CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1139	**Date: DECEMBER 22, 2006**
	Change Request 5438

Subject: January 2007 Update of the Hospital Outpatient Prospective Payment System (OPPS): Summary of Payment Policy Changes and OPPS PRICER Logic Changes and Instructions for Updating the Outpatient Provider Specific File (OPSF)

I. SUMMARY OF CHANGES: This Recurring Update Notification describes changes to, and billing instructions for, various payment policies implemented in the January 2007 OPPS update. The January 2007 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. Also, please note that we are revising the language found in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 4, §61.3.2, to add a discussion of how hospitals should bill in cases in which the credit they receive is for an amount that is less than the amount that the device would otherwise cost.

New / Revised Material
Effective Date: January 1, 2007
Implementation Date: January 2, 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	4/61.3.1/Reporting and Charging Requirements When a Device is Replaced Without Cost to the Hospital
R	4/61.3.2/ Reporting and Charging Requirements When the Hospital Receives Credit for the Replaced Device against the Cost of a More Expensive Replacement Device
R	4/160/Clinic and Emergency Visits
N	4/160.1/Critical Care Services
R	4/220.1/Billing for IMRT Planning and Delivery
R	4/220.2/Additional Billing Instructions for IMRT Planning
R	4/220.3/ Billing for Multi-Source Photon (Cobalt 60-Based)

	Stereotactic Radiosurgery (SRS) Planning and Delivery
R	4/220.4/ Billing for Linear Accelerator (Robotic Image-Guided and Non-Robotic Image-Guided) SRS Planning and Delivery
R	4/230.2/Coding and Payment for Drug Administration
D	4/230.2.1/Administration of Drugs Via Implantable or Portable Pumps
D	4/230.2.2/Chemotherapy Drug Administration
D	4/230.2.3/ Non-Chemotherapy Drug Administration

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: 1139	Date: December 22, 2006	Change Request: 5438

SUBJECT: January 2007 Update of the Hospital Outpatient Prospective Payment System (OPPS): Summary of Payment Policy Changes and OPPS PRICER Logic Changes and Instructions for Updating the Outpatient Provider Specific File (OPSF)

Effective Date: **January 1, 2007**

Implementation Date: January 2, 2007

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to, and billing instructions for, various payment policies implemented in the January 2007 OPPS update. The January 2007 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.

January 2007 revisions to OPPS OCE data files, instructions, and specifications are provided in Change Request (CR) 5425, "January 2007 Outpatient Prospective Payment System Code Editor (OPPS OCE) Specifications Version 8.0."

B. Policy:

1. New Device Pass-Through Categories

Section 1833(t)(6)(B) of the Social Security Act (the Act) requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that we create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

We are establishing two new device pass-through categories as of January 1, 2007. The following table provides a listing of new coding and payment information concerning the new device categories for transitional pass-through payment.

Table 1: New Device Pass-Through Codes

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Device Offset from Payment
C1821	01/01/07	H	1821	Interspinous implant	Interspinous process distraction device (implantable)	$0.00
L8690	01/01/07	H	1032	Aud osseo dev, int/ext comp	Auditory osseointegrated device, includes all internal and	$0.00

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Device Offset from Payment
					external components	

Device Offset from Payment: Section 1833(t)(6)(D)(ii) of the Act requires that we deduct from pass-through payments for devices an amount that reflects the portion of the APC payment amount that we determine is associated with the cost of the device (70 FR 68627-8). For the two categories listed above, C1821 and L8690, we determined that there are no similar devices in the respective APCs with which the new device categories would be billed that are similar to the devices of the new categories. Therefore, the device offsets are set to $0 for both of these new device categories.

For CY 2006, when we created the new category C1820, Generator, neurostimulator (implantable), with rechargeable battery and charging system, we determined that we are able to identify the portion of the APC payment amount associated with the cost of the historically utilized device, that is, the non-rechargeable neurostimulator generator implanted through procedures assigned to APC 222, Implantation of Neurological Device, which C1820 replaces in some cases. The device offset from the pass-through payment for C1820 represents the deduction from the pass-through payment for category C1820 that will be made when C1820 is billed with a service assigned to APC 222. **For CY 2007, the device offset portion for C1820 is $8,668.94.** Please note that the offset amount from the APC payment is wage adjusted before it is subtracted from the device cost.

2. Payment for Brachytherapy Sources

The Medicare Modernization Act of 2003 (MMA) requires us to pay for brachytherapy sources in separately paid APCs, and for the period of January 1, 2004, through December 31, 2006, to pay for brachytherapy sources at hospitals' charges adjusted to their cost. Effective January 1, 2007, we are still paying for specified brachytherapy sources separately, pursuant to MMA, and at hospitals' charges adjusted to their cost pursuant to the Tax Relief and Health Care Act of 2006, which extends the charges adjusted to cost payment for brachytherapy sources until January 1, 2008. Therefore, the prospective payment rates for each source, which are listed in Addendum B to our CY 2007 final rule, will <u>not</u> be used for payment. In addition, because of their cost-based payment methodology for CY 2007, brachytherapy sources will not be eligible for outlier payments in CY 2007. Instead, the status indicators of brachytherapy source HCPCS codes will return to "H" effective January 1, 2007, for payment of brachytherapy sources at hospitals' charges adjusted to their cost. The CY 2007 HCPCS codes for the currently separately paid sources, long descriptors, and APCs are listed below.

CPT/ HCPCS	Long Descriptor	SI	APC
A9527	Iodine I-125, sodium iodide solution, therapeutic, per millicurie	H	2632
C1716	Brachytherapy source, Gold 198, per source	H	1716
C1717	Brachytherapy source, High Dose Rate Iridium 192, per source	H	1717
C1718	Brachytherapy source, Iodine 125, per source	H	1718

C1719	Brachytherapy source, Non-High Dose Rate Iridium 192, per source	H	1719
C1720	Brachytherapy source, Palladium 103, per source	H	1720
C2616	Brachytherapy source, Yttrium-90, per source	H	2616
C2632		D	
C2633	Brachytherapy source, Cesium-131, per source	H	2633
C2634	Brachytherapy source, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source	H	2634
C2635	Brachytherapy source, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source	H	2635
C2636	Brachytherapy linear source, Palladium-103, per 1MM	H	2636
C2637	Brachytherapy source, Ytterbium-169, per source	H	2637

Please note that C2632 has been deleted and replaced by A9527, effective January 1, 2007.

3. Adjustment to Payment in Cases of Devices Replaced without Cost or With Credit for the Replaced Device

Effective for services furnished on or after January 1, 2007, Medicare will reduce the amount of payment for certain APCs when the hospital reports that it received a listed device without cost or where the hospital received a full credit for the cost of a replaced listed device. The reduction applies only to specific APCs when specific devices are replaced. Instructions for reporting these circumstances are contained in CMS Transmittal 1103, Change Request 5263, "Reporting and Payment of No-Cost Devices Furnished by Outpatient Prospective Payment System (OPPS) Hospitals," issued November 3, 2006. It is important that hospitals read and follow the instructions for reporting the FB modifier carefully to ensure that they report accurately. Inaccurate reporting of the modifier may result in incorrect payment. Hospitals should not report the FB modifier if they received partial credit for the device being explanted.

Where the FB modifier is reported with any of the APCs in Table 3 below, Medicare will deduct the amount of the adjustment shown before wage adjusting the Medicare payment. The copayment will be based on the reduced payment. The modifier FB should be reported on the procedure code contained in any of these APCs **only** if the device being replaced is one of the devices in Table 4.

Table 3: APCs Subject to Adjustment When Billed with Modifier FB

APC	SI	APC Group Title	CY 2007 Adjustment Percent	CY 2007 Payment	CY 2007 Adjustment amount
39	S	Level I Implantation of Neurostimulator	78.85%	$11,518.00	$9,081.94
40	S	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve	54.06%	$3,477.28	$1,879.82

APC	SI	APC Group Title	CY 2007 Adjustment Percent	CY 2007 Payment	CY 2007 Adjustment amount
61	S	Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve	60.06%	$5,175.40	$3,108.35
89	T	Insertion/Replacement of Permanent Pacemaker and Electrodes	77.11%	$7,601.70	$5,861.67
90	T	Insertion/Replacement of Pacemaker Pulse Generator	74.74%	$6,042.45	$4,516.13
106	T	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	41.88%	$3,617.97	$1,515.21
107	T	Insertion of Cardioverter-Defibrillator	90.44%	$18,716.35	$16,927.07
108	T	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	89.40%	$23,341.48	$20,867.28
222	T	Implantation of Neurological Device	77.65%	$11,164.12	$8,668.94
225	S	Implantation of Neurostimulator Electrodes, Cranial Nerve	79.04%	$13,593.72	$10,744.48
227	T	Implantation of Drug Infusion Device	80.27%	$10,720.36	$8,605.23
229	T	Transcatheter Placement of Intravascular Shunts	46.17%	$4,208.70	$1,943.16
259	T	Level VI ENT Procedures	84.61%	$25,499.72	$21,575.31
315	T	Level II Implantation of Neurostimulator	76.03%	$14,932.81	$11,353.42
385	S	Level I Prosthetic Urological Procedures	83.19%	$4,868.83	$4,050.38
386	S	Level II Prosthetic Urological Procedures	61.16%	$8,445.07	$5,165.00
418	T	Insertion of Left Ventricular Pacing Elect.	87.32%	$18,888.06	$16,493.05
654	T	Insertion/Replacement of a permanent dual chamber pacemaker	77.35%	$6,931.86	$5,361.79
655	T	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	76.59%	$9,382.43	$7,186.00
680	S	Insertion of Patient Activated Event Recorders	76.40%	$4,462.71	$3,409.51
681	T	Knee Arthroplasty	73.37%	$12,642.83	$9,276.04

