Analysis of Final Rule for 2006 Revisions to the Medicare Hospital Outpatient Prospective Payment System

The final rule for calendar year 2006 revisions to the Medicare Hospital Outpatient Prospective Payment System (HOPPS) was published in the Federal Register on November 7, 2005. This rule becomes effective for services rendered on or after January 1, 2006.

This analysis will cover highlights of the revisions to the HOPPS that are of particular interest to HIM professionals. The listed page numbers refer to the beginning of the relevant section of the final rule published in the Federal Register. The Federal Register may be accessed at: http://a257.g.akamai.net/7/257/2422/01jan20051800/edocket.access.gpo.gov/2005/pdf/05-22136.pdf This is a very large file (50+ MB) that takes a considerable time to download.

As always, the OPPS final rule is extensive. This year, much of the content relates to reimbursement for specific drugs and drug classes. We have not included all details relative to drug reimbursement, but have attempted to summarize the appropriate sections.

Packaged Services

Table 2 (page 68541) contains a listing of all