2006 OPPS Final Rule—Summary of Changes

OBSERVATION SERVICES
NEW CODES

CMS has created two new HCPCS G-codes for reporting observation services effective January 1, 2006. They are as follows:

G0378—Hospital observation services, per hour
G0379—Direct admission of patient for hospital observation care

The new G-codes have been assigned a status indicator of “Q”. OPPS explanation: Addendum B displays APC assignments when services are separately payable (1) Separate APC payment based on OPPS payment criteria (2) If criteria are not met, payment is packaged into payment for other services, including outliers, therefore there is no separate APC payment.

CMS is changing the status of 99217—99220 and 99234—99236 from status indicator “N” (packaged) to “B” (code not recognized by the OPPS). Hospitals will no longer report the 992XX range of codes to report observation services that do not qualify for separate reimbursement as previously required.

CMS says that it is reducing the hospitals’ burden of determining whether or not a Medicare beneficiary meets criteria for either paid or packaged observation. They will be using hospitals’ billing information to determine the reimbursement for a qualified observation stay by using the OCE logic.

In order for the logic to work, the hospital claim must include G0378 and/or G0379 as applicable, number of units (hours), all CPT/HCPCS code representing the services provided the day before or same day, and the qualifying ICD-9-CM diagnosis codes.

Although CMS will rely heavily on the billing information reported by hospitals for reimbursing separately payable observation services, the documentation in the patient medical record will still have to support the services billed in the event of an audit by CMS or the fiscal intermediary. Each observation stay must have the following documented in the patient’s medical record:

1. Specific ICD-9-CM diagnostic codes (congestive heart failure, chest pain, or asthma),
2. Length of time patient is in observation status (begins with the patient’s admission to an observation bed and ends when all clinical or medical interventions have been completed),
3. Services provided before, during, and after the observation stay, and
4. On-going physician evaluation of patient’s status.

CMS also clarified, at the request of the APC Panel, the issuance of ABNs. CMS’ response in the final rule is as follows:

“In response to the APC Panel’s recommendation for clarification concerning if and when a hospital may issue an ABN, all hospital observation services, regardless of the duration of the observation care, that are medically reasonable and necessary are covered by Medicare, and hospitals receive OPPS payments for such observation services.

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We make separate payment for observation care only for the three conditions previously defined that also meet our specific criteria, and payments for all other reasonable and necessary observation services are packaged into the payments for other separately payable services provided to the patient on the same day. An ABN should not be issued in the context of reasonable and necessary observation services, whether packaged or not.”

CODING AND PAYMENT FOR DRUG ADMINISTRATION

CMS has created six new HCPCS C-codes for billing and payment. According to the final rule, CMS is adopting 20 of the 33 CPT codes originally proposed, and will instead be instructing hospitals to use the new C-codes for CY 2006.

The use of the new codes will simplify changing any current processes already in place at hospitals. The codes represent infusions and intravenous pushes, for the first hour and then each additional hour of infusion or for each intravenous push.

The new C-codes are as follows:

- **C8950**—Intravenous infusion for therapy/diagnosis; up to 1 hour
- **C8951**—Intravenous infusion for therapy/diagnosis; each additional hour (List separately in addition to C8950)
- **C8952**—Therapeutic, prophylactic or diagnostic injection; intravenous push
- **C8953**—Chemotherapy administration, intravenous; push technique
- **C8954**—Chemotherapy administration, intravenous; infusion technique, up to one hour
- **C8955**—Chemotherapy administration, intravenous; infusion technique, each additional hour (List separately in addition to C8954)

Both C8951 and C8955 are considered add-on codes and have an APC status indicator of “N”. However, hospitals should continue to report the correct number of units (hours) for infusion services so that CMS can collect the data needed to assess hospitals’ charges and costs for future reimbursement considerations.

CMS plans on releasing instructions for drug administration billing and coding guidance for hospitals for CY 2006 separate from the final rule.

PAYMENT FOR MULTIPLE DIAGNOSTIC IMAGING PROCEDURES

In the proposed rule, CMS indicated that it wanted to change its policy on reimbursement for multiple imaging procedures by reducing payments for subsequent procedures within the identified families just as with its policy for multiple surgical procedures. The original analysis of data conducted by CMS included consideration of clinical labor activities in which they determined these activities are reduced when additional imaging procedures are performed during the same session.