Table 4: Devices for which Procedure Code for Replacement Device is to be Reported With Modifier FB When the Device is Replaced Without Cost or With Credit

Device	Description
C1721	AICD, dual chamber
C1722	AICD, single chamber
C1764	Event recorder, cardiac

C1767	Generator, neurostim, imp
C1771	Rep dev, urinary, w/sling
C1772	Infusion pump, programmable
C1776	Joint device (implantable
C1777	Lead, AICD, endo single coil
C1778	Lead, neurostimulator
C1779	Lead, pmkr, transvenous VDD
C1785	Pmkr, dual, rate-resp
C1786	Pmkr, single, rate-resp
C1813	Prosthesis, penile, inflatab
C1815	Pros, urinary sph, imp
C1820	Generator, neuro rechg bat sys
C1882	AICD, other than sing/dual
C1891	Infusion pump, non-prog, perm
C1895	Lead, AICD, endo dual coil
C1896	Lead, AICD, non sing/dual
C1897	Lead, neurostim, test kit
C1898	Lead, pmkr, other than trans
C1899	Lead, pmkr/AICD combination
C1900	Lead coronary venous
C2619	Pmkr, dual, non rate-resp
C2620	Pmkr, single, non rate-resp
C2621	Pmkr, other than sing/dual
C2622	Prosthesis, penile, non-inf
C2626	Infusion pump, non-prog, temp
C2631	Rep dev, urinary, w/o sling
L8614	Cochlear device/system

4. Changes to Device Edits for January 2007

Effective for services furnished on or after January 1, 2007, there will be two types of device edits that claims for OPPS services must pass to be accepted for processing:

a. Procedure to Device Edits

Procedure to device edits, which have been in place for many APCs since 2005, continue to be in place. These edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code. Failure to pass these edits will result in the claim being returned to the provider. These edits can be found at www.cms.hhs.gov/HospitalOutpatientPPS/ under downloads on the OPPS page. Note that new edits for January 1, 2007, are found in yellow highlighting.

b. Device to Procedure Code Edits

Effective for services furnished on or after January 1, 2007, CMS will require that a claim that contains one of a specified set of device codes be returned to the provider if it fails to also contain an appropriate procedure code. We have determined that the devices contained in this list cannot be correctly reported without one of the specified procedure codes also being reported on the same claim. Where these devices are currently being billed without an appropriate procedure code, the cost of the device is being packaged into the median cost for an incorrect procedure code and therefore is inflating the payment rate for the incorrect procedure code. Simultaneously the hospital is being incorrectly paid.

For example, HCPCS code C1722, AICD, single chamber, sometimes appears on a claim on which the only procedure code on the claim is CPT code 33241, Remove pulse generator. Clearly, if a single chamber AICD device code is correctly reported on a claim, there must have been a procedure to implant a single chamber AICD and the hospital should have reported G0297, Insert single chamber/cd, or G0299, Inser/repos single icd+leads, with or without CPT code 33241, and the claim is not correct as submitted. In this case, the cost of the device is being packaged into CPT code 33241, which is assigned to APC 105, Revision/Removal of AICD, Pacemaker or Vascular Device, where it clearly does not belong. The median cost for CPT code 33241 is being incorrectly inflated, and the hospital is being paid for one unit of APC 105 (often with outlier payment) but is not being paid for one unit of APC 107, Insertion of Cardioverter-Defibrillator, or 108, Insertion/Replacement/Repair of Cardioverter Defibrillator Leads. We note that APC 108 is populated by G0299 and G0300, each of which require that an AICD be implanted, as well as leads being inserted, replaced or repaired.

These edits are located at www.cms.hhs.gov/HospitalOutpatientPPS/ under downloads on the OPPS page. These edits have been open to public comment since August 2006. Comments on these edits should be directed to OutpatientPPS@cms.hhs.gov.

5. Statewide Default Cost to Charge Ratio (CCR)

CMS uses default statewide CCRs for several groups of hospitals, including, but not limited to, hospitals that are new and have not yet submitted a cost report, hospitals that have a CCR higher than the predetermined ceiling threshold for a valid CCR, and hospitals that have recently given up their all-inclusive rate status. Current OPPS policy also requires hospitals that experience a change of ownership, but that do not accept assignment of the previous hospital's provider agreement, to use the previous provider's CCR. Change Request 3756, issued in April 2005, established the current ceiling threshold of 1.2 for replacing a calculated CCR with a statewide default CCR.

For CY 2007, we will apply this treatment of using the default statewide CCR to include an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with 42 CFR §489.18, and that has not yet submitted its first Medicare cost report. This policy is effective for hospitals experiencing a change of ownership on or after January 1,

2007. A hospital that has not accepted assignment of an existing hospital's provider agreement is similar to a new hospital that will establish its own costs and charges. The hospital that has chosen not to accept assignment may have different costs and charges than the existing hospital. Furthermore, the hospital should be provided time to establish its own costs and charges. Therefore, the FI should use the default statewide CCR to determine cost-based payments until the hospital has submitted its first Medicare cost report.

6. Changes to the Calculation of the Hospital-Specific Overall CCR

CMS has revised the methodology for calculation of the hospital-specific overall CCR effective January 1, 2007 to remove the costs of nursing and paramedical education programs and to weigh hospital costs by part B charges. See CMS Transmittal 1030, CR 5238, "Policy Changes to the Fiscal Intermediary Calculation of Hospital Outpatient Payment System (OPPS) and Community Mental Health Center (CMHC) Cost to Charge Ratios (CCRs)" issued November 3, 2006.

The hospital-specific overall CCR is used by fiscal intermediaries to calculate the payment for radiopharmaceuticals, brachytherapy sources, and pass-through devices which are paid at charges reduced to cost. The hospital-specific overall CCR is also used to calculate outlier payments, if any, that are due to the provider.

7. Rural Payments to Essential Access Community Hospitals (EACHs)

Section 5105 of the Deficit Reduction Act (DRA) (Pub. L. 109-171) reinstituted the hold harmless transitional outpatient payments (TOPs) for covered OPD services furnished on or after January 10, 2006, and before January1,2009, for rural hospitals having 100 or fewer beds that are not sole community hospitals (SCHs). When the OPPS payment is less than the payment the provider would have received under the previous reasonable cost-based system, the amount of payment is increased by 95 percent of the amount of the difference between those two payment systems for CY 2006, by 90 percent of the amount of that difference for CY 2007, and by 85 percent of the amount of that difference for CY 2008. For CY 2006, we have implemented this policy through Transmittal 877, issued on February 24, 2006. We did not specifically address whether TOPs payments apply to essential access community hospitals (EACHs), which are considered to be SCHs under Section 1886(d)(5)(D)(iii)(III) of the Act. Accordingly, under the statute, EACHs are treated as SCHs. Therefore, beginning January 1, 2006, EACHs are not eligible for TOPs payment.

For CY 2007, we will continue to apply a payment increase of 7.1 percent to rural SCHs for all services and procedures paid under the OPPS, excluding drugs, biologicals, brachytherapy sources, and services paid under the pass-through payment policy. This adjustment is budget neutral and applied before calculating outliers and coinsurance. We did not specifically address whether the adjustment applies to EACHs. Therefore, because EACHs are treated as SCHs, we are clarifying that EACHs are treated as SCHs for purposes of receiving this adjustment retroactive to January 1, 2006, assuming these entities otherwise meet the rural adjustment criteria.

8. Packaged Services

For CY 2007, we are creating a new category of packaged codes, called "special" packaged codes, for which we pay separately when the codes appear on a claim with no separately payable OPPS services also reported for the same date of service.

Through OCE logic, the PRICER will automatically assign payment for a "special" packaged service reported on a claim if there are no other services separately payable under the OPPS on the claim for

the same date of service. In all other circumstances, the "special" packaged codes would be treated as packaged services. We assign status indicator "Q" to these "special" packaged codes to indicate that they are usually packaged, except for special circumstances when they are separately payable. Through OCE logic, the status indicator of a "special" packaged code would be changed either to "N" or to the status indicator of the APC to which the code is assigned for separate payment, depending upon the presence or absence of other OPPS services also reported on the claim for the same date. Table 5 lists the status indicators and APC assignments for these "special" packaged codes when they are separately payable. We note that the payment for these "special" packaged codes is intended to make payment for all of the associated hospital costs, which may include patient registration and establishment of a medical record, in an outpatient hospital setting when the hospital provides no other separately payable services under the OPPS to the patient on that day.

