Clinically Appropriate APCs

- CMS is assigning non-myocardial PET procedures to a clinically appropriate APC. The CPT codes 78608, 78811, 78812, and 78813 will be assigned to APC 0308 with an APC national payment of $862.29 for 2007. The payment rate for 2007 is significantly reduced from $1,150.00. This is due to the fact that the results of CMS’ claims analysis from calendar year 2005 revealed the hospital median costs claimed for these services were found to be $865.30.

- Several stereotactic radiosurgery (SRS) clinical APCs of different levels are being added for 2007. The HCPCS codes affected by this change are G0173, G0251, G0339, and G0340. See table below for changes:

<table>
<thead>
<tr>
<th>CPT</th>
<th>Short Description</th>
<th>APC</th>
<th>APC $</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0173</td>
<td>Linear acc stereo radsur com</td>
<td>0067</td>
<td>3,895.59</td>
</tr>
<tr>
<td>G0251</td>
<td>Linear acc based stero radio</td>
<td>0065</td>
<td>1,249.18</td>
</tr>
<tr>
<td>G0339</td>
<td>Robot lin-radsurg com, first</td>
<td>0067</td>
<td>3,895.59</td>
</tr>
<tr>
<td>G0340</td>
<td>Robt lin-radsurg fractx 2-5</td>
<td>0066</td>
<td>2,644.95</td>
</tr>
</tbody>
</table>

Cardiac Computed Tomography and Computed Tomographic Angiography

- Several Category III codes were created for use in 2006 to report CCT and CCTA, which are considered new technology services. These codes 0144T – 0151T are being assigned to clinical APCs and all have a status indicator of “S”

Transluminal Balloon Angioplasty

- CMS added two new HCPCS G codes to report angioplasty procedures not currently represented by permanent CPT codes, they are:

  - G0392 - transluminal balloon angioplasty, percutaneous; for maintenance of hemodialysis access, arteriovenous fistula or graft; arterial
  - G0393 - transluminal balloon angioplasty, percutaneous; for maintenance of hemodialysis access, arteriovenous fistula or graft; venous

- Hospitals will no longer report CPT codes 35475 and 35476 for hemodialysis access fistulas or graft services; however the codes will remain active to report all other clinical services described by these codes

Continued on page 2
2007 OPPS FINAL RULE—SUMMARY cont’d

Stereotactic Radiosurgery Services (SRS)

- Four new CPT codes are added to report SRS:
  - 77371 – radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cerebral lesion(s) consisting of 1 session; multi-source cobalt 60 based
  - 77372 – radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cerebral lesion(s) consisting of 1 session; linear accelerator based
  - 77373 – stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions
  - 77435 – stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions

- The payment status for these codes is as follows:
  - 77371 – APC SI “S”
  - 77372 – APC SI “B”
  - 77373 – APC SI “B”
  - 77435 – APC SI “N”

- Report HCPCS codes G0173 or G0339 instead of 77372, when appropriate
- Report HCPCS codes G0251, G0339, or G0340 instead of 77373, when appropriate

New Category III Codes

- Two codes were added effective July 1, 2006 to report insertion of posterior spinous distraction device:
  - 0171T and 0172T have been assigned status indicator “T” (multiple procedure discounting applies)
  - A new device code (C1821 – interspinous process distraction device, implantable) has been added to report with the procedure

Diagnostic Imaging Discounts

- Discounts for Multiple Diagnostic Imaging was proposed for 2007, but has been deferred
  - CMS states in the final rule that discounts are again deferred until a future date while the proposal is studied further

Screening for AAA

- Ultrasound Screening for Abdominal Aortic Aneurysm (AAA) will be reported utilizing HCPCS code G0389. National APC payment rate of $95.93. Medicare will only allow payment for a one-time only screening examination. Test is available even if the qualifying patient does not present signs or symptoms of disease or illness.
Payment Policy for Devices

Effective for services furnished on or after January 1, 2007, to reduce the APC payment and beneficiary copayment for selected APCs in cases in which an implanted device is replaced without cost to the hospital or with full credit for the removed device.