CMS performed additional analyses of CY 2004 OPPS claims. They determined that it is possible that payment for certain diagnostic procedures may already be reduced due largely in part to how hospitals...
PAYMENT FOR MULTIPLE DIAGNOSTIC IMAGING PROCEDURES (continued)

currently report their cost and charges in modality cost-to-charge revenue centers versus putting them into one center specific to diagnostic radiology.

Therefore the median costs calculated by CMS in its analysis would not accurately reflect a true picture for determining payment reduction for multiple diagnostic procedures.

CMS stated in the final rule that it would not be adopting this discounting policy for CY 2006. Based on the recommendations of the APC Panel, evidence presented by commenters, and its further analyses, they would continue to collect data in the coming year to assess their median cost calculations.

MODIFIER 52 PAYMENT CHANGE

CMS performed an analysis of CY 2004 hospital claims data in which they discovered that 120,000 procedures were reported with modifier 52. They found that the majority of these services were for imaging procedures that were not associated with the use of contrast.

Also, CMS determined that hospitals did not incur increased costs with reporting the incomplete procedures, since it was found that these procedures were often performed in procedure rooms and other nonspecific areas and did not require significant use of supplies.

For CY 2006, CMS is adopting the policy of applying a 50 percent reduction to APC payments for interrupted procedures reported with modifier 52.

DRUGS, BIOLOGICALS & RADIOPHARMACEUTICAL C-CODES TO BE DELETED

Approximately 72 C-codes are to be deleted on December 31, 2005 and replaced by A, J, and Q-codes for CY 2006. CMS found that there are several C-codes for drugs, biologicals, and radiopharmaceuticals that can be replaced with new permanent HCPCS codes. They also determined that there are some C-codes that are also described by other permanent HCPCS codes that existed in CY 2005. In cases where it is appropriate to do so, the C-codes are being deleted and replaced with the new CY 2006 HCPCS codes or existing HCPCS codes that appropriately describe products.

The following are examples of codes scheduled for deletion:

<table>
<thead>
<tr>
<th>Deleted C-Code</th>
<th>Description</th>
<th>Replacement Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1305</td>
<td>Apligraf</td>
<td>J7340</td>
</tr>
<tr>
<td>C9105</td>
<td>Hep B imm glob, per 1 ml</td>
<td>90371</td>
</tr>
<tr>
<td>C9223</td>
<td>Inj adenosine, tx dx</td>
<td>J0150</td>
</tr>
</tbody>
</table>

PHYSICIAN OVERSIGHT OF NPPs IN CRITICAL ACCESS HOSPITALS

CMS addressed in the proposed rule a change to the Conditions of Participation (CoP) for Critical Access Hospitals (CAH). The existing regulations do not distinguish between inpatient and outpatient physician oversight. Nonphysician practitioners (NPP) are concerned that in many states they are able to practice independently of physicians and that current CMS regulations impede their ability to practice in CAHs.

Therefore, CMS is adopting the changes to Section 485.631 of the CoP to defer to State law regarding the review of records for outpatients cared for by NPPs. Physicians would not be required to review and sign the medical records of these outpatients. However, in those states that have restrictions to independent practice of NPPs, CMS will require physician review and signature on a sample of outpatient records at least every two weeks according to facility policy. The requirement for inpatient records remains unchanged.
Q. Is it appropriate for a hospital to separately bill for medical devices used during a surgical procedure when there is no associated HCPCS code to apply?

A. CMS encourages hospitals to report all associated medical devices with a charge. These devices however require an applicable assignment of a revenue code (e.g., 272, 275, 278). CMS will take into consideration all charges and costs for medical devices associated with a surgical procedure in order to set future APC payment rates.

Q. Should a hospital report HCPCS code C9713 (“non-contact”) instead of the CPT code 52648 (“contact”) for laser vaporization of the prostate when the physician states that a contact procedure was performed?

A. For calendar years 2004 and 2005, HCPCS code C9713 is appropriate when the hospital uses the GreenLight Laser System to perform the laser vaporization procedure on outpatients. This code was introduced in April 2004 to allow hospitals to be appropriately reimbursed for this new technology. Any other technology used to perform the procedure should be coded with CPT code 52647 or 52648 as applicable.

The information contained herein is solely for the purpose of informing you the health care professional of current changes. Every effort has been made to ensure the accuracy of the contents. However, this newsletter does not replace policies or guidelines set by your Medicare FI or replace the ICD-9-CM or CPT/HCPCS coding manuals. It serves only as a resource.

Do you have a specific coding question or topic that you would like to see addressed in our next newsletter? You may fax your question to (615) 661-5147 or go to “contact us” on our website at www.hmi-corp.com. We would like to hear from you.