In the case of a claim with two or more "special" packaged codes only reported on a single date of service, the PRICER will assign separate payment only to the "special" packaged code that will receive the highest payment. The other "special" codes will remain packaged and will not receive separate payment.

Both the OCE and the PRICER will implement these new policies without any coding change required on the part of hospitals.

Table 5: "Special" Packaged Codes

CPT Code	Descriptor	CY 2007 APC	Status Indicator
36540	Collect blood, venous access device	0624	S
36600	Arterial puncture; withdrawal of blood for diagnosis	0035	T
38792	Sentinel node identification	0389	S
75893	Venous sampling through catheter, with or without angiography, radiological supervision and interpretation	0668	S
94762	Noninvasive ear or pulse oximetry for oxygen saturation by continuous overnight monitoring	0443	X
96523	Irrigation of implanted venous access device	0624	S

We are clarifying that CMS receives claims that contain only packaged codes. We note that although these claims are processed by the OCE and are ultimately rejected for payment, they are received by CMS, and we have cost data for packaged services based upon these claims. While we have been told that some hospitals may bill for a low-level visit if a packaged service only is provided so that they receive some payment for the encounter, we note that providers should bill a low-level visit code in such circumstances only if the hospital provides a significant, separately identifiable low-level visit in association with the packaged service. This general rule applies to any service provided by a hospital. We would expect that the hospital resources associated with a visit would be reflected in the hospital's internal guidelines used to select the level of reporting for the visit. The hospital should bill the visit code that most appropriately describes the service provided. In circumstances where there is no applicable HCPCS code to describe a distinct service, hospitals should continue to report the most appropriate unlisted procedure or unlisted services CPT code. In summary, with respect to the billing of visit CPT codes, as described above, our current policy dictates that hospitals may only bill a visit code if the hospital provides services during a significant, separately identifiable visit which can be distinguished from any other services provided.

Earlier guidance issued January 3, 2003 in section XII of Transmittal A-02-129 was based upon our past policy that a hospital could bill a low-level visit code in addition to CPT code 97602, which was packaged in CY 2003 at the time of the instruction. However, beginning in CY 2006 we have provided separate payment for CPT 97602 when it is performed as a nontherapy service in the hospital outpatient setting. Therefore, hospitals are now able to report and be paid for this wound care service with the most specific CPT code available. This OPPS payment policy for nontherapy, nonselective wound care services will continue for CY 2007.

9. Coding and Payment for Visits

We will not replace CPT E/M codes with G-codes for CY 2007. Hospitals should continue to bill CPT E/M codes to report visits provided in hospital outpatient clinics and in emergency departments that meet the definition of a Type A emergency department as described below. However, for CY 2007, we are distinguishing between two types of emergency departments: Type A emergency departments and Type B emergency departments.

A Type A emergency department is defined as an emergency department that is available 24 hours a day, 7 days a week and is either licensed by the State in which it is located under applicable State law as an emergency room or emergency department or it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

This definition of Type A emergency departments should neither narrow nor broaden the group of emergency departments or facilities that are currently correctly billing CPT emergency department visit E/M codes.

Type A emergency departments should bill CPT emergency department E/M codes, as they have been billing in the past.

A Type B emergency department is defined as an emergency department that meets the definition of a "dedicated emergency department" as defined in 42 CFR 489.24 under the EMTALA regulations. It must meet at least one of the following requirements:

(1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;

(2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or

(3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

For CY 2007, because there are no CPT codes that describe Type B emergency departments, we are creating 5 new G-codes, G0380, G0381, G0382, G0383, and G0384, that describe the 5 levels of emergency visits provided in Type B emergency departments. These new codes will allow us to track the resource costs of Type B emergency departments and determine how the costs for services

provided in Type B emergency departments differ from clinic and Type A emergency department visit costs. Table 6 lists the short descriptors of the new codes.

Table 6: New Codes for Emergency Visits Provided in Type B Emergency Departments

HCPCS Code	Short Descriptor
G0380	Lev 1 hosp type B ED visit
G0381	Lev 2 hosp type B ED visit
G0382	Lev 3 hosp type B ED visit
G0383	Lev 4 hosp type B ED visit
G0384	Lev 5 hosp type B ED visit

For CY 2007, we will pay at 5 payment levels for clinic and Type A emergency department visits, instead of the current 3 payment levels. This should have minimal impact on hospital coding since hospitals will continue to bill 5 levels of CPT codes. Hospitals should ensure that their internal coding guidelines accurately reflect resource distinctions between the 5 levels of codes. Type A emergency department visits will continue to be paid at emergency department rates. Type B emergency department visits will be paid at clinic visit rates until we collect enough data to better determine their resource costs.

CMS will work with the AHA, AHIMA and other interested parties to develop national guidelines for consistent reporting of hospital visits. We continue to encourage public input in the form of suggestions, problems, or successful models. CMS will provide a minimum of 6-12 months notice to hospitals prior to implementation of national guidelines to ensure sufficient time for providers to make the necessary systems changes and educate their staff. We do not anticipate implementing guidelines prior to CY 2008.

As we indicated in the proposed and final rules, we believe the AHA/AHIMA guidelines are promising, although we identified some areas that we believed require additional development. The original and modified guidelines are available on the OPPS Web site at http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/list.asp#TopOfPage. The files are included as supporting documents under the CY 2007 Proposed Rule, CMS-1506-P. We continue to welcome input specifically on these models.

Until national guidelines are implemented, providers should continue to apply their current guidelines to the existing CPT codes. Hospitals that will be billing the new Type B ED visit codes may need to update their internal guidelines for use to report these codes.

10. Coding and Payment for Critical Care

For CY 2007, we will pay for critical care at 2 levels, depending on the presence or absence of trauma activation. Providers will receive one payment rate for critical care without trauma activation and will receive additional payment when critical care is associated with trauma activation.

To determine whether trauma activation occurs, providers are to follow the National Uniform Billing Committee (NUBC) guidelines related to the reporting of the trauma revenue codes in the 68x series. The guidelines are listed in the Medicare Claims Processing Manual, Pub 100-04, Chapter 25, §60.4. In summary, revenue code series 68x can be used only by trauma centers/hospitals as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons. Different subcategory revenue codes are reported by designated Level 1-4 hospital trauma centers. Only patients for whom there has been prehospital notification based on triage information from prehospital caregivers, who meet either local, state or American College of Surgeons field triage criteria, or are delivered by inter-hospital transfers, and are given the appropriate team response can be billed a trauma activation charge.

We have created G0390, Trauma response team activation associated with hospital critical care service, effective January 1, 2007, which is assigned to APC 0618, Critical Care with Trauma Response. When at least 30 minutes of critical care is provided without trauma activation, the hospital will bill CPT code 99291, Critical care evaluation and management of the critically ill or critically injured patient; first 30-74 minutes (and 99292, if appropriate) as usual, and receive payment for APC 0617, Critical Care. If trauma activation occurs under the circumstances described by the NUBC guidelines that would permit reporting a charge under 68x and the hospital provides at least 30 minutes of critical care so that CPT code 99291 is appropriately reported, the hospital may also bill one unit of HCPCS code G0390, reported with revenue code 68x on the same date of service as CPT code 99291, and the hospital will receive an additional payment under APC 0618. The OCE will edit to ensure that G0390 appears with revenue code 68x on the same date of service as CPT code 99291 and that only one unit of G0390 is billed. We believe that trauma activation is a one-time occurrence in association with critical care services, and therefore, we will only pay for one unit of G0390 per day. We will monitor usage of the CPT codes for critical care services and the new G-code to ensure that their utilization remains at anticipated levels.

The CPT code 99291 is defined by CPT as the first 30-74 minutes of critical care. This 30 minute minimum has always applied under the OPPS and will continue to apply for CY 2007. We are continuing to provide packaged payment for CPT code 99292, Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes, for those periods of critical care services extending beyond 74 minutes, so hospitals do not have the ongoing administrative burden of reporting precisely the time for each critical care service provided. As the CPT guidelines indicate, hospitals that provide less than 30 minutes of critical care should bill for a visit, typically an emergency department visit, at a level consistent with their own internal guidelines. Hospitals that provide less than 30 minutes of critical care when trauma activation occurs under the circumstances described by the NUBC guidelines that would permit reporting a charge under revenue code 68x, may report a charge under 68x, but they may not report HCPCS code G0390. In this case, payment for the trauma response is packaged into payment for the other services provided to the patient in the encounter, including the visit that is reported.