- Append modifier “FB” to the applicable CPT/HCPCS procedure code, in which the device is inserted, if the device has been provided without cost to provider or has received a credit for replaced device. Example of no-cost/replacement: covered under warranty, replaced due to defect, “free sample”, etc. Charge for replaced device set at or below $1.01 is Medicare approved. Charge the difference between usual charge and charge for device when being replaced as an upgrade (can be same or different type of device).

Packaged Items to be Paid

Certain packaged services may be performed alone and will be paid when no billable service is listed on the claim.

- 36540 – Blood collection from VAD
- 36600 – Arterial Puncture
- 38792 – Sentinel Node Injection
- 75983 – Venous Sampling through catheter
- 94762 – Overnight Pulse Ox
- 96523 – Irrigation of VAD

These codes are assigned a status indicator of “Q” and when billed alone (without another procedure), the OCE will automatically convert the status indicator for appropriate payment. When these codes are billed with another procedure, the OCE will automatically convert the status indicator to “N” and payment will be bundled into the primary procedure.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>APC SI</th>
</tr>
</thead>
<tbody>
<tr>
<td>36540</td>
<td>Collect blood, venous access device</td>
<td>S</td>
</tr>
<tr>
<td>36600</td>
<td>Arterial puncture; withdrawal of blood for diagnosis</td>
<td>T</td>
</tr>
<tr>
<td>38792</td>
<td>Sentinel node identification</td>
<td>S</td>
</tr>
<tr>
<td>75983</td>
<td>Venous sampling through catheter, with or without angiography, radiological supervision and interpretation</td>
<td>S</td>
</tr>
<tr>
<td>94762</td>
<td>Noninvasive ear or pulse oximetry for oxygen saturation by continuous overnight monitoring</td>
<td>X</td>
</tr>
<tr>
<td>96523</td>
<td>Irrigation of implanted venous access device</td>
<td>S</td>
</tr>
</tbody>
</table>
2007 OPPS FINAL RULE—SUMMARY cont’d

Device Dependent Codes
- The list of device-dependent code edits will be updated, effective January 1, 2007. The following edits are being added:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Description</th>
<th>Device</th>
</tr>
</thead>
<tbody>
<tr>
<td>19296</td>
<td>Place po breast cath for rad</td>
<td>C1728</td>
</tr>
<tr>
<td>19297</td>
<td>Place breast cath for rad</td>
<td>C1728</td>
</tr>
<tr>
<td>36566</td>
<td>Insert tunneled cv cath</td>
<td>C1881</td>
</tr>
<tr>
<td>65770</td>
<td>Revise cornea with implant</td>
<td>C1818, L8609</td>
</tr>
</tbody>
</table>

Emergency Department Visits
- Postponing finalization of the proposed G-codes for Type A (continue to use 99281-99285)
- CMS has defined an Emergency Department that is not open 24 hours per day for 7 days per week, and has EMTALA responsibility, as a Type B Emergency Department (i.e., Urgent Care Center). Type A Emergency Departments are open 24 hours per day and 7 days per week. G-codes for Type B Emergency Department are as follows:
  - 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
- Type B visits will be paid at the same rate as clinic visits (e.g., 99201-99205, 99211-99215). CMS will track the utilization of the G codes reported and update future payments as necessary to ensure that facilities are adequately reimbursed.
- Hospitals will continue to report 99291 and 99292 for Critical Care Services.

Clinic Visits
- CMS is postponing the implementation of the proposed G-codes. Outpatient departments will continue to report E/M services utilizing CPT codes in the 992XX range.

Continued on page 5
2007 OPPS FINAL RULE—SUMMARY cont’d

Drugs and Biologicals
Several temporary HCPCS C codes are being deleted and replaced/assigned to permanent codes

- C9220 – report J7319
- C9221 – report J7344
- C9222 – report J7346
- C9224 – report J1458
- C9225 – report J7311
- C9227 – report J2248
- C9228 – report J3243
- C9229 – report J1740
- C9230 – report J0129
- C9231 – report J0894

Packaging Payment for Drugs, Biologicals and Radiopharmaceuticals
- For CY 2007 and beyond, drugs, biologicals and radiopharmaceuticals that are not new and do not have pass-through status will be packaged if their calculated per day cost is equal to or less than $55 for CY 2007 or equal to or less than the updated threshold established, rounded to the nearest $5 increment, for the relevant update year.

