CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1209	**Date: MARCH 21, 2007**
	Change Request 5544

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

I. SUMMARY OF CHANGES: This Recurring Update Notification describes changes to, and billing instructions for, various payment policies implemented in the April 2007 OPPS update. The April 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.

New / Revised Material
Effective Date: April 1, 2007
Implementation Date: April 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	4/220.2/Additional Billing Instructions for IMRT Planning

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:

Recurring Update Notification
Manual Instruction

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1209	Date: March 21, 2007	Change Request: 5544

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

Effective Date: **April 1, 2007**

Implementation Date: April 2, 2007

I. GENERAL INFORMATION

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

April 2007 revisions to OPPS OCE data files, instructions, and specifications are provided in Change Request (CR) 5522, "April 2007 Outpatient Prospective Payment System Code Editor (OPPS OCE) Specifications Version 8.1."

B. Policy:

1. Additional Payment Information for Current Pass-Through Category C1820

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 CY 2006, when we created 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. In Transmittal 1139, CR 5438, issued December 22, 2006, we indicated that for CY 2007, the device offset portion for C1820, when billed with a procedure in APC 0222, is $8,668.94.

We have recently been informed that at least some rechargeable neurostimulators described by C1820 may also be used and therefore be billed with CPT code 61885, Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to single array, and we have changed the procedure to device edits accordingly. This change is effective January 1, 2006, and is implemented in the April 2007 OPPS OCE.

The CPT code 61885 maps to APC 0039, which has a CY 2007 offset percent of 78.85 percent (71 FR 68077). Based on this percent, the device offset to be subtracted from the payment for

C1820, when it is billed with CPT code 61885, is $9081.94. We note that the offset amount from the APC payment is wage adjusted before it is subtracted from the device cost.

2. Payment for Certain Laboratory Services

Effective for services furnished on or after the date listed in the table below, the unlisted laboratory CPT codes in the table are assigned to a status indicator of "A." The clinical lab fee schedule does not provide a payment amount for these unlisted laboratory CPT codes, since the carrier prices them. Therefore, the FI must review the narrative description of the test submitted by the hospital to determine if a specific HCPCS code is available to describe the laboratory test. If there is a specific HCPCS code available, this code should be reported by the hospital for the laboratory test, rather than an unlisted laboratory CPT code. If there is no appropriate specific code, the FI should determine if the laboratory test is covered and, if so, the FI should contact the carrier in the hospital's jurisdiction to obtain an appropriate payment amount for the laboratory test reported with the unlisted laboratory CPT code. If that carrier cannot provide a payment amount for the service, then to establish a payment rate the FI should contact the carrier in the jurisdiction of the reference laboratory that performed the test. If neither carrier has a payment amount for the test and the FI determines that the service is covered, the FI must determine the payment amount.

Contractors should not search to adjust payment for claims previously paid. However, contractors shall adjust paid claims brought to their attention.

Beneficiary co-insurance and deductible are not applied to unlisted clinical laboratory services.

If an FI requires a payment rate for an unlisted laboratory CPT code to pay a non-OPPS hospital's claim, the FI should follow the process described above to develop a payment amount for the laboratory test.

HCPCS Code	Long Descriptor	Effective Date
81099	Unlisted urinalysis procedure	08/01/00
84999	Unlisted chemistry procedure	08/01/00
85999	Unlisted hematology and coagulation procedure	08/01/00
86849	Unlisted immunology procedure	08/01/00
87999	Unlisted microbiology procedure	08/01/00

3. Clarification to Billing and Payment for Intensity Modulated Radiation Therapy (IMRT) Planning

In Transmittal 1139, CR 5438, issued December 22, 2006, we indicated that payment for the services identified by CPT codes 77280 through 77295, 77300, and 77305 through 77321, 77336, and 77370 was included in the APC payment for IMRT planning and therefore, these codes should not be billed in addition to the IMRT planning code.