Under the OPPS, the time that can be reported as critical care is the time spent by a physician and/or hospital staff engaged in active face-to-face critical care of a critically ill or critically injured patient. If the physician and hospital staff or multiple hospital staff members are simultaneously engaged in this active face-to-face care, the time involved can only be counted once.

11. Billing for Stereotactic Radiosurgery

Stereotactic radiosurgery (SRS) is a form of radiation therapy for treating abnormalities, functional disorders, and tumors of the brain and neck, and most recently has expanded to treating tumors of

the spine, lung, pancreas, prostate, bone, and liver. There are two basic methods in which SRS can be delivered to patients, linear accelerator-based treatment and multi-source photon-based treatment (often referred to as Cobalt 60). Advances in technology have further distinguished linear accelerator-based SRS therapy into two types: gantry-based systems and image-guided robotic SRS systems. These two types of linear accelerator-based SRS therapies may be delivered in a complete session or in a fractionated course of therapy up to a maximum of five sessions.

For CY 2007, the CPT Editorial Panel created four new SRS Category I CPT codes in the Radiation Therapy section of the 2007 CPT manual. Specifically, the CPT Editorial Panel created CPT codes 77371, Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cerebral lesion[s] consisting of 1 session; multi-source Cobalt 60 based; 77372, Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cerebral lesion[s] consisting of 1 session; linear accelerator based; 77373, Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions; and 77435, Stereotactic body radiation therapy, treatment management, per treatment course, to one or more lesions, including image guidance, entire course not to exceed 5 fractions.

As we clarified in the 2007 OPPS Final Rule, HCPCS G0243 will no longer be reportable under the hospital OPPS because the code will be deleted and replaced with CPT code 77371, effective January 1, 2007. Moreover, for SRS services described by CPT codes 77372, 77373, and 77435, hospital outpatient facilities must use the corresponding G-codes that specifically describe these services. Because the CPT codes are not as specific in their descriptors as the G-codes that describe SRS services, CPT codes 77372, 77373, and 77435 have been assigned to status indicator "B" under the OPPS effective January 1, 2007.

Additionally, for CY 2007, we will continue our recent practice of not recognizing established CPT code 61793, Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator), one or more sessions, under the OPPS because the OPPS will utilize more specific SRS codes to provide appropriate payment for the facility resources associated with specific types of SRS treatment delivery.

12. Billing for Drugs, Biologicals, and Radiopharmaceuticals

a. New HCPCS Codes and Dosage Descriptors for Certain 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.

Several new HCPCS codes relating to drugs, biologicals and radiopharmaceuticals have been created for use in CY 2007. In addition, there is one HCPCS code that has been deleted for CY 2007 and does not have a replacement HCPCS code payable under the OPPS. Furthermore, HCPCS code J7345 will be recognized for services not described by HCPCS code C9351. These new and deleted HCPCS codes are presented in the table below:

Table 7: New and Deleted HCPCS Codes Effective for Certain Drugs, Biologicals, and

Radiopharmaceuticals in CY 2007

2007 HCPCS	2007 Descriptor	2007 SI	2007 APC
C9232	Injection, idursulfase, 1 mg	G	9232
C9233	Injection, ranibizumab, 0.5 mg	G	9233
C9234	Injection, alglucosidase alfa, 10 mg	K	9234
C9235	Injection, panitumumab, 10 mg	K	9235
C9350	Microporous collagen tube of non-human origin, per centimeter length	G	9350
C9351	Acellular dermal tissue matrix of non-humn origin, per square centimeter (Do not report C935x in conjunction with J7345)	G	9351
J0348	INJECTION, ANIDULAFUNGIN, 1 MG	G	0760
J1324	INJECTION, ENFUVIRTIDE, 1MG	K	0767
J1562	Injection, Immune Globulin, subcutaneous, 100 mg	K	0804
J2170	INJECTION, MECASERMIN, 1MG	K	0805
J2315	INJECTION, NALTREXONE, DEPOT FORM, 1 MG	K	0759
J3473	Injection, Hyaluronidase, recombinant, 1 usp unit	G	0806
J7345	Non-human, non-metab tissue	K	0837
J8650	Nabilone, oral, 1 mg	K	0808
J9261	Injection, Nelarabine, 50 mg	K	0825
J2912	INJECTION, SODIUM CHLORIDE, 0.9%, PER 2 ML	Deleted 2007	

Many HCPCS codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS code descriptors that will be effective in CY 2007. In addition, several temporary C-codes have been deleted effective December 31, 2006 and replaced with permanent HCPCS codes in CY 2007. Hospitals should pay close attention to accurate billing for units of service consistent with the dosages contained in the new long descriptors of the active CY 2007 HCPCS codes. The affected HCPCS codes are listed below:

Table 8: HCPCS Code and Dosage Descriptor Changes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals in CY 2007

CY 2006 HCPCS	CY 2006 Descriptor	CY 2007 HCPCS	CY 2007 Descriptor
90655	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, PRESERVATIVE FREE, FOR CHILDREN 6-35 MONTHS OF AGE, FOR INTRAMUSCULAR USE	90655	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, PRESERVATIVE FREE, WHEN ADMINISTERED TO CHILDREN 6-35 MONTHS OF AGE, FOR INTRAMUSCULAR USE
90656	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, PRESERVATIVE FREE, FOR USE IN INDIVIDUALS WHEN ADMINISTERED TO 3 YEARS AND ABOVE, FOR INTRAMUSCULAR USE	90656	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, PRESERVATIVE FREE, WHEN ADMINISTERED TO 3 YEARS AND ABOVE, FOR INTRAMUSCULAR USE
90657	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, FOR CHILDREN 6-35 MONTHS OF AGE, FOR INTRAMUSCULAR USE	90657	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, WHEN ADMINISTERED TO CHILDREN 6-35 MONTHS OF AGE, FOR INTRAMUSCULAR USE
90658	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, FOR USE IN INDIVIDUALS 3 YEARS OF AGE AND ABOVE, FOR INTRAMUSCULAR USE	90658	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, WHEN ADMINISTERED TO 3 YEARS OF AGE AND ABOVE, FOR INTRAMUSCULAR USE
90669	PNEUMOCOCCAL CONJUGATE VACCINE, POLYVALENT, FOR CHILDREN YOUNGER THAN 5	90669	PNEUMOCOCCAL CONJUGATE VACCINE, POLYVALENT, WHEN ADMINISTERED TO CHILDREN

CY 2006 HCPCS	CY 2006 Descriptor	CY 2007 HCPCS	CY 2007 Descriptor
	YEARS, FOR INTRAMUSCULAR USE		YOUNGER THAN 5 YEARS, FOR INTRAMUSCULAR USE
90700	DIPHTHERIA, TETANUS TOXOIDS, AND ACELLULAR PERTUSSIS VACCINE (DTAP), FOR USE IN INDIVIDUALS YOUNGER THAN 7 YEARS, FOR INTRAMUSCULAR USE	90700	DIPHTHERIA, TETANUS TOXOIDS, AND ACELLULAR PERTUSSIS VACCINE (DTAP), WHEN ADMINISTERED TO YOUNGER THAN 7 YEARS, FOR INTRAMUSCULAR USE
90702	DIPHTHERIA AND TETANUS TOXOIDS (DT) ADSORBED FOR USE IN INDIVIDUALS YOUNGER THAN 7 YEARS, FOR INTRAMUSCULAR USE	90702	DIPHTHERIA AND TETANUS TOXOIDS (DT) ADSORBED WHEN ADMINISTERED TO YOUNGER THAN 7 YEARS, FOR INTRAMUSCULAR USE
90714	TETANUS AND DIPHTHERIA TOXOIDS (TD) ADSORBED, PRESERVATIVE FREE, FOR USE IN INDIVIDUALS 7 YEARS OR OLDER, FOR INTRAMUSCULAR USE	90714	TETANUS AND DIPHTHERIA TOXOIDS (TD) ADSORBED, PRESERVATIVE FREE, WHEN ADMINISTERED TO 7 YEARS OR OLDER, FOR INTRAMUSCULAR USE
90715	TETANUS, DIPHTHERIA TOXOIDS AND ACELLULAR PERTUSSIS VACCINE (TDAP), FOR USE IN INDIVIDUALS 7 YEARS OR OLDER, FOR INTRAMUSCULAR USE	90715	TETANUS, DIPHTHERIA TOXOIDS AND ACELLULAR PERTUSSIS VACCINE (TDAP), WHEN ADMINISTERED TO 7 YEARS OR OLDER, FOR INTRAMUSCULAR USE
90718	TETANUS AND DIPHTHERIA TOXOIDS (TD) ADSORBED FOR USE IN INDIVIDUALS 7 YEARS OR OLDER, FOR INTRAMUSCULAR USE	90718	TETANUS AND DIPHTHERIA TOXOIDS (TD) ADSORBED WHEN ADMINISTERED TO 7 YEARS OR OLDER, FOR INTRAMUSCULAR USE
90732	PNEUMOCOCCAL POLYSACCHARIDE VACCINE, 23-VALENT, ADULT OR IMMUNOSUPPRESSED PATIENT DOSAGE, FOR USE IN INDIVIDUALS 2 YEARS OR OLDER, FOR SUBCUTANEOUS OR INTRAMUSCULAR USE	90732	PNEUMOCOCCAL POLYSACCHARIDE VACCINE, 23-VALENT, ADULT OR IMMUNOSUPPRESSED PATIENT DOSAGE, WHEN ADMINISTERED TO 2 YEARS OR OLDER, FOR SUBCUTANEOUS OR INTRAMUSCULAR USE
C1178	INJECTION, BUSULFAN, PER 6 MG	J0594	INJECTION, BUSULFAN, 1 MG
C9220	Sodium hyaluronate per 30 mg dose, for intra-articular injection	Q4086	HYALURONAN OR DERIVATIVE, ORTHOVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE
C9222	Decellularized soft tissue scaffold, per 1 cc	J7346	Dermal (substitute) tissue of human origin, injectable, with or without other bioengineered or processed elements, but without metabolically active elements, 1 cc
C9224	Injection, galsulfase, per 5 mg	J1458	Injection, galsulfase, 1 mg
C9225	Injection, fluocinolone acetonide intravitreal implant, per 0.59 mg	J7311	Fluocinolone acetonide, intravitreal implant
C9227	Injection, micafungin sodium, per 1 mg	J2248	Injection, micafungin sodium, 1 mg
C9228	Injection, tigecycline, per 1 mg	J3243	Injection, tigecycline, 1 mg
C9229	Injection, ibandronate sodium, per 1 mg	J1740	Injection, ibandronate sodium, 1 mg
C9230	Injection, abatacept, per 10 mg	J0129	Injection, abatacept, 10 mg
C9231	Injection, decitabine, per 1 mg	J0894	Injection, decitabine, 1 mg
J7188	Injection, von willebrand factor complex, human, iu	J7187	Injection, von willebrand factor complex, human, ristocetin cofactor, per iu