Low Osmolar Contrast Material
- HCPCS Q-codes will be paid separately in CY 2007
  - They will be paid at the same rate as other separately payable drugs and biologicals in the OPPS for CY 2007, which in general will be equal to ASP+6 percent, subject to adjustments based on the quarterly update process.

Brachytherapy Solution
- Payment has historically been made on a per mCi basis, and this approach will continue for CY 2007 (permanent A-code A9527). When a vial of I-125 solution contains 150 mCi, there are 150 billing units of I-125 solution per vial, resulting in an OPPS payment, if all billing units are used, of $2,898 based on the CY 2007 proposed payment rate. CMS issued instructions, CR 3154, March 30, 2004.

Drug Administration Coding
- CMS is deleting the temporary HCPCS C codes (C8950 – C8955). C8957 will still be used since there is no comparable permanent CPT code to report this service. Hospitals will report the 907XX and 964XX codes as indicated by the CPT code descriptions. AMA has removed “up to 8 hours” and “1 to 8 hour” from several of the descriptions.

Continued on page 6
2007 OPPS FINAL RULE—SUMMARY cont’d

Other Areas Addressed
- Blood and Blood Products
  - No major coding changes
  - Payments are revised using more recent data
- Observation
  - No change for 2007
- Inpatient Only Procedures
  - Changes to the list are in the final rule
  - Use of the CA modifier is continued
- Medication Therapy Management Services (category III codes 0115T – 0117T)
  - Continue under status indicator “B”
- IVIG Preadministration
  - No change for 2007

Critical Access Hospitals
- The CAH EMTALA rules are changed to make them similar to Acute Care Hospitals. Nurses can be used to provide an EMTALA screening if:
  * The nurse has training and experience in emergency care
  * It is within the Scope of Practice under state law
  * It is allowed by the CAH bylaws

Go to the link provided to review the final rule in its entirety:
http://www.cms.hhs.gov/HospitalOutpatientPPS/Downloads/CMS1506FC.pdf

CHANGES TO CWF FOR BILLING TECHNICAL COMPONENT OF RADIOLOGY AND PHYSICIAN PATHOLOGY SERVICES

For claims with a date of service on or after January 1, 2007, independent laboratories may not bill CMS for the technical component (TC) of physician pathology services.

The TC of radiology services provided during an inpatient stay may be billed only by the hospital. Radiology suppliers that provide services to Medicare patients during the course of an inpatient stay may not bill the Medicare carrier for the technical component of the service.

Beginning April 1, 2007, CMS will install systems edits in the Common Working File (CWF) to prevent additional improper payments to radiology suppliers, physicians, and independent laboratories for TC or globally billed radiology/physician pathology services provided during a hospital stay.

To view the Transmittal in its entirety, please go to:
The following is an excerpt from CR5244 (Attachment A, Appendix L). It summarizes the key modifications of the OCE/APC for the October 2006 release (V7.3):

**REPORTING INFLUENZA VIRUS VACCINE - UPDATE**

CMS is clarifying its policy regarding payment for Influenza and/or PPV vaccines and its administration. Currently, providers are required to report diagnosis codes V03.82 for PPV and its administration and diagnosis code V04.81 for Influenza Virus vaccine and its administration. This instruction allows the reporting of diagnosis code V06.6 in place of V03.82 and V04.81 when reporting Influenza Virus and/or PPV vaccines when the purpose of the visit was to receive both vaccines. In addition, this instruction requires Medicare carriers/FIs to accept claims containing CPT code 90660 for the Influenza Virus vaccine. Effective for dates of service on or after October 1, 2006, the following are the new instructions:

- **Report diagnosis code V06.6** on claims that contain Influenza Virus and/or PPV vaccines and their administration when the purpose of the visit was to receive both vaccines.

