



# MLN Matters



Information for Medicare Fee-for-Service Health Care Professionals

Related Change Request (CR) #: 3154

MLN Matters Number: MM3154

Related CR Release Date: March 30, 2004

Related CR Transmittal #: 132

Effective Date: April 1, 2004, except as otherwise noted

Implementation Date: April 5, 2004

## *MMA - April 2004 Update of the Hospital Outpatient Prospective Payment System (OPPS)*

### Provider Types Affected

Hospitals and other providers paid under the OPPS.

### Provider Action Needed

This article describes changes to the Medicare claims processing systems for OPPS claims. These changes will be implemented by Medicare fiscal intermediaries on April 5, 2004.

### Background

This article outlines changes in the OPPS for the April 1, 2004 quarterly update of Medicare's claims processing systems. Unless otherwise noted, all changes in this instruction are effective for services furnished on or after April 1, 2004. The changes in this instruction will be implemented through revisions to the Outpatient Code Editor (OCE) and the OPPS PRICER.

Changes in payment for certain drugs, biologicals, and radiopharmaceuticals mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) that are being implemented in the April 1, 2004 quarterly OPPS update are addressed in CR 3144 and CR 3145, which are being issued separately. MLN Matters articles MM3144 and MM3145 cover the changes conveyed by those earlier CRs.

Also, providers should remember that the provision of a HCPCS code and a payment rate under the OPPS for a drug, device, procedure, or service 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.

Intermediaries must 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.

### Revised Addenda A and B

Beginning April 1, 2004, the Centers for Medicare & Medicaid Services (CMS) will post revised Addenda A and B on the hospital OPPS website (<http://www.cms.hhs.gov/HospitalOutpatientPPS/>) to reflect quarterly changes in the OPPS.

#### Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

The revised Addenda will represent a "snapshot" of the codes and payment rates in effect at the beginning of each quarter. Mid-quarter changes, or changes that are retroactive to an earlier quarter, will not necessarily be captured in the quarterly revised Addenda, nor will CMS update Addenda that are posted for prior quarters.

For example, an HCPCS code listed in the January update of the OPSS, which is deleted effective April 1, will appear in the January Addendum B as "Deleted with Grace Period (DG)." However, the code will **not** reappear in the April quarterly update of Addendum B because, effective April 1, the code is deleted from the OPSS.

The deleted code will be listed as a deleted code in the Summary of Data Changes that is attached to the April quarterly update, but will not otherwise be flagged in the updated Addendum B. Condition codes will not be included in the quarterly updates of Addenda A and B. (See the *Additional Information* section below for a listing and definitions of Condition Codes.)

CMS will post updates to Addenda A and B for the April 1, July 1, and October 1 quarterly releases, in addition to the Addenda that are issued each year as part of the January 1 annual update of the OPSS following publication of the final rule.

## Summary of Current Changes

### Billing for Intensity Modulated Radiation Therapy

The following language (*italicized*) replaces section I.B.5, included in Transmittal 32, issued December 19, 2003, that notified contractors of changes in the OPSS resulting from the annual update of the OPSS effective January 1, 2004. Changes are **bolded and italicized**.

*Intensity modulated radiation therapy (IMRT), also known as conformal radiation, delivers radiation with adjusted intensity to preserve adjoining normal tissue. IMRT has the ability to deliver a higher dose of radiation within the tumor and a lower dose of radiation to surrounding healthy tissue. Two types of IMRT are multi-leaf collimator-based IMRT and compensator-based IMRT. IMRT is provided in two treatment phases, planning and delivery. Effective January 1, 2004, when IMRT is furnished to beneficiaries in a hospital outpatient department that is paid under the OPSS, hospitals are to bill according to the following guidelines:*

- A. If using CPT code 77301 to report IMRT planning services, do not report CPT 77301 with the same line item date of service reported for CPT codes 77280 - 77295, 77305 - 77321, or 77336 if these codes are also billed during a patient course of therapy.*
- B. Hospitals are not prohibited from using existing IMRT CPT codes 77301 and 77418 to bill for compensator-based IMRT technology in the hospital outpatient setting.*
- C. Payment for IMRT planning does not include payment for CPT codes 77332 - 77334 when furnished on the same day. When provided, these services are to be billed in addition to the IMRT planning code 77301.*
- D. 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.*

#### Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

**Billing and Payment for Brachytherapy Sources**

- A. Report charges related to supervision, handling, and loading of radiation sources, including brachytherapy sources, in one of two ways:
  - 1. Report separately using CPT code 77790, in addition to reporting the associated HCPCS procedure code(s) for application of the radiation source;
  - OR**
  - 2. Include the charge as part of the charge reported with the HCPCS procedure code(s) for application of the radiation source.
  - 3. Do not bill a separate charge for brachytherapy source storage costs. These costs are treated as part of the department's overhead costs.
- B. The MMA (Section 621(b)) establishes separate payment for devices of brachytherapy consisting of a seed or seeds (or radioactive source), based on the hospital's charges for the source(s), adjusted to cost, effective January 1, 2004 through December 31, 2006. The following codes are to be reported **only for payment of brachytherapy sources under the OPPS.**

**Codes for Brachytherapy Sources**

HCPCS	Descriptor	APC	APC title	NEW Status Indicator
C1716	Brachytx source, Gold 198	1716	Brachytx source, Gold 198	H
C1717	Brachytx source, HDR Ir-192	1717	Brachytx source, HDR Ir-192	H
C1718	Brachytx source, Iodine 125	1718	Brachytx source, Iodine 125	H
C1719	Brachytx sour, Non-HDR Ir-192	1719	Brachytx source, Non-HDR Ir-192	H
C1720	Brachytx source, Paladium 103	1720	Brachytx source, Paladium 103	H
C2616	Brachytx source, Yttrium-90	2616	Brachytx source, Yttrium-90	H
C2633	Brachytx source, Cesium-131	2633	Brachytx source, Cesium-131	H
C2632*	Brachytx sol, I-125, per mCi*	2632*	Brachytx sol, I-125, per mCi	H

\*APC 2632 has pass-through status.

**Payment for Ammonia N-13**

HCPCS A9526 and Q4078 were incorrectly assigned **status indicator 'N'** in the December 31, 2003 Correction Notice (68FR75442). Effective January 1, 2004, the correct **status indicator for these HCPCS codes is 'K'**. See the *Additional Information* section below for a listing and explanation of Payment Status Indicators for the Hospital OPPS.

As soon as the April 2004 OPPS OCE release is installed, hospitals may submit an adjustment bill to receive appropriate payment for HCPCS codes A9526 or Q4078 furnished on or after January 1, 2004 through March 31, 2004 that were processed to payment prior to installation of the April 1 release.

**Disclaimer**

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

**Ammonia N-13 Rates**

HCPCS	SI	Cond	APC	Description	Payment Rate	Minimum Unadjusted Co-payment
A9526	K	NI	0737	Ammonia N-13, per dose	\$162.63	\$32.53
Q4078	K	DG	0737	Ammonia N-13, per dose	\$162.63	\$32.53

**Payment for HCPCS Code C9207, Injection, Bortezomib, per 3.5 mg (“Velcade”)**

CMS inadvertently installed an incorrect effective date in PRICER for APC 9207. CMS has corrected the effective date to October 1, 2003. Hospitals that billed HCPCS C9207 for services furnished on or after October 1, 2003 through December 31, 2003, and which did not receive payment, may resubmit claims following installation of the April 2004 PRICER.

**PRICER Logic Changes Resulting from Section 621 of the MMA Effective January 1, 2004**

- A. Co-payment amounts are calculated for the following APCs: 1716, 1717, 1718, 1719, 1720, 2616, and 2633.
- B. Co-payment amounts are not calculated for the following APC: 2632.
- C. Outlier payments are not calculated for APCs with Status Indicator “K,” **except** for the following APCs:

0701	1089	1619	9118
0702	1091	1620	9400
0704	1092	1622	9402
0705	1095	1624	9403
0737	1096	1625	9404
1045	1122	1628	9405
1064	1200	1775	9408
1065	1201	9013	9434
1079	1600	9025	
1080	1603	9100	
1081	1604	9117	

**Reminder Regarding Reporting of Implantable Devices**

Hospitals are strongly encouraged to separately bill devices using a device category “C” code or other appropriate HCPCS code for implantable devices along with the charge for the device. Complete and accurate reporting of the codes and the charges for the devices is critical to ensuring that the relative weights for the services are accurate and thus, for ensuring proper payment to hospitals for the procedures that use implanted devices. All device category “C” codes for both current pass-through devices as well as packaged devices can be found in Addendum B at

<http://www.cms.hhs.gov/HospitalOutpatientPPS/Downloads/CR3154.pdf> on the CMS website.

Devices, whether packaged or paid as pass-through devices, are reported using revenue codes: 272, 275, 276, 278, 279, 280, 289 or 624.