CY 2006 HCPCS	CY 2006 Descriptor	CY 2007 HCPCS	CY 2007 Descriptor
J7317	SODIUM HYALURONATE, PER 20 TO 25 MG DOSE FOR INTRA-ARTICULAR INJECTION	Q4083	HYALURONAN OR DERIVATIVE, HYALGAN OR SUPARTZ, FOR INTRA-ARTICULAR INJECTION, PER DOSE
		Q4085	HYALURONAN OR DERIVATIVE, EUFLEXXA, FOR INTRA-ARTICULAR INJECTION, PER DOSE
J7320	HYLAN G-F 20, 16 MG, FOR INTRA ARTICULAR INJECTION	Q4084	HYALURONAN OR DERIVATIVE, SYNVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE
J7350	Dermal (substitute) tissue of human origin, injectable, with or without other bioengineered or processed elements, but without metabolized active elements, per 10 mg	J7346	Dermal (substitute) tissue of human origin, injectable, with or without other bioengineered or processed elements, but without metabolically active elements, 1 cc
J9264	Paclitaxel protein bound	J9264	Paclitaxel injection
S0167	Injection, apomorphine hydrochorlide, 1mg	J0364	INJECTION, APOMORPHINE HYDROCHLORIDE, 1MG

b. Coding Changes for Sodium Hyaluronan Intra-Articular Injection Products .

After carefully examining Section 1847A of the Social Security Act, CMS has decided to establish separate payment for sodium hyaluronate products that have come onto the market since October 2003. In order to facilitate that separate payment, we are creating 4 interim Q codes that will be effective January 1, 2007. Corresponding ASP amounts will be reflected in updated 2007 ASP pricing files to be posted on the CMS website. The payment indicators are identical for all services. Thus, the payment indicators will only be listed for the first service (Q4083). The following codes are effective for services performed on or after January 1, 2007. (**NOTE**: These codes are not on the 2007 HCPCS file and contractors shall manually add these codes to their systems.)

Effective January 1, 2007, HCPCS code J7319, Hyaluronan (sodium hyaluronate) or derivative, intra-articular injection, per injection, will not be recognized by Medicare and will be assigned to status indicator "E" under the OPPS.

Table 9: Interim Q-Codes for Sodium Hyaluronate Products

HCPCS code	Long Descriptor
Q4083	HYALURONAN OR DERIVATIVE, HYALGAN OR SUPARTZ, FOR INTRA-ARTICULAR INJECTION, PER DOSE
Q4084	HYALURONAN OR DERIVATIVE, SYNVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE
Q4085	HYALURONAN OR DERIVATIVE, EUFLEXXA, FOR INTRA-ARTICULAR INJECTION, PER DOSE
Q4086	HYALURONAN OR DERIVATIVE, ORTHOVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE

c. Billing for Pre-administration Related Services Associated With Intravenous Immune Globulin Administration

In the CY 2007 hospital outpatient prospective payment system final rule that went on display on November 1, 2006, we announced that we would continue the temporary add-on payment for hospital outpatient departments that administer intravenous immune globulin (IVIG) to Medicare beneficiaries. This additional payment continues to provide for pre-administration related services, such as locating and acquiring adequate IVIG product and preparing for an infusion of IVIG. This separate preadministration-related services payment will continue to be made to hospital outpatient departments for dates of service on or after January 1, 2007. Hospitals will continue to bill HCPCS code G0332 only once per patient per day of IVIG administration, and payment will continue to be mapped to APC 1502 (payment rate of $75). Hospitals must continue to bill HCPCS code G0332 on the same claim form as the IVIG product (J1566 and/or J1567) and have the same date of service as the IVIG product and a drug administration service. This IVIG pre-administration related services payment is in addition to Medicare's payments to the hospital for the IVIG product itself and for administration of the IVIG product via intravenous infusion.

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

In the CY 2007 OPPS final rule, 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. Effective January 1, 2007, payment rates for many drugs and biologicals have changed from the values published in the CY 2007 OPPS final rule as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2006. In cases where adjustments to payment rates are necessary, we will incorporate changes to the payment rates in the January 2007 release of the OPPS PRICER. We are not publishing the updated payment rates in this program instruction implementing the January 2007 update of the OPPS. However, the updated payment rates effective January 1, 2007, can be found in the January 2007 update of the OPPS Addendum A and Addendum B on the CMS Web site.

13. Coding and Payment for Drug Administration Services

a. General Drug Administration Update

Drug administration services furnished under the hospital Outpatient Prospective Payment System (OPPS) during CY 2005 were reported using CPT codes 90780, 90781, and 96400-96459. Effective January 1, 2006, some of these CPT codes were replaced with more detailed CPT codes incorporating specific procedural concepts, as defined and described by the CPT manual, such as initial, concurrent, and sequential.

In order to facilitate the transition to more specific CPT codes within the hospital environment and to assist hospitals in ensuring continued correct coding concepts, drug administration services provided in CY 2006 under the OPPS were billed using a combination of CPT codes and C-codes and did not include the newly introduced CPT concepts of initial, concurrent and sequential.

Hospitals are instructed to use the full set of CPT codes, including those codes referencing concepts of initial, concurrent, and sequential, to bill for drug administration services furnished in the hospital outpatient department beginning January 1, 2007. In addition, hospitals are instructed to continue billing the HCPCS codes that most accurately describe the service(s) provided.

Hospitals are reminded to bill a separate Evaluation and Management code (with modifier 25) only if a significant, separately identifiable E/M service is performed in the same encounter with OPPS drug administration services.

b. Administration of Vaccines that are Covered Part D Drugs

HCPCS code G0377, Administration of vaccine for Part D drug, will be effective under the OPPS beginning January 1, 2007. It will be assigned to APC 0437, Level II Drug Administration, with status indicator "S" and a national unadjusted payment rate of $24.25, with a minimum unadjusted copayment of $4.85.

14. Updating the Outpatient Specific File (Effective January 1, 2007)

For January 1, 2007, contractors shall maintain the accuracy of the provider records in the Outpatient Providers Specific File (OPSF). This includes updating the Core-Based Statistical Area (CBSA) in the provider records, as well as updating the "special wage index" value for those providers who qualify for the 505 adjustment and/or are held harmless (for re-designation from an urban MSA to a rural CBSA under the new geographic definitions) as annotated in Table 10.[1] As always, the IPPS fiscal year 2007 wage index is applied to all hospitals participating in OPPS for the 2007 calendar year.

Contractors shall do the following to update the OPSF (effective 1/1/2007):

1. Update the CBSA value for each provider (as given in Table 10);

2. For providers who qualify for the 505 adjustment and/or are held harmless in CY 2007;

   a) Enter a value of "1" in the Special Payment Indicator field on the OPSF; and

   b) Enter the final wage index value (given for the provider in Table 10) in the Special Wage Index field in the OPSF.

3. For providers who received a special wage index in CY 2006, but no longer receive it in CY 2007;

   a) Create a new provider record, effective January 1, 2007; and

   b) Enter a blank in the Special Payment Indicator field; and

   c) Enter zeroes in the special wage index field.

