CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 970

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: MAY 30, 2006

Change Request 5121

SUBJECT: July 2006 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 the OPPS to be implemented in the July 2006 OPPS update. The July 2006 OPPS Outpatient Code Editor (OCE) and OPPS 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.

NEW/REVISED MATERIAL

EFFECTIVE DATE: July 1, 2006

IMPLEMENTATION DATE: July 3, 2006

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

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 970	Date: May 30, 2006	Change Request 5121

SUBJECT: July 2006 Update of the Hospital Outpatient Prospective Payment System (OPPS): Summary of Payment Policy Changes

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to the OPPS to be implemented in the July 2006 OPPS update. The July 2006 OPPS Outpatient Code Editor (OCE) and OPPS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS) and Ambulatory Payment Classification (APC) additions, changes, and deletions identified in this notification.

The July 2006 revisions to the OPPS OCE data files, instructions, and specifications are provided in Change Request (CR) 5065, Transmittal 962, issued May 26, 2006, "July 2006 Outpatient Prospective Payment System Code Editor (OPPS OCE) Specifications Version 7.2."

B. Policy:

1. Category III CPT Codes

The American Medical Association (AMA) releases Category III CPT codes in January, for implementation beginning the following July, and in July, for implementation beginning the following January. Prior to Calendar Year (CY) 2006 CMS implemented new Category III CPT codes once a year, in January.

As stated in the November 10, 2005 final rule with comment period (70 FR 68567), for CY 2006 CMS has modified Medicare's process for implementing the Category III codes that the AMA releases each January for implementation in July. Beginning July 1, 2006, the OCE will recognize tracking codes that AMA implements in July, rather than deferring recognition until the following January. Therefore, the following seven Category III CPT codes that the AMA released in January 2006 for implementation in July 2006 will be reportable for services furnished on or after July 1, 2006. The codes, along with their status indicators and APCs are shown in the table below.

Category III CPT Codes Implemented in July 2006

HCPCS Code	Long Descriptor	SI	APC	Payment Rate	Minimum Unadjusted Copayment
0155T	Laparoscopy, surgical, implantation or replacement of gastric stimulation electrodes, lesser curvature (i.e., morbid obesity)	T	0130	$1,896.93	$379.39
0156T	Laparoscopy, surgical, revision or removal of gastric stimulation electrodes, lesser	T	0130	$1,896.93	$379.39

HCPCS Code	Long Descriptor	SI	APC	Payment Rate	Minimum Unadjusted Copayment
	curvature (i.e., morbid obesity)				
0157T	Laparotomy, implantation or replacement of gastric stimulation electrodes, lesser curvature (i.e., morbid obesity)	C			
0158T	Laparotomy, revision or removal of gastric stimulation electrodes, lesser curvature (i.e., morbid obesity)	C			
0159T	Computer aided detection, including computer algorithm analysis of MRI image data for lesion detection/characterization, pharmacokinetic analysis, with further physician review for interpretation, breast MRI	N			
0160T	Therapeutic repetitive transcranial magnetic stimulation treatment planning	X	0340	$36.52	$7.30
0161T	Therapeutic repetitive transcranial magnetic stimulation treatment delivery and management, per session	X	0340	$36.52	$7.30

2. Replacement of Upgraded Devices with Full Credit for the Replaced Device

It is not uncommon for a recalled or defective device to be replaced with an upgraded device for which the cost to the hospital is greater than the cost of the device being replaced. The manufacturer may give the hospital a credit for the sales price of the device being replaced due to recall or defect. The hospital is then liable to the manufacturer for the difference between the price for the replaced device and the price of the upgraded replacement device. Hospitals have asked how to bill in these cases.

The hospital should report the device code being implanted, which in these cases, is the HCPCS code for the upgraded device being implanted. The hospital should not report the FB modifier because the device being implanted is not furnished without cost by the manufacturer and therefore does not meet the definition of the modifier. The hospital should report condition code 50, defined as "**Product Replacement for Known Recall of a Product**—Manufacturer or FDA has identified the product for recall and therefore replacement" to signify that the device is being replaced due to recall or under warranty. The hospital should report a charge for the upgraded replacement device that equals the difference between its usual charge for the replaced device and its usual charge for the upgraded replacement device.

3. Drugs and Biologicals

a. Drugs and Biologicals with Payment Rates Based on Average Sales Price (ASP) Effective July 1, 2006

In the CY 2006 OPPS final rule (70 FR 68643), it was stated that payments for 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, CMS will incorporate changes to the payment rates in the July 2006 release of the OPPS PRICER. The updated payment rates effective July 1, 2006, will be included in the July 2006 update of the OPPS Addendum A and Addendum B which will be posted at the end of June on the CMS Web site.

b. Newly-Approved Drugs Eligible for Pass-Through Status

The following drugs have been designated as eligible for pass-through status under the OPPS effective July 1, 2006. Payment rates for these items can be found in the July 2006 update of OPPS Addendum A and Addendum B which will posted on the CMS Web site at the end of June.