We are clarifying our policy in this transmittal. Specifically, payment for the services identified by CPT codes 77280-77295, 77305-77321, 77331, 77336, and 77370 is included in the APC payment for IMRT planning when these services are performed as part of developing an IMRT plan that is reported using CPT code 77301. Under those circumstances, these codes should not be billed in addition to CPT code 77301 for IMRT planning.

4. Clarification to Payment Policy for 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.

This transmittal clarifies payment policy for stereotactic radiosurgery (SRS) service described by CPT code 77435. In Transmittal 1139, CR 5438, issued December 22, 2006, we inadvertently listed 77435 with status indicator of "B." However, the January 2007 update of the OPPS Addendum B posted on the CMS Web site, and the January 2007 OPPS OCE, contained the correct status indicator of "N."

5. Payment Status Indicators for "Special" Packaged CPT Codes: 36540, Collection of Blood Specimen from a Completely Implantable Venous Access Device; and 96523, Irrigation of Implanted Venous Access Device for Drug Delivery Systems

"Special" packaged CPT codes 36540 and 96523 were erroneously listed with status indicator "S" in Transmittal 1139, CR 5438, issued on December 22, 2006, and in the CY 2007 OPPS final rule. Although this error does not affect payment rates for the services described by these CPT codes, we are clarifying that their correct status indicator assigned by the OCE for separate payment is "X," as assigned to APC 624, Minor Vascular Access Device Procedures, in the January 2007 OPPS update of Addendum A.

6. Billing for Drugs, Biologicals, and Radiopharmaceuticals

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

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

In the CY 2007 OPPS final rule, it was stated that payments for separately payable drugs and biologicals based on average sale prices (ASPs) will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, we will incorporate changes to the payment rates in the April 2007 release of the OPPS PRICER. The updated payment rates effective April 1, 2007, will be included in the April 2007 update of the OPPS Addendum A and Addendum B, which will be posted on the CMS Web site at the end of March.

b. Updated Payment Rates for Certain Drugs and Biologicals Effective July 1, 2006 through September 30, 2006

The payment rates for the drugs and biologicals listed below were incorrect in the January 2007 OPPS PRICER. The corrected payment rates will be installed in the April 2007 OPPS PRICER effective for services furnished on July 1, 2006, through September 30, 2006.

HCPCS	APC	Short Description	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
90371	1630	Hep b ig, im	$118.29	$23.66
J2430	0730	Pamidronate disodium /30 MG	$36.17	$7.23
J7340	1632	Metabolic active D/E tissue	$25.66	$5.13
J7344	9156	Nonmetabolic active tissue	$93.06	$18.61
J9015	0807	Aldesleukin/single use vial	$723.38	$144.68

c. Updated Payment Rates for Certain Drugs and Biologicals Effective October 1, 2006 through December 31, 2006

The payment rates for the drugs and biologicals listed below were incorrect in the January 2007

OPPS PRICER. The corrected payment rates will be installed in the April 2007 OPPS PRICER effective for services furnished on October 1, 2006, through December 31, 2006.

HCPCS	APC	Short Description	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
90371	1630	Hep b ig, im	$113.27	$22.65
J2430	0730	Pamidronate disodium /30 MG	$35.46	$7.09
J7340	1632	Metabolic active D/E tissue	$21.37	$4.27
J7344	9156	Nonmetabolic active tissue	$89.31	$17.86
90716	9142	Chicken pox vaccine, sc	$72.28	$14.46
J0637	9019	Caspofungin acetate	$32.22	$6.44
J9265	0863	Paclitaxel injection	$15.11	$3.02

d. Correct Reporting of Units for Drugs

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

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.

7. Modification of Blood Deductible Edits

Joint Signature Memorandum (JSM) 07202 was issued on January 26, 2007, to notify contractors of the modification to CWF edit 61#8 so blood deductible is acceptable for ALL 38x revenue codes, instead of only revenue codes 380-382. In a similar manner, the CWF also modified all other CWF edits that require blood deductible, or "blood pints left," to only be acceptable on 380-382 revenue codes. The modified edits were put into production on January 29, 2007, and were effective for dates of service on or after July 1, 2005.