NOTE: Although the 505 adjustment is static for each qualifying county for 3 years, the special wage index will need to be updated (using the final wage index in Table 10) because the post-reclassification CBSA wage index has changed.

NOTE: Payment for Distinct Part Units (DPUs) located in an acute care hospital is based on the wage index for the labor market area where the hospital is located even if the hospital has a reclassified wage index. If the DPU falls in a CBSA eligible to receive the 505 outmigration adjustment, the DPU's final wage index should consist of the geographic wage index plus the appropriate outmigration adjustment.

Table 10: Wage Index by CBSA for NON-IPPS Hospitals that are Eligible for the CBSA Hold Harmless Provision and Section 505 Out-Commuting Adjustment[1]

Provider	CBSA	Section 505 Out commuting Adjustment	Hold Harmless	Final Wage Index for Calendar Year
013027	01	YES	YES	0.7968
014008	33660	YES	YES	0.7968
014009	19460	YES		0.8157
042007	38220	YES		0.8717
052035	42044	YES		1.1379
052037	40140	YES		1.1354
052039	42044	YES		1.1379
053034	42044	YES		1.1379
053037	40140	YES		1.1354
053304	42044	YES		1.1379
053306	42044	YES		1.1379
053308	42044	YES		1.1379
054074	46700	YES		1.5063
054077	37100	YES		1.1358
054089	41884	YES		1.5445
054093	40140	YES		1.1354
054111	40140	YES		1.1354
054122	34900	YES		1.3411
054123	44700	YES		1.2029
054135	42044	YES		1.1379
054141	46700	YES		1.5063
054144	41884	YES		1.5445
063033	22660	YES		0.9386
064007	14500	YES		1.0284
074000	14860	YES		1.2793
074003	25540	YES		1.2525
074012	14860	YES		1.2793
074014	14860	YES		1.2793
082000	48864	YES		1.0633
083300	48864	YES		1.0633
084001	48864	YES		1.0633
084002	48864	YES		1.0633
084003	48864	YES		1.0633
114018	11	YES		0.8086
153040	15	YES		0.8753
154047	15	YES		0.8753
154050	15	YES	YES	0.9699
183028	21060	YES		0.8716
184012	21060	YES		0.8716
192034	19	YES	YES	0.8643
192036	19	YES		0.8061
192040	19	YES		0.8061
192046	19	YES		0.8305
192050	19		YES	0.8408
193044	19	YES		0.8061
193079	35380	YES		0.8061

Provider	CBSA	Section 505 Out commuting Adjustment	Hold Harmless	Final Wage Index for Calendar Year
193091	19	YES		0.7767
194063	19		YES	0.8649
194080	19	YES		0.8305
194085	19		YES	0.766
194088	19		YES	0.766
212002	25180	YES		0.9443
213029	13644	YES		1.0888
214003	25180	YES		0.9443
214013	13644	YES		1.0888
222000	15764	YES		1.1252
222003	15764	YES		1.1252
222026	21604	YES		1.1063
222044	21604	YES		1.1063
222047	21604	YES		1.1063
222048	49340	YES		1.0852
223026	15764	YES		1.1252
223028	21604	YES		1.1063
223029	49340	YES		1.0852
223033	49340	YES		1.0852
224007	15764	YES		1.1252
224022	15764	YES		1.1252
224026	49340	YES		1.0852
224032	49340	YES		1.0852
224033	21604	YES		1.1063
224038	15764	YES		1.1252
232020	13020	YES		1.0179
232023	47644	YES		1.019
232025	35660	YES		0.9164
232028	12980	YES		0.9811
232034	23		YES	0.9554
232036	27100	YES		1.0106
233025	12980	YES		0.9811
233028	47644	YES		1.0199
234011	47644	YES		1.0199
234021	47644	YES		1.019
234023	47644	YES		1.0199
234039	47644	YES		1.019
254009	25	YES		0.8438
293029	16180	YES		0.9929
303026	40484	YES		1.2093
304001	40484	YES		1.2093
312018	20764	YES		1.1752
312019	35084	YES		1.2107
313025	35084	YES		1.2107
313027	45940	YES		1.1494
314010	35084	YES		1.2107
314011	20764	YES		1.1752
314013	45940	YES		1.1494

Provider	CBSA	Section 505 Out commuting Adjustment	Hold Harmless	Final Wage Index for Calendar Year
314020	35084	YES		1.2107
323032	29740	YES		0.9187
324010	29740	YES		0.9187
324012	29740	YES		0.9187
334017	39100	YES		1.1526
334061	39100	YES		1.1526
344001	39580	YES		0.9775
344004	34	YES		0.959
344014	39580	YES		0.9775
362007	36	YES		0.8896
362032	15940	YES		0.9076
364031	15940	YES		0.9076
364040	44220	YES		0.8851
372016	37		YES	0.8883
372019	37	YES	YES	0.8203
374017	37	YES		0.804
384008	41420	YES		1.0358
392031	27780	YES		0.8574
392034	10900	YES		1.1602
393026	39740	YES		0.9909
393037	49620	YES		0.9594
394014	39740	YES		0.9909
394016	39	YES		0.8354
394020	30140	YES		0.9015
423029	11340	YES		0.9129
424011	11340	YES		0.9129
444008	44	YES		0.8529
452018	23104	YES		0.9653
452019	23104	YES		0.9653
452028	23104	YES		0.9653
452041	43300	YES		0.8783
452088	23104	YES		0.9653
453040	23104	YES		0.9653
453041	23104	YES		0.9653
453042	23104	YES		0.9653
453089	45	YES		0.842
453094	23104	YES		0.9653
453300	23104	YES		0.9653
454009	45	YES		0.8553
454012	23104	YES		0.9653
494029	49	YES		0.8123
503301	45104	YES		1.0765
504003	45104	YES		1.0765
513025	51340	YES		0.8795
522005	39540	YES		0.9807

Table 10 includes a list of CBSAs and special wage index values for Non-IPPS hospitals (based on November 2006 OSCAR data and the October 2006 OPSF) that are eligible to receive either the 505

adjustment in CY 2007 and/or qualify for the hold harmless provision in CY 2007. A final special wage index is given for each hospital and the components of that final wage index. All other Non-IPPS providers not subject to a special wage index should use the post reclassification wage index for their CBSA location.

Some special wages for hospitals participating in IPPS will change after the first quarter of OPPS implementation, on April 1, 2007, due to expiring reclassifications authorized by section 508 of the MMA. The inpatient PSF will need to be updated by April 1, 2007. The CMS plans to send a Joint Signature Memorandum (JSM) reminding contractors to update the Special Wage Index field in March 2007. Because only providers participating in IPPS are eligible to receive the section 508 reclassification, special wage changes will be handled through the IPSF and not the OPSF.

The expiring reclassification also changes the geographic wage index for a handful of CBSAs between the first and final quarters of the calendar year. So long as the contractor has entered the appropriate CBSA in the OPSF for non-IPPS providers, PRICER will handle this change. In table 10, above, no non-IPPS providers receiving the 505 out-commuting adjustment or held harmless for changes in geographic classification were located in a CBSA with different wage indices between January and April, and April and December, requiring the contractors to enter only one special wage.

15. Changes to OPPS PRICER Logic

a. Hospitals reclassified for IPPS effective October 1, 2006, will be reclassified for OPPS effective January 1, 2007.

b. Section 401 designations and floor MSA designations effective October 1, 2006, will be effective for OPPS January 1, 2007.

c. Rural sole community hospitals will receive a 7.1 percent payment increase in 2007.

d. Effective for services furnished on or after January 1, 2006, Essential Access Community Hospitals (EACH) (provider types 21 and 22) will receive a 7.1 percent payment increase.

e. New OPPS payment rates and coinsurance amounts will be effective January 1, 2007. All coinsurance rates will be limited to 40 percent of the APC payment rate. Coinsurance rates cannot exceed the inpatient deductible of $992.

f. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2007. This threshold of 1.75 is multiplied by the total line item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount. The payment formula is (cost-(APC payment x 1.75))/2.

g. However, there will be a change in the fixed threshold in 2007. The estimated cost of service must be greater than the APC payment amount plus $1,825 in order to qualify for outlier payments. The previous fixed dollar threshold was $1,250.

h. For outliers for Community Mental Health Centers (CMHC: bill type 76x), there will be no change in the multiple threshold of 3.4 for 2007. This threshold of 3.4 is multiplied by the total line item APC payment to determine eligibility for outlier payments. This factor is also used to

determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment formula is (cost-(APC payment x 3.4))/2.

i. Effective January 1, 2007, the device offset amount will be updated as explained in Section B.1 above.

j. Effective January 1, 2007, the OPPS PRICER will respond to lines that have a new OCE Payment Adjustment Flag (PAF) #7 (i.e., No Cost Item) applied to the line. The OPPS OCE will apply the PAF #7 whenever a line comes in with a HCPCS on the list of codes subject to this adjustment (as specified in Section B.3 above) along with a subsequent –FB modifier. When the PAF #7 comes to OPPS PRICER, it will apply the offset reduction to offset the device portion from the procedure/device APC payment. The procedure payment amount remaining after the offset reduction is subject to normal procedure discounting rules. That means the procedure payment amount remaining after the offset reduction should be discounted, if appropriate, for lines that have an -FB modifier and are on the list of APCs to receive the offset. The OPPS PRICER will take the line item payment and apply the offset before coinsurance logic so that the coinsurance is based on the payment amount remaining after the offset reduction is taken.

k. Effective January 1, 2007, blood and blood products will be eligible for outlier payments.