HCPCS Code	APC	SI	Long Description
C9229	9229	G	Injection, ibandronate sodium, per 1 mg
C9230	9230	G	Injection, abatacept, per 10 mg

c. Payment for New, Unclassified Drugs or Biologicals Before Assignment of a Product-Specific Drug/Biological HCPCS Code

CR 3287, Transmittal 188, issued on May 28, 2004, allows hospitals to report C9399 to bill for **new drugs and biologicals that are approved by the FDA on or after January 1, 2004**, for which pass-through status has not been approved and a C-code and APC payment are not assigned (http://www.cms.hhs.gov/transmittals/Downloads/R188CP.pdf). Contractors shall not allow payment for any drugs and biologicals billed using C9399 for which FDA approval was granted before January 1, 2004. They shall refer to the FDA's Web site at www.fda.gov to obtain the information on the FDA approval dates.

d. Payment Rates for Tetanus and Diphtheria Vaccine Effective July 1, 2005 through December 31, 2005

The payment rates for the vaccine listed below were not included in the April 2006 OPPS PRICER, effective for services furnished on July 1, 2005 through December 31, 2005. The payment rates will be installed in the July 2006 OPPS PRICER.

Payment Rate for Tetanus and Diphtheria Vaccine Effective July 1, 2005 through September 30, 2005

HCPCS	APC	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment
90714	1634	Tetanus and diphtheria toxoids (td) absorbed,	$17.81	$3.56

		preservative free, for use in individuals 7 years or older, for intramuscular use.		

Payment Rate for Tetanus and Diphtheria Vaccine Effective October 1, 2005 through December 31, 2005

HCPCS	APC	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment
90714	1634	Tetanus and diphtheria toxoids (td) absorbed, preservative free, for use in individuals 7 years or older, for intramuscular use.	$17.81	$3.56

e. 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 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. The HCPCS short descriptors are limited to 28 characters, which includes 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.

The full descriptors for the Level II HCPCS codes can be found in the latest code books or from the latest Level II HCPCS file, which is available for downloading from the CMS Web site at: http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp#TopOfPage.

Providers are reminded to check HCPCS descriptors for any changes to the units when HCPCS definitions or codes are changed.

4. Overpayment of Certain Blood Products

Beginning with dates of service July 1, 2005, providers are required to report a charge for processing/storage of blood (39X revenue code) when they also report a charge for blood or blood products (38x revenue code). PRICER determines a ratio of the total 38x charges to the combined 38x-39x charges. This allows PRICER to pay each line according to the respective blood portion so that only

one APC payment is made per unit. However, just recently, CMS realized that PRICER is only computing this ratio for blood products to which the blood deductible applies, and not for all blood products. This means that PRICER is pricing twice the amount it should on 38x-39x line pairs for the following blood HCPCS: P9011, P9012, P9017, P9019, P9020, P9023, P9031, P9032, P9033, P9034, P9035, P9036, P9037, P9043, P9044, P9048, P9050, P9053, P9055, P9059, and P9060. Claims with dates on or after July 1, 2005, shall be mass adjusted to pay correctly using the July 2006 OPPS PRICER.

5. Error in CR 3681 With Regard to Use of Bill type 12X to Bill Blood and Blood Products

The policy statement under section I. B. of CR 3681, Transmittal 496, issued March 4, 2005, erroneously lists bill type 12X as a bill type on which blood and blood products could be billed under OPPS. The error exists only in the statement of policy and does not exist in the Internet Only Manual section issued by this change request.

Blood and blood products cannot be billed on bill type 12X because blood and blood products, like drugs, are covered as incident to a physician's service when furnished in a hospital outpatient department and therefore cannot be paid when the service is furnished to an inpatient of a hospital, notwithstanding that the beneficiary has exhausted Part A benefits (the circumstance in which bill type 12X is used).

6. Modification to the Long Descriptor for C8952

To clarify the current policy for drug administration, effective July 1, 2006, CMS is modifying the long descriptor for C8952.