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**OCTOBER 2006 OCE UPDATE**

<table>
<thead>
<tr>
<th>Mod. Type</th>
<th>Effective Date</th>
<th>Edit</th>
<th>Update Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Logic</td>
<td>10/1/2006</td>
<td>74</td>
<td>New edit 74 – Units greater than one for bilateral procedure billed with modifier 50….Return to Provider. For any code on the Conditional or Independent bilateral list that is submitted with modifier 50 and units of service greater than one on the same line (Appendix A).</td>
</tr>
<tr>
<td>2 Logic</td>
<td>4/1/2005</td>
<td></td>
<td>Modify appendix F to bypass edits 8, 9, 11, 12, 44, 50, 53, 54, 55, 59 &amp; 69 for bill types 71x and 73x. Modify appendix E to reflect the changes made in appendix F.</td>
</tr>
<tr>
<td>3 Logic</td>
<td>10/1/2006</td>
<td></td>
<td>Modify appendix D to apply bilateral procedure discounting to Non-type T procedures that are on the Conditional bilateral list, when submitted with modifier 50. [The bilateral indicator to supersede the SI, to determine discounting].</td>
</tr>
<tr>
<td>4 Content</td>
<td></td>
<td></td>
<td>Make HCPCS/APC/SI changes, as specified by CMS.</td>
</tr>
<tr>
<td>5 Content</td>
<td>7/1/2006</td>
<td>19, 20, 39, 40</td>
<td>Implement version 12.2 of the NCCI file, removing all code pairs which include Anesthesia (00100-01999), E&amp;M (92002-92014, 99201-99499), or MH (90804-90911); and the following Drug Admin code pairs: C8950-C8952, C8953-C8950, C8953-C8952, C8954-C8950, C8954-C8952, C8954-C8953.</td>
</tr>
<tr>
<td>6 Content</td>
<td>10/1/2006</td>
<td>1</td>
<td>Update valid diagnosis code lists with ICD-9-CM changes.</td>
</tr>
<tr>
<td>7 Content</td>
<td>10/1/2006</td>
<td>2, 3</td>
<td>Update diagnosis/age and diagnosis/sex conflict edits with MCE changes.</td>
</tr>
<tr>
<td>8 Content</td>
<td>1/1/2005</td>
<td>22</td>
<td>Add new CPT modifiers (genetic testing category) to global valid modifier list.</td>
</tr>
<tr>
<td>9 Content</td>
<td>1/1/2006</td>
<td>71</td>
<td>Update procedure/device edit list.</td>
</tr>
</tbody>
</table>

Continued on page 8
REPORTING INFLUENZA VIRUS VACCINE - UPDATE cont’d

- Continue reporting diagnosis code V03.82 on claims that contain only PPV vaccine and its administration.
- Continue reporting diagnosis code V04.81 on claims that contain only Influenza Virus vaccine and its administration.
- Use CPT code 90660 on claims when billing for Influenza Virus vaccine, live, for Intranasal use.
- Neither a deductible nor a coinsurance will be applied to Influenza Virus vaccine, CPT code 90660, and its administration.
- Use HCPCS code G0008 when billing for the administration of code 90660.

Go to the link provided to view the MLN Matters Article:

CMS DELETES G0107 EFFECTIVE JANUARY 1, 2007

Effective January 1, 2007, HCPCS code G0107 for screening Fecal Occult Blood Tests (FOBT) is being terminated and replaced by CPT code 82270. If you use HCPCS code G0107 for FOBT on or after this date, your reimbursement could be impacted as the claim will be returned as unprocessable.

82270 - Colorectal Cancer Screening; Fecal-Occult Blood Test, 1-3 Simultaneous Determinations

The following excerpt from the transmittal states when FOBT will be paid:

“Effective for services furnished on or after January 1, 1998, screening FOBT may be paid for beneficiaries who have attained age 50, and at a frequency of once every 12 months (i.e., at least 11 months have passed following the month in which the last covered screening FOBT was performed). This screening FOBT means a guaiac-based test for peroxidase activity, in which the beneficiary completes it by taking samples from two different sites of three consecutive stools. This screening requires a written order from the beneficiary’s attending physician. (The term “attending physician” is defined to mean a doctor of medicine or osteopathy (as defined in §1861(r)(1) of the Act) who is fully knowledgeable about the beneficiary’s medical condition, and who would be responsible for using the results of any examination performed in the overall management of the beneficiary’s specific medical problem.)