16. 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/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5438.1	Medicare contractors shall install the January 2007 OPPS PRICER.	X		X			X	X				
5438.2	Medicare contractors shall mass adjust all paid OPPS claims for EACHs (provider type "21" or "22" in the OPSF) that have dates of service in 2006 and were not priced using the new 2007 OPPS PRICER.	X		X			X					

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5438.3	Medicare contractors shall update the OPSF provider records for CY 2007.	X		X			X					
5438.3.1	Medicare contractors shall update the CBSA value for each provider (as given in table 10).	X		X			X					
5438.3.2	Medicare contractors shall update the OPSF for providers who qualify for the 505 adjustment and/or are held harmless in CY 2007, by doing the following: 1) Enter a value of "1" in the Special Payment Indicator field on the OPSF; and 2) Enter the final wage index value (given for the provider in Table 10) in the Special Wage Index field in the OPSF.	X		X			X					
5438.3.3	Medicare contractors shall update the OPSF records for providers who received a special wage index in CY 2006, but no longer receive it in CY 2007 by doing the following: 1) Create a new provider record, effective January 1, 2007; and 2) Enter a blank in the special payment indicator field; and 3) Enter zeroes in the special wage index field. **NOTE:** Although the 505 adjustment is static for each qualifying county for 3 years, the special wage index will need to be updated (using the final wage index in Table 10) because the post- reclassification CBSA wage index has changed. **NOTE:** Payment for Distinct Part Units (DPUs) located in an acute care hospital is based on the wage index for the labor market	X		X			X					

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	area where the hospital is located even if the hospital has a reclassified wage index. If the DPU falls in a CBSA eligible to receive the 505 outmigration adjustment, the DPU's final wage index should consist of the geographic wage index plus the appropriate outmigration adjustment.											

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5438.4	A provider education article related to this instruction will be available at 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 one 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.	X		X			X					

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 the space below:

V. CONTACTS

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

Post-Implementation Contact(s): Regional Office

VI. FUNDING

A. *For TITLE XVIII Contractors*, 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 only one of the following statements:

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 specified 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. 1139, 12-22-06)

Transmittals for Chapter 4

Crosswalk to Old Manuals

61.3.1 - Reporting and Charg*ing* Requirements When a Device is Replaced Without Cost to the Hospital

(Rev. 1139, Issued: 12-22-06; Effective: 01-01-07; Implementation: 01-02-07)

When a hospital: 1) replaces a device listed on the table of devices subject to warranty or recall adjustment (found on the CMS Web site at: www.cms.hhs.gov/HospitalOutpatientPPS); and 2) receives the device without cost from a manufacturer, the hospital must append modifier -FB to the procedure code (not the device code) that reports the services provided to replace the device. The hospital must report a token charge for the device (less than $1.01) in the covered charges field.

This includes circumstances in which the cost of the replacement device is less than the cost of the device being replaced, such that the hospital incurs no net cost for the device being inserted. For example, if a device that originally cost $20,000 fails and is replaced by a device that costs $16,000 and for which the manufacturer gives a credit of $16,000, there is no cost to the hospital for the device being inserted and the hospital would report the FB modifier (assuming that the APC and device code criteria are met).

61.3.2 - Reporting and Charg*ing* Requirements When the Hospital Receives Credit for the Replaced Device against the Cost of a More Expensive Replacement Device

(Rev. 1139, Issued: 12-22-06; Effective: 01-01-07; Implementation: 01-02-07)

When a hospital: 1) replaces a device listed on the table of devices subject to warranty or recall adjustment (found on the CMS Web site at: www.cms.hhs.gov/HospitalOutpatientPPS); and 2) receives a credit in the amount that the device being replaced would otherwise cost, the hospital must append modifier -FB to the procedure code (not on the device code) that reports the services provided to replace the device. The hospital must charge the difference between its usual charge for the device being implanted and its usual charge for the device for which it received credit. This charge should be billed in the covered charges field.

Hospitals should not report modifier -FB when the hospital receives a credit for a failed device that appears on the table of devices subject to warranty or recall adjustment and the amount of the credit is less than the amount that the device would otherwise cost the hospital. For example, a device fails in the 6th month of a 1 year warranty and under the terms of the warranty, the hospital receives a credit of 50 percent of the cost of a replacement device. The hospital should not report modifier –FB on the procedure code in which the device is implanted.

160 - *Clinic and Emergency Visits*

(Rev. 1139, Issued: 12-22-06; Effective: 01-01-07; Implementation: 01-02-07)

We have acknowledged from the beginning of the OPPS that we believe that CPT Evaluation and Management (E/M) codes were designed to reflect the activities of

physicians and do not describe well the range and mix of services provided by hospitals during visits of clinic and emergency department patients. While awaiting the development of a national set of facility-specific codes and guidelines, providers should continue to apply their current internal guidelines to the existing CPT codes. Each hospital's internal guidelines should follow the intent of the CPT code descriptors, in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the codes. Hospitals should ensure that their guidelines accurately reflect resource distinctions between the five levels of codes.

Effective January 1, 2007, we are distinguishing between two types of emergency departments: Type A emergency departments and Type B emergency departments.

A Type A emergency department is defined as an emergency department that is available 24 hours a day, 7 days a week and is either licensed by the State in which it is located under applicable State law as an emergency room or emergency department or it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

A Type B emergency department is defined as an emergency department that meets the definition of a "dedicated emergency department" as defined in 42 CFR 489.24 under the EMTALA regulations. It must meet at least one of the following requirements:

(1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;

(2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or

(3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

Hospitals must bill for visits provided in Type A emergency departments using CPT emergency department E/M codes. Hospitals must bill for visits provided in Type B emergency departments using the G-codes that describe visits provided in Type B emergency departments.

Hospitals that will be billing the new Type B ED visit codes may need to update their internal guidelines to report these codes.

160.1 Critical Care Services

(Rev. 1139, Issued: 12-22-06; Effective: 01-01-07; Implementation: 01-02-07)

Beginning January 1, 2007, critical care services will be paid at two levels, depending on the presence or absence of trauma activation. Providers will receive one payment rate for critical care without trauma activation and will receive additional payment when critical care is associated with trauma activation.

To determine whether trauma activation occurs, follow the National Uniform Billing Committee (NUBC) guidelines in the Claims Processing Manual, Pub 100-04, Chapter 25, §60.4 related to the reporting of the trauma revenue codes in the 68x series. The revenue code series 68x can be used only by trauma centers/hospitals as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons. Different subcategory revenue codes are reported by designated Level 1-4 hospital trauma centers. Only patients for whom there has been prehospital notification based on triage information from prehospital caregivers, who meet either local, state or American College of Surgeons field triage criteria, or are delivered by inter-hospital transfers, and are given the appropriate team response can be billed a trauma activation charge.

When critical care services are provided without trauma activation, the hospital may bill CPT code 99291, Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes (and 99292, if appropriate). If trauma activation occurs under the circumstances described by the NUBC guidelines that would permit reporting a charge under 68x, the hospital may also bill one unit of code G0390, which describes trauma activation associated with hospital critical care services. Revenue code 68x must be reported on the same date of service. The OCE will edit to ensure that G0390 appears with revenue code 68x on the same date of service and that only one unit of G0390 is billed. We believe that trauma activation is a one-time occurrence in association with critical care services, and therefore, we will only pay for one unit of G0390 per day.

The CPT code 99291 is defined by CPT as the first 30-74 minutes of critical care. This 30 minute minimum has always applied under the OPPS. The CPT code 99292, Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes, remains a packaged service under the OPPS, so that hospitals do not have the ongoing administrative burden of reporting precisely the time for each critical service provided. As the CPT guidelines indicate, hospitals that provide less than 30 minutes of critical care should bill for a visit, typically an emergency department visit, at a level consistent with their own internal guidelines.

Under the OPPS, the time that can be reported as critical care is the time spent by a physician and/or hospital staff engaged in active face-to-face critical care of a critically ill or critically injured patient. If the physician and hospital staff or multiple hospital staff members are simultaneously engaged in this active face-to-face care, the time involved can only be counted once.