Old Long Descriptor	New Long Descriptor
Therapeutic, prophylactic or diagnostic injection; intravenous push	Therapeutic, prophylactic or diagnostic injection; intravenous push of each new substance/drug

7. Revised Long and Short Descriptors for C1767

Transmittal 805, CR 4250 issued on January 3, 2006, stated that the January 2006 OCE did not contain the short descriptor for C1767 which was revised effective January 1, 2006. The revised short descriptor was included in the April 2006 OCE update as well as in the January 2006 and April 2006 releases of the Addendum A and B on the CMS Web site.

Old Long Descriptor	New Long Descriptor
Generator, neurostimulator (implantable)	Generator, neurostimulator (implantable), non-rechargeable
Old Short Descriptor	**New Short Descriptor**
Generator, neurostim, imp	Generator, neuro non-recharg

8. Payment for 20979, Low Intensity Ultrasound Stimulation to Aid Bone Healing, Noninvasive (Nonoperative)

Effective for services furnished on or after July 1, 2006, CPT code 20979 is assigned to APC 0340, Minor Ancillary Procedures, with status indicator "X" under OPPS.

9. Payment for Certain Pathology Services

Effective for services furnished on or after the dates listed in the table below, CPT codes listed in the table are assigned to APC 0342, Level I Pathology, with status indicator "X" under OPPS.

HCPCS Code	Long Descriptor	Effective Date
81099	Unlisted urinalysis procedure	08/01/00
84999	Unlisted chemistry procedure	08/01/00
85999	Unlisted hematology and coagulation procedure	08/01/00
86849	Unlisted immunology procedure	08/01/00
87999	Unlisted microbiology procedure	08/01/00
88199	Unlisted cytopathology procedure	10/01/00
88399	Unlisted surgical pathology procedure	10/01/00
89240	Unlisted miscellaneous pathology test	01/01/04

10. Changes to the FISS Provider Specific File

Per CR 4279, Transmittal 817, issued January 20, 2006, CMS created a new provider type 45 for provider-based Rural Health Clinics (RHCs). FISS allows FIs to store provider type 45 for provider-based RHCs with an OSCAR provider range of XX-39xx on the FISS Provider Specific File. Provider range XX-39xx has since been exhausted and, therefore, provider range xx8500 - xx8899 should also be used for such providers. However, FISS does not allow provider range xx8500 - xx8899 as a valid range for provider-based RHCs on the FISS Provider Specific File. CMS has included instructions in this CR to instruct FISS to accept provider range xx8500 - xx8899 for provider-based RHCs.

11. 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 service meets all program requirements for coverage. For example, that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5121.1	The Shared System Maintainer (SSM) shall install the OPPS PRICER for July 2006.					X				
5121.2	Contractors shall not allow payment for any drugs and biologicals billed using C9399 for which FDA approval was granted before January 1, 2004.	X	X							
5121.2.1	Contractors shall check the FDA's Web site at www.fda.gov to obtain the information on the FDA approval dates.	X	X							
5121.3	Contractors shall adjust as appropriate claims brought to their attention: 1) Whose dates of service fall within the timely filing limit, and; 2) That contain at least one of the following HCPCS: 81099, 84999, 85999, 86849, 87999, 88199, 88399, and 89240.	X	X							
5121.4	Contractors shall mass adjust claims that meet all of the following conditions: (1) Were incorrectly paid for services furnished on or after July 1, 2005, through June 30, 2006 (2) Were processed before the installation of the July 2006 OPPS PRICER (3) Contain any of the following HCPCS: P9011, P9012, P9017, P9019, P9020, P9023, P9031, P9032, P9033, P9034, P9035, P9036, P9037, P9043, P9044, P9048, P9050, P9053, P9055, P9059, and P9060.	X	X							
5121.5	FISS shall accommodate the provider range expansion for provider-based Rural Health Clinics (RHCs), codified as Provider type 45 in the Inpatient Provider Specific File and Outpatient Provider Specific File, to include the					X				

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	"xx8500 - xx8899" series.									
5121.6	Contractors shall adjust as appropriate claims brought to their attention that meet all of the following conditions: (1) Were incorrectly paid for services furnished on or after July 1, 2005, through December 31, 2005 2) Were processed before the installation of the July 2006 OPPS PRICER with updated ASP payment rates (3) Contain HCPCS 90714.	X	X							
5121.6.1	Contractors shall follow the business requirements listed in CR 5125 or CR 4371 to "hook" claims that contain HCPCS 90714 since 90714 is on the list of drug codes that need to be "hooked".	X	X							

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5121.7	A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive notification of the article release via the	X	X							

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	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 and incorporated into any educational events on this topic. 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 AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: July 1, 2006 **Implementation Date:** July 3, 2006 **Pre-Implementation Contact(s):** Marina Kushnirova, marina.kushnirova@cms.hhs.gov **Post-Implementation Contact(s):** Regional Office	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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