Addendum B* of the *latest OPPS update* regulation each year at <http://www.cms.hhs.gov/HospitalOutpatientPPS/HOPPSTrans/list.asp#TopOfPage>. *Please note that this link may change depending on CMS web design requirements.*

61.2 - Edits for Claims on Which Specified Procedures are to be Reported With Device Codes *and For Which Specific Devices are to be Reported With Procedure Codes*

(Rev. 1336; Issued: 09-14-07; Effective/Implementation Dates: 10-01-07)

The OCE will return to the provider any claim that reports a HCPCS code for a procedure listed in the table of device edits that does not also report at least one device HCPCS code required for that procedure as listed on the CMS Web site at <http://www.cms.hhs.gov/HospitalOutpatientPPS/>. The table shows the effective date for each edit. If the claim is returned to the provider for failure to pass the edits, the hospital will need to modify the claim by either correcting the procedure code or ensuring that one of the required device codes is on the claim before resubmission. While all devices that have device HCPCS codes and that were used in a given procedure should be reported on the claim, where more than one device code is listed *in the table of device edits* for a given procedure code, only one of the possible device codes is required to be on the claim for payment to be made, unless otherwise specified.

Device edits do not apply to the specified procedure code if the provider reports one of the following modifiers with the procedure code:

52 - Reduced Services;

73 -- Discontinued outpatient procedure prior to anesthesia administration; and

74 -- Discontinued outpatient procedure after anesthesia administration.

Where a procedure that normally requires a device is interrupted, either before or after the administration of anesthesia if anesthesia is required or at any point if anesthesia is not required, and the device is not used, hospitals should report modifier 52, 73 or 74 as applicable. The device edits are not applied in these cases.

The OCE will also return to the provider claims for which specified devices are billed without the procedure code that is necessary for the device to have therapeutic benefit to the patient. These edits are also listed on the CMS Web site at <http://www.cms.hhs.gov/HospitalOutpatientPPS/>. The table shows the effective date for each edit. If the claim is returned to the provider for failure to pass the edits, the hospital will need to modify the claim by either correcting the device code or ensuring that one of the required procedure codes is on the claim before resubmission.