- *In CY 2007 hospitals may continue to report a charge with RC 68x without any HCPCS code when trauma team activation occurs. In order to receive additional payment when critical care services are associated with trauma activation, the hospital must report G0390 on the same date of service as RC 68x, in addition to CPT code 99291 (or 99292, if appropriate.)*

- *In CY 2007 hospitals should continue to report 99291 (and 99292 as appropriate) for critical care services furnished without trauma team activation. CPT 99291 maps to APC 0617 (Critical Care). (CPT 99292 is packaged and not paid separately, but should be reported if provided.)*

220 - Billing Codes for Intensity Modulated Radiation Therapy (IMRT) and Stereotactic Radiosurgery (SRS)

(Rev. 1139, Issued: 12-22-06; Effective: 01-01-07; Implementation: 01-02-07)

220.1 - Billing for IMRT Planning and Delivery

(Rev. 1139, Issued: 12-22-06; Effective: 01-01-07; Implementation: 01-02-07)

Effective for services furnished on or after April 1, 2002, *HCPCS* codes G0174 *(IMRT delivery) and G0178 (IMRT planning) are no longer valid codes. HCPCS code G0174 has been replaced with CPT codes 77418 and 0073T for IMRT delivery and HCPCS code G0178 with CPT code 77301. Therefore, hospitals must use CPT codes 77418 or 0073T for IMRT delivery and CPT code 77301 for IMRT planning. Any of the CPT codes 77401 through 77416 or 77418 may be reported on the same day as long as the services are furnished at a separate treatment sessions. In these cases, modifier -59 must be appended to the appropriate codes. Additionally, in the context of billing 77301, regardless of the same or different dates of service, CPT codes 77280-77295, 77305-77321, 77331, 77336, and 77370 may only be billed in addition to 77301 if they are not provided as part of developing the IMRT treatment plan.*

77301	*Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications*
77418	*Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic mlc, per treatment session*
0073T	*Compensator-based beam modulation treatment delivery of inverse planned treatment using three or more high resolution (milled or cast) compensator convergent beam modulated fields, per treatment session*

220.2 *- Additional Billing Instructions for IMRT Planning*

(Rev. 1139, Issued: 12-22-06; Effective: 01-01-07; Implementation: 01-02-07)

Payment for the services identified by CPT codes 77280 through 77295, 77300, and 77305 through 77321, 77336, and 77370 are included in the APC payment for IMRT

planning. Therefore, these codes should not be billed in addition to the IMRT planning code.

However, payment for IMRT planning does not include payment for services described by CPT codes 77332 through 77334. When provided, these services should be billed in addition to the IMRT planning code.

220.3 - *Billing for Multi-Source Photon (Cobalt 60-Based) Stereotactic Radiosurgery (SRS) Planning and Delivery*

(Rev. 1139, Issued: 12-22-06; Effective: 01-01-07; Implementation: 01-02-07)

Effective for services furnished on or after *January 1, 2006,* hospitals must bill for *multi-source photon (cobalt 60-based) SR planning using existing CPT codes that most accurately describe the service furnished, and HCPCS code G0243 for the delivery. For CY 2007, HCPCS code G0243 will no longer be reportable under the hospital OPPS because the code will be deleted and replaced with CPT code 77371, effective January 1, 2007.*

77371 Radiation treatment delivery, stereotactic radiosurgery (SRS) (complete course of treatment of cerebral lesion[s] consisting of 1 session); multi-source Cobalt 60 based.

Payment for CPT code 20660 is included in CPT code 77371; therefore, hospitals should not report 20660 separately.

220.4 - *Billing for Linear Accelerator (Robotic Image-Guided and Non-Robotic Image-Guided) SRS Planning and Delivery*

(Rev. 1139, Issued: 12-22-06; Effective: 01-01-07; Implementation: 01-02-07)

Effective for services furnished on or after January 1, 2006, hospitals must bill using existing CPT codes that most accurately describe the service furnished for both robotic and non-robotic image-guided SRS planning. For robotic image-guided SRS delivery, hospitals must bill using HCPCS code G0039 for the first session and HCPCS code G0340 for the second through the fifth sessions. For non-robotic image-guided SRS delivery, hospitals must bill G0173 for delivery if the delivery occurs in one session, and G0251 for delivery per session (not to exceed five sessions) if delivery occurs during multiple sessions.

Linear Accelerator-Based Robotic Image-Guided SRS	
Planning	Use existing CPT codes
Delivery	G0339 (complete, 1st session) G0340 (2nd – 5th session)

Linear Accelerator-Based Non-Robotic Image-Guided SRS	
Planning	Use existing CPT codes

Delivery	G0173 (single session) G0251 (multiple)

G0173 *Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, complete course of treatment in one session, all lesions.*

G0251 *Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum 5 sessions per course of treatment.*

G0339 *Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment.*

G0340 *Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment*

230.2 - Coding and Payment for Drug Administration

(Rev. 1139, Issued: 12-22-06; Effective: 01-01-07; Implementation: 01-02-07)

A. Overview

Drug administration services furnished under the Hospital Outpatient Prospective Payment System (OPPS) during CY 2005 were reported using CPT codes 90780, 90781, and 96400-96459.

Effective January 1, 2006, some of these CPT codes were replaced with more detailed CPT codes incorporating specific procedural concepts, as defined and described by the CPT manual, such as *initial, concurrent, and sequential.*

Hospitals are instructed to use the full set of CPT codes, including those codes referencing concepts of initial, concurrent, and sequential, to bill for drug administration services furnished in the hospital outpatient department beginning January 1, 2007. In addition, hospitals are instructed to continue billing the HCPCS codes that most accurately describe the service(s) provided.

Hospitals are reminded to bill a separate Evaluation and Management code (with modifier 25) only if a significant, separately identifiable E/M service is performed in the same encounter with OPPS drug administration services.

B. Billing for Infusions and Injections

In CY 2007, hospitals are instructed to use the full set of drug administration CPT codes (90760-90779; 96401-96549) when billing for drug administration services provided in the hospital outpatient department. In addition, hospitals are to continue to bill HCPCS code C8957 (Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump) when appropriate. Hospitals are expected to report all drug administration CPT codes in a manner

consistent with their descriptors, CPT instructions, and correct coding principles. Hospitals should note the conceptual changes between CY 2006 drug administration codes effective under the OPPS and the CY 2007 CPT codes in order to ensure accurate billing under the OPPS.

Medicare's general policy regarding physician supervision within hospital outpatient departments meets the physician supervision requirements for use of CPT codes 90760-90779, 96401-96549. (Reference: Medicare Benefit Policy Manual, Pub.100-02, Chapter 6, §20.4.1.)

C. Payments For Drug Administration Services

For CY 2007, OPPS drug administration APCs have been restructured resulting in a six-level hierarchy where active HCPCS codes have been assigned according to their clinical coherence and resource use. Contrary to the CY 2006 payment structure that bundled payment for several instances of a type of service (non-chemotherapy, chemotherapy by infusion, non-infusion chemotherapy) into a per-encounter APC payment, the CY 2007 structure provides a separate APC payment for each reported unit of a separately payable HCPCS code.

Hospitals should note that the transition to the full set of CPT drug administration codes provides for conceptual differences when reporting, such as those noted below.

- *In CY 2006, hospitals were instructed to bill for the first hour (and any additional hours) by each type of infusion service (non-chemotherapy, chemotherapy by infusion, non-infusion chemotherapy). In CY 2007, the first hour concept no longer exists. CY 2007 CPT codes allow for only one initial service per encounter, for each vascular access site, no matter how many types of infusion services are provided; however, hospitals will receive an APC payment for the initial service and separate APC payment(s) for additional hours of infusion or other drug administration services provided that are separately payable.*

- *In CY 2006, hospitals providing infusion services of different types (non-chemotherapy, chemotherapy by infusion, non-infusion chemotherapy) received payment for the associated per-encounter infusion APC even if these infusions occurred during the same time period. In CY 2007, CPT instructions allow reporting of only one initial drug administration service, including infusion services, per encounter for each distinct vascular access site, with other services through the same vascular access site being reported via the sequential, concurrent or additional hour codes.*

*(**NOTE**: This list provides a brief overview of a limited number of the conceptual changes between CY 2006 OPPS drug administration codes and CY 2007 OPPS drug administration codes - this list is not*

comprehensive and does not include all items hospitals will need to consider during this transition)

For CY 2007 APC payment rates, refer to Addendum B on the CMS Web site at http://www.cms.hhs.gov/HospitalOutpatientPPS/.

D. Infusions Started Outside the Hospital

Hospitals may receive Medicare beneficiaries for outpatient services who are in the process of receiving an infusion at their time of arrival at the hospital (e.g. a patient who arrives via ambulance with an ongoing intravenous infusion initiated by paramedics during transport). Hospitals are reminded to bill for all services provided using the HCPCS code(s) that most accurately describe the service(s) they provided. *This includes hospitals reporting an initial hour of infusion, even if the hospital did not initiate the infusion, and additional HCPCS codes for additional or sequential infusion services if needed.*