Effective for services furnished on or after January 1, 2004, payment may be made for an immunoassay-based FOBT (G0328, described below) as an alternative to the guaiac-based FOBT, 82270* (G0107*). Medicare will pay for only one covered FOBT per year, either 82270* (G0107*) or G0328, but not both.”

To view the transmittal in its entirety, go to:
DRUG ADMINISTRATION CODING FOR 2007

In the 2007 OPPS Final Rule, CMS stated that hospitals will need to use the CPT codes (90760 -90779, 96401 -96425) as indicated in the 2007 CPT Code Book to report drug administration services. The only HCPCS C code effective for use for 2007 is C8957 (intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump), since there is no permanent CPT code available to report this service.

Most of the drug administration codes have been assigned to a status indicator of “S” (significant procedure, not subject to discounting). The exceptions are CPT code 90768 (N, payment packaged into primary service), and 96523 (Q, will be converted to status indicator S when reported alone, or converted to N when billed with primary service).

CPT added instructions for 2007 to the drug administration section of the code book. See excerpt:

“A therapeutic, prophylactic, or diagnostic IV infusion or injection (90765-90779) (other than hydration) is for the administration of substances/drugs. When fluids are used to administer the drug(s), the administration of the fluid is considered incidental hydration and is not separately reportable. These services typically require direct physician supervision of or any or all purposes of patient assessment, provision of consent, safety oversight, and intra-service supervision of staff. Typically, such infusions require special consideration to prepare, dose or dispose of, require practice training and competency for staff who administer the infusions, and require periodic patient assessment with vital sign monitoring during the infusion.”

This means that infusion therapy and injections can be coded and separately billable procedures when they are separate and distinct services (does not conflict with existing coding policies). For example:

- Do not code a separate injection if this service is inherent or incident to another main procedure (e.g., administration of contrast material for a diagnostic imaging study)
- Do not code an injection when a surgery or procedure is performed and there is an injection of a local or block anesthetic
- Do not code infusion therapy if it is part of a routine protocol and there is no medically necessary condition such as dehydration

CMS transmittals should be monitored for future guidance and/or clarification as they update the Medicare Claims Processing Manual, Chapter 14, Section 230.2. for 2007.

REPORT CORRECT UNITS FOR DRUGS

In the October 2006 HOPPS update, CMS stresses that providers and hospitals should be sure to accurately report units of drugs administered to patients in terms of the dosage specified in the full HCPCS code descriptor. Units should be reported in multiples of the units included in the HCPCS descriptor. For example, if the HCPCS code description for a drug is 50 mg but a patient received 200 mg, the units billed should be 4. Along the same line, if the HCPCS descriptor for a drug specifies 1 mg, and a 10 mg vial of the drug was administered, 10 units should be billed even though only 1 vial was administered.

CMS also emphasizes the importance of reviewing the complete long descriptors for the applicable HCPCS codes. HCPCS short descriptors are limited to just 28 characters, so sometimes they do not always capture the complete description of a drug. Providers are reminded to review HCPCS descriptors for any changes to the units when HCPCS definitions or codes are revised.

A MedLearn Matters article pertaining to the above information is available for viewing/download at: http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5304.pdf
Q. Can our hospital bill for discarded drugs (wastage). Does Medicare have any specific guidance for reporting?

A. Yes. CMS originally addressed this question in the Federal Register, Friday, November 1, 2002, p. 66770. In the Medicare Claims Processing Manual, Chapter 17, Section 40 – Discarded Drugs and Biologicals, they give examples for appropriate billing of the wastage. CMS also provides guidance on proper application of the “JW” modifier.

Medicare Claims Processing Manual, Chapter 17, Section 40 and 100.2.9

(The above question was submitted from Lexington, KY)