**Newly-Approved Drugs and Biologicals Eligible for Pass-Through Payment**

The following drugs have been designated as eligible for pass-through payment under the OPSS effective April 1, 2004:

**Disclaimer**

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

HCPCS	Effective Date for Pass-Through Status	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Co-payment	Effective Date for Payment Rate
C9124	4/1/2004	G	9124	Injection, daptomycin	Injection, daptomycin, per 1 mg	\$0.31	\$0.05	1/1/2004
C9125	4/1/2004	G	9125	Injection, risperidone	Injection, risperidone, per 12.5 mg	\$131.86	\$19.71	1/1/2004
J2783	4/1/2004	G	0738	Rasburicase	Injection, rasburicase, 0.5 mg	\$105.54	\$17.63	4/1/2004

Note that the effective date for pass-through status for C9124 and C9125 coincides with the date of assignment of HCPCS codes for each of these drugs. Pass-through payment for C9124 and C9125 equals 95 percent of average wholesale price (AWP).

Beginning in 2004, the MMA requires payment at 95 percent of AWP for a drug before it receives a HCPCS code. Therefore, C9124 and C9125 will be paid at 95 percent of AWP for the period prior to assignment of a HCPCS code and for the duration of their pass-through status.

The code for rasburicase (J2783) was assigned effective January 1, 2004. Therefore, the MMA provision governing payment for drugs without HCPCS does not apply to J2783 and the payment will be at 85 percent of AWP for the duration of its pass-through status. In addition, effective January 1, 2004, as mentioned in MLN Matters article MM3145, the correct payment rate for HCPCS code J9395, Injection, Fulvestrant, 25 mg, is \$78.36 and the correct co-payment for that HCPCS code is \$13.09.

**Services Added to New Technology APCs**

The following services are assigned for payment in new technology service APCs under the OPPS OCE, version 5.1, effective April 1, 2004:

**Services Added to New Technology APCs**

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment
C9712*	04/01/04	S	1506	Insert pH capsule, GERD	Insertion of a pH capsule for measurement and monitoring of gastroesophageal reflux disease, includes data collection and interpretation	\$450.00	\$90.00
C9713	04/01/04	S	1525	Non-contact laser vap prosta	Non-contact laser vaporization of prostate, including coagulation control of intraoperative and post-operative bleeding	\$3,750.00	\$750.00

**Disclaimer**

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment
C9714	04/01/04	S	1523	Breast inters rad tx, immed	Placement of balloon catheter into the breast for interstitial radiation therapy following a partial mastectomy; concurrent/immediate (add-on)	\$2,750.00	\$550.00
C9715	04/01/04	S	1524	Breast inters rad tx, delay	Placement of balloon catheter into the breast for interstitial radiation therapy following a partial mastectomy; delayed	\$3,250.00	\$650.00

\*C9712 may involve a single endoscopy. If an endoscopy is used with this procedure, report the endoscopic procedure separately. Only one endoscopy procedure/encounter may be associated with insertion of this device.

**Summary of April 2004 Modifications**

The OPSS OCE Final Summary of Data Changes Effective April 1, 2004 can be found in Attachment A of CR3154 at <http://www.cms.hhs.gov/transmittals/Downloads/R132CP.pdf> on the CMS website.

Attachment A of CR3154 summarizes all of the modifications made to APCs, HCPCS/CPT procedure codes, APC assignments, status indicators, modifiers, revenue codes, and edits, to update the OPSS for the April 1, 2004 quarterly release.

**Implementation**

The implementation date for this instruction is April 5, 2004.

**Additional Information**

The official instruction issued to your carrier regarding this change may be found by going to <http://www.cms.hhs.gov/transmittals/Downloads/R132CP.pdf> on the CMS website.

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

The CMS Hospital Outpatient Prospective Payment System website can be found at <http://www.cms.hhs.gov/HospitalOutpatientPPS/> on the CMS website. The Payment Status Indicators for the Hospital Outpatient Prospective Payment System for FY 2004 was published by CMS as Addendum D in the Federal Register: January 6, 2004 (Volume 69, Number 3). It can be found at the CMS web site (Proposed CY 2004 Hospital Outpatient Prospective Payment System for Proposed Changes to the Hospital Outpatient Prospective Payment System (OPSS) and Calendar Year 2004 Payment Rates) located at [http://www.cms.hhs.gov/hospitaloutpatientpps/downloads/cms1471fc\\_addd.zip](http://www.cms.hhs.gov/hospitaloutpatientpps/downloads/cms1471fc_addd.zip) on the CMS website.

**Disclaimer**

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.