The CMS intended to apply the same edit modification to the Fiscal Intermediary Standard System (FISS) as well. However, expanding the revenue code range for blood deductible to all 38x revenue codes would be inconsistent with existing CMS policy to not calculate blood deductible for individual components of blood (e.g., plasma). Therefore, CMS is instructing FISS to expand the revenue code range for blood deductible to be allowable on revenue code lines 380-382 and 389, instead of only 380-382.

The CMS does not intend to revise the recently modified CWF edit parameters since the more rigid FISS editing will capture any incorrect application of the blood deductible before it processes through to CWF editing.

8. 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	
5544.1	Effective for dates of service during CY 2006, the April OPPS PRICER shall deduct $9,148.81 from the device pass-through payment for C1820 when it is billed with the implantation CPT code 61885 (APC 39).											OPPS PRICER

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	
5544.2	Effective for dates of service during CY 2007, the April OPPS PRICER shall deduct $9,081.94 from the device pass-through payment for C1820 when it is billed with the implantation CPT code 61885 (APC 39).											OPPS PRICER
5544.3	Medicare contractors shall install the April 2007 OPPS PRICER.	X		X			X	X				
5544.4	The FI shall review the narrative description of the test submitted by the hospital to determine if a specific HCPCS code is available to describe the laboratory test.	X		X			X					
5544.4.1	The FI shall contact the carrier in the hospital's jurisdiction to obtain an appropriate payment amount for the laboratory test reported with the unlisted laboratory CPT code when there is no appropriate specific code and if it was determined by the FI that the laboratory test was covered.	X		X			X					
5544.4.2	The FI shall contact the carrier in the jurisdiction of the reference laboratory that performed the test in order to establish a payment rate if that carrier cannot provide a payment amount for the service.	X		X			X					
5544.4.3	The FI shall determine the payment amount if neither carrier has a payment amount for the test and it was determined by the FI that the service is covered.	X		X			X					
5544.4.4	The FI shall follow the process described above to develop a payment amount for the laboratory test, if an FI requires a payment rate for an unlisted laboratory CPT code to pay a non-OPPS hospital's claim.	X		X			X					
5544.4.5	Contractors shall adjust paid claims brought to their attention that contain the following laboratory CPT codes: 81099, 84999, 85999, 86849, 87999, rather than search to adjust payment for claims previously paid.	X		X			X					
5544.5	Medicare contractors shall adjust as appropriate claims brought to their attention that:	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	
	1) Have dates of service that fall on or after July 1, 2006, but before October 1, 2006; 2) Contain at least one of the following HCPCS: 90371, J2430, J7340, J7344, J9015; and 3) Were previously processed through the January 2007 OPPS PRICER.											
5544.6	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service that fall on or after October 1, 2006, but before January 1, 2007; 2) Contain at least one of the following HCPCS: 90371, J2430, J7340, J7344, 90716, J0637, J9265; and 3) Were previously processed through the January 2007 OPPS PRICER.	X		X			X					
5544.7	Effective for dates of service on or after July 1, 2005, contractors shall modify any edits and reason codes so blood deductible, or "blood pints left" is acceptable on revenue codes 380, 381, 382 **and 389** (instead of only revenue codes 380-382, as is currently being edited).	X		X			X	X				

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	
5544.8	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	X		X			X					

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	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.											

IV. SUPPORTING INFORMATION

A. N/A

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. N/A

V. CONTACTS

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

Post-Implementation Contact(s): Regional office

VI. FUNDING

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

B. The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not

obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

220.2 - Additional Billing Instructions for IMRT Planning

(Rev. 1209, Issued: 03-21-07; Effective Date: 04-01-07; Implementation Date: 04-02-07)

Payment for the services identified by CPT codes 77280-77295, 77305-77321, *77331,* 77336, and 77370 *is included in the APC payment for IMRT planning when these services are performed as part of developing an IMRT plan that is reported using CPT code 77301. Under those circumstances, these codes should not be billed in addition to CPT code 77301 for IMRT planning.*

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.