CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 896

Department of Health & Human Services DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: MARCH 24, 2006

Change Request 5011

SUBJECT: April 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 April 2006 OPPS update. The April 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.

NEW/REVISED MATERIAL
EFFECTIVE DATE: April 01, 2006
IMPLEMENTATION DATE: April 03, 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 – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title

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: 896	Date: March 24, 2006	Change Request 5011

SUBJECT: April 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 April 2006 OPPS update. The April 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.

April 2006 revisions to the OPPS OCE data files, instructions, and specifications are provided in Change Request 4360, "April 2006 Outpatient Prospective Payment System Code Editor (OPPS OCE) Specifications Version 7.1." April 2006 instructions related to bills for certain ASP-priced drugs were provided in Change Request (CR) 4371, Transmittal 875, issued February 24, 2006.

This notification further describes changes to, and billing instructions for, various payment policies to be implemented in the April 2006 OPPS update.

B. Policy:

1. Billing Clarification for Intensity Modulated Radiation Therapy (IMRT)

Intensity modulated radiation therapy (IMRT), also known as conformal radiation, delivers radiation with adjusted intensity to preserve adjoining normal tissue. The IMRT has the ability to deliver a higher dose of radiation within the tumor while delivering a lower dose of radiation to surrounding healthy tissue. The IMRT is provided in two treatment phases, planning and delivery. Two methods by which IMRT can be delivered to patients include multi-leaf collimator-based IMRT and compensator-based IMRT.

We have received several inquiries seeking clarification of the appropriate billing of certain radiation oncology services when such services are performed in conjunction with an IMRT planning service. We have provided such clarification of our billing policy under (a) below. Our billing instructions described under (b) thru (e) below remain unmodified since our issuance of CR 4250, Transmittal 804, issued January 3, 2006.

Effective January 1, 2006, when IMRT is furnished to beneficiaries in a hospital outpatient department that is paid under the hospital outpatient prospective payment system (OPPS), hospitals should bill according to the following guidelines:

a.) Do not report CPT codes 77280-77295, 77305-77321, 77331, 77336, and 77370 when these services are directly linked to and performed as part of developing an IMRT plan that is reported using CPT code 77301. When the above-mentioned services are performed as part of developing an IMRT plan, the charges for these services should be included in the charge associated with CPT code 77301, even if the individual services associated with IMRT planning are performed on dates of service other than the date on which CPT code 77301 is reported.

b.) Hospitals are not prohibited from using existing CPT code 77301 to bill for compensator-based IMRT planning in the hospital outpatient setting.

c.) As instructed in the 2006 CPT manual, hospitals should bill CPT code 77418 for multi-leaf collimator-based IMRT delivery, and Category III CPT code 0073T for compensator-based IMRT delivery in the hospital outpatient setting.

d.) Payment for IMRT planning does not include payment for CPT codes 77332 - 77334 when furnished on the same day. When services described by CPT codes 77332-77334 are furnished on the same date of service with 77301, these services are to be billed in addition to the IMRT planning code 77301.

e.) Providers billing for both CPT codes 77301 (IMRT treatment planning) and 77334 (design and construction of complex treatment devices) on the same day should append a modifier –59.

2. Provider Information on Drug Administration Correct Coding Initiative (CCI) Edits

The CCI edits will be activated under the OPPS for drug administration services beginning in April 2006. CMS developed the Correct Coding Initiative (CCI) to promote national correct coding methodologies and to prevent improper coding that could lead to inappropriate Part B payments. The CCI edits are based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. Appropriate CCI edits already apply to many services billed under the OPPS.

CMS suspended application of the CCI edits for OPPS drug administration codes for a brief period to allow hospitals sufficient time to incorporate into their systems a series of coding changes that were being implemented under the OPPS. However, the drug administration CCI edits support correct coding and they are appropriate for the coding of hospital outpatient services. Therefore, CMS is reinstating the drug administration CCI edits in April 2006.

As with other CCI edits that will be implemented beginning in April 2006 (OCE CCI version 12.0), the applicable drug administration edits will be posted on the CMS Web site at: http://www.cms.hhs.gov/ shortly before they are activated. Hospitals can refer to the CCI Coding Manual for Medicare Services posted on the CMS Web site for a discussion of CCI principles relating to drug administration services. In addition, hospitals may want to review the CCI edits implemented by Medicare carriers in January 2006 for more information, as OPPS edits are implemented one-calendar quarter behind carrier edits. However, it is important to note that specific CCI edits in the OCE may differ from edits used by carriers, both with respect to whether a modifier is allowed with a specific code pair and to whether certain edits are actually incorporated in the OCE.

