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Information for Medicare Fee-For-Service Health Care Professionals

Do you have your NPI? National Provider Identifiers (NPIs) will be required on claims sent on or after May 23, 2007. Every health care provider needs to get an NPI. Learn more about the NPI and how to apply for an NPI by visiting http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/index.html/NationalProvIdentStand/ on the CMS website.

MLN Matters Number: MM5438 | Related Change Request (CR) #: 5438

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Related CR Transmittal #: R1139CP | Implementation Date: January 2, 2007

Note: This article was updated on October 31, 2012, to reflect current Web addresses. All other information remains unchanged.

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)

Provider Types Affected

Providers submitting claims to Medicare fiscal intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs) and/or regional home health intermediaries (RHHIs) for outpatient services furnished under the OPPS.

Background

This article and related Change Request (CR) 5438 describes the 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 CR 5438.

Also take note, the language in the *Medicare Claims Processing Manual*, Publication 100-04, Chapter 4, 61.3.2, was revised to reflect discussions as to 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 cost.

In addition, the January 2007 revisions to OPPS OCE data files, instructions and specifications are provided in CR5425, "January 2007 Outpatient Prospective Payment System Code Editor (OPPS OCE) Specifications Version 8.0." The MLN Matters article related to CR5424 can be found at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM5425.pdf on the CMS website.

CR5348 contains a number of tables and detailed discussion that are not included in this article. For those interested in thes details, CR5438 may be accessed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1139CP.pdf on the CMS website. A summary of the key changes of CR5348 of interest to providers is in the next section of this article.

Key Points

- New Device Pass-Through Categories

  Section 1833(t)(6)(B) of the Social Security 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.

  CMS is establishing two new device pass-through categories as of January 1, 2007. Those codes are as follows:

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Device Offset From Payment
C1821	January 1, 2007	H	1821	Interspinous implant	Interspinous Process Distraction Device (implantable	$0.00
L8690	January 1, 2007	H	1032	Aud osseo Dev, int/ext comp	Auditory Osseo-integrated Device, includes all internal and external components	$0.00

- Device Offset from Payment

  Section 1833(t)(6)(D)(ii) of the Act requires that CMS 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, CMS 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 CMS created new category C1820, Generator, neurostimulator (implantable), with rechargeable battery and charging system, it was determined that CMS was 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.

- Payment for Brachytherapy Sources

  The Medicare Modernization Act of 2003 (MMA) requires Medicare 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, Medicare is still paying for specified brachytherapy sources separately, pursuant to the MMA; and at hospitals' charges adjusted to their cost per the Tax Relief and Health Care Act of 2006, which extends the charges adjusted to cost payment for brahytherapy sources until January 1, 2008. Therefore, the prospective payment rates for each source, which are listed in Addendum B to the CY 2007 final rule will not be used for payment. In addition, because of their cost-based payment methodology for CY2007, brachytherapy sources will not be eligible for outlier payments in CY2007. 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 codes for the CY 2007 separately paid sources, long descriptors and APCs are listed in the following table.

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.

- 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, CR5263, "Reporting and Payment of No-Cost Devices Furnished by Outpatient Prospective Payment System (OPPS) Hospitals", issued November 3, 2006. The MLN Matters article that relates to CR5263 is at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM5263.pdf on the CMS website. It is important that hospitals be familiar with the instructions in CR5263 regarding the reporting of the FB modifier, which is not to be reported if the hospital received partial credit for the device explanted. Incorrect reporting of the modifier may result in incorrect payment. Also, see Tables 3 and 4 of CR5438 for details of reporting devices with modifier FB. Wher a modifier is reported with any of the APCs in Table 3 of CR5438, Medicare will deduct the amount of the adjustment shown in the table before wage adjusting the Medicare payment. The copayment will be based on the reduced payment.

- 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:
  - Procedure to device edits that 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 http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html/HospitalOutpatientPPS/ under downloads on the OPPS page. Note that new edits for January 1, 2007 are found in yellow highlighting.
  - Device to procedure code edits, which are 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. 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 paid incorrectly.

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 is correctly reported on a claim, there must have been implantation of 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 http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html 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.

- 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 that falls outside predetermined floor and ceiling thresholds 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. CR3756, 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.

- 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.

- Rural Payments to Essential Access Community Hospitals (EACHs)
  Section 5105 of the DRA (Pub. L. 109-171) reinstituted the hold harmless transitional outpatient payments (TOPs) for covered OPD services furnished on or after January 1, 2006, and before January 1, 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. CMS 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, Medicare 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. CMS did not specifically address whether the adjustment applies to EACHs. Therefore, because EACHs are treated as SCHs, CMS is 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.

- Packaged Services

  For CY 2007, CMS is 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. Medicare assigns 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. The table below lists the status indicators and APC assignments for these "special" packaged codes when they are separately payable. 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 hospitals 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 of "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

CR5438 clarifies that CMS receives claims that contain only packaged codes. Note that although these claims are processed by the OCE and are ultimately rejected for payment, they are received by CMS, and CMS has cost data for packaged services based upon these claims. While CMS has 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, 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. CMS expects 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 low-level visit CPT codes, as described above, our current policy dictates that hospitals may only bill a low-level visit code if the hospital provides a significant, separately identifiable visit from any other services provided.

Earlier guidance, issued January 3, 2003, in section 12 of Transmittal A-02-129 was based upon past Medicare policy that a hospital could bill a low-level visit in addition to CPT code 97602, which was packaged in CY 2003 at the time of that instruction. However, beginning in CY 2006, Medicare provided for

separate payment for CPT code 97602, when it is performed as a nontherapy service in the hospital outpatient setting. Therefore, hospitals can report and be paid for this wound care service with the more specific CPT code available. This OPPS payment policy for nontherapy, nonselective wound care service will continue for CY 2007.