Please note that when an OPPS claim triggers a CCI edit, the entire claim **WILL NOT** be rejected or returned, only the line item will be rejected. The CCI edits identify a pair of codes where the second code should not be payable with the first code unless an edit permits use of a modifier. The CCI edits may not allow payment of the second code (likely a drug administration code), when reported with the first code in the edit pair. **The claim will continue to process to payment for the first code**. Hospitals may want to review their use of applicable modifiers to ensure that services that are appropriate for separate payment are properly coded.

CMS has posted a series of drug administration questions and answers (Q and As) on the CMS Web site [available by going to the OPPS portion of the CMS Web site and selecting "OPPS Guidance" from the menu on the left side of the page], which includes links to the CCI portion of the CMS Web site. Information about the CCI can also be accessed from the CMS Web site by going to www.cms.hhs.gov , clicking "Medicare", then under the "Coding" heading, clicking "National Correct Coding Initiative Edits". If, after reading the posted information, hospitals continue to have questions about the CCI edit process, or specific hospital outpatient billing questions, they should contact the Medical Director at their local FI. The contractor Medical Directors are in the best position to answer provider questions accurately and in a timely manner, taking into account both local and national policies. Hospitals should direct questions about specific CCI edits to the National Correct Coding Initiative at the address listed on the CCI portion of the CMS Web site.

3. Drugs and Biologicals

a.) Drugs and Biologicals with Payment Rates Based on Average Sales Price (ASP) Effective April 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, we will incorporate changes to the payment rates in the April 2006 release of the OPPS PRICER. We are not publishing the updated payment rates in this program instruction implementing the April 2006 update of the OPPS. However, the updated

payment rates effective April 1, 2006, can be found in the April 2006 update of the OPPS Addendum A and Addendum B on the CMS Web site.

b.) Updated Payment Rate for HCPCS C9129 Effective July 1, 2005 through September 30, 2005

The payment rate for the drug listed below was incorrect in the October 2005 OPPS PRICER. The corrected payment rate was installed in the January 2006 OPPS PRICER, effective for services furnished on July 1, 2005, through implementation of the October 2005 update.

HCPCS	APC	Short Description	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9129	9129	Inj clofarabine	$116.83	$23.37

c.) Updated Payment Rates for Certain Drugs and Biologicals Effective October 1, 2005 through December 31, 2005

The payment rates for the drugs and biologicals listed below were incorrect in the October 2005 OPPS PRICER. The corrected payment rates were installed in the January 2006 OPPS PRICER, effective for services furnished on October 1, 2005, through implementation of the January 2006 update.

HCPCS	APC	Short Description	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9129	9129	Inj clofarabine	$116.87	$23.37
C9212	9212	Inj, alefacept, IM	$398.34	$79.67
J9216	0838	Interferon gamma 1-b inj	$272.44	$54.49
Q4079	9126	Injection, Natalizumab, 1 MG	$6.39	$1.28

d.) Newly-Approved Drugs Eligible for Pass-Through Status

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

HCPCS	APC	SI	Long Description
C9227	9227	G	Injection, micafungin sodium, per 1 mg
C9228	9228	G	Injection, tigecycline, per 1 mg

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. 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 per HCPCS when HCPCS definitions or codes are changed.

4. Coverage Determinations

The fact that a drug, device, procedure, or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Fiscal intermediaries determine whether a drug, device, procedure, or 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	
5011.1	The Shared System Maintainer (SSM) shall install the OPPS PRICER for April 2006.					X				
5011.2	Contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service that fall on or after July 1, 2005, but before January 1, 2006; and 2) Contain HCPCS C9129; and 3) Were previously processed through the October 2005 OPPS PRICER.	X	X							
5011.3	Contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service that fall on or after October 1, 2005, but before January 1, 2006; and 2) Contain at least one of the following HCPCS: C9212, J9216, Q4079; and 3) Were previously processed through the October 2005 OPPS PRICER.	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	
5011.4	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn 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 Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X							

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*: April 1, 2006 **Implementation Date:** April 3, 2006 **Pre-Implementation Contact(s):** Marina Kushnirova at 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.**

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