- Coding and Payment for Visits

  CMS will not replace CPT /E/M codes with G-codes for CY2007. 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, CMS is 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, CMS is 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 CMS to track the resource costs of Type B emergency departments (EDs) and determine how the costs for services provided in Type B EDs differ from clinic and Type A emergency department visit costs. The following table lists the short descriptors of the new codes.

Table of 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, Medicare will pay at 5 payment levels for clinic and 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 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 CMS collects 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. CMS continues 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. CMS does not anticipate implementing guidelines prior to CY 2008.

As indicated in the proposed and final rules, CMS believes the AHA/AHIMA guidelines are promising, although CMS identified some areas that it believed require additional development. The original and modified guidelines are available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html/HospitalOutpatientPPS/HORD/list.asp#TopOfPage on the CMS website. The files are included as supporting documents under the CY 2007 Proposed Rule, CMS-1506-P. CMS continues 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.

- Coding and Payment for Critical Care

  For CY 2007, Medicare 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*, Publication 100-04, Chapter 25, § 60.4. (That manual is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS site.) 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.

  CMS 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 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. CMS believes that trauma activation is a one-time occurrence in association with critical care services, and therefore, will only pay for one unit of G0390 per day. CMS 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.

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. CMS is 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 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 or 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.

- 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. These are:

- 77371 – Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cerebral lesions(s) consisting of 1 session; multi-source Cobalt60 based.
- 77372 – Radiation treatment delivery stereotactic radiosurgery (SRS), complete course of treatment of cerebral lesions(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.

HCPCS G0243 will no longer be reportable, because the code is deleted and replaced with CPT code 77371, effective January 1, 2007. 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. Note that for 2007, CMS will continue to not recognize CPT code 61793 under the OPPS, because the OPPS uses more specific SRS codes to provide appropriate payment for the facility resources associated with specific types of SRS treatment delivery.

- 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.

  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. These new and deleted HCPCS codes are presented in the tables (Tables 7 and 8) within CR5438, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1139CP.pdf on the CMS site.

- Coding Changes for Sodium Hyaluronan Intra-Articular Injection Products

  CMS has decided to establish separate payment for sodium hyaluronate products that have come on the market since October 2003. To facilitate the separate payment, 4 interim Q codes will be effective for services performed on or after January 1, 2007. Corresponding ASP amounts will be reflected in updated 2007 ASP pricing files to be posted on the CMS website. The following table shows the codes and their descriptors.

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

  Effective January 1, 2007, HCPCS code J7319, (Hyaluronan (sodium hyaluronate) or derivative, intra-articular injection, per injection) will not be recognized by Medicare.

- Billing for Pre-Administration Related Services Associated with Intravenous Immune Globulin (IVIG) Administration

  As noted in the CY 2007 OPPS final rule, Medicare will continue the temporary add-on payment for hospital outpatient departments that administer IVIG to Medicare patients. Continue to bill HCPCS code G0332 only once per patient per day of IVIG administration and payment will continue to map to APC 1502 with a payment rate of $75. The G0332 code must continue to be reported 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 drug administration service. This payment is in addition to Medicare's payment to

the hospital for the IVIG product itself and for administration of the IVIG product via intravenous infusion.

- 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, CMS will incorporate changes to the payment rates in the January 2007 release of the OPPS PRICER. The updated payment rates in CR5438, which is 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 at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html/HospitalOutpatientPPS/AU/list.asp#TopOfPage on the CMS website.

- Coding and Payment for Drug Administration

  Drug administration services furnished under the 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 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 should 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. Continue to bill the HCPCS codes that most accurately describe the service(s) provided. Remember to bill a separate Evaluation and Management code (with modifier 25) only if significant, separately identifiable E/M service is performed in the same encounter with OPPS drug administration.

- 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 of "s" and a national unadjusted payment of $24.25, with a minimum unadjusted copayment of $4.85.

- Additional Information

  Other points of interest contained in CR5438 include:

  - Hospitals reclassified for IPPS effective October 1, 2006, will be reclassified for OPPS effective January 1, 2007.
  - Section 401 designations and floor MSA designations effective October 1, 2006, will be effective for OPPS on January 1, 2007.
  - Rural sole community hospitals will receive a 7.1 percent payment increase in 2007.
  - For services on or after January 1, 2006, EACHs will receive a 7.1 percent payment increase.
  - New OPPS payment rates and coinsurance amounts are effective on January 1, 2007, with coinsurance rates limited to 40 percent of the APC payment and coinsurance cannot exceed the inpatient 2007 deductible of $992.
  - For hospital outlier payments, there is no change for the multiple threshold in 2007, but there is a change for the fixed threshold. The estimated cost of service must be greater than the APC payment amount plus $1,825 in order to qualify for outlier payment in 2007. The previous fixed threshold was $1,250.
  - Effective January 1, 2007, blood and blood products will be eligible for outlier payments.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5438) issued to your Medicare FI, RHHI or A/B MAC. That instruction may be viewed by going to http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1139CP.pdf on the CMS website.

If you have questions, please contact your Medicare FI, RHHI or A/B MAC, at their toll-free number which may be found at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

Flu Shot Reminder It's Not Too Late to Get the Flu Shot. We are in the midst of flu season and a flu vaccine is still the best way to prevent infection and the complications associated with the flu. But re-vaccination is necessary each year because the flu viruses change each year. Encourage your Medicare patients who haven't already done so to get their annual flu shot and don't forget to immunize yourself and your staff. **Protect yourself, your patients, and your family and friends. Get Your Flu Shot**. **It's Not Too Late!** Remember - Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. For more information about Medicare's coverage of adult immunizations and educational resources, go to CMS's website: http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0667.pdf on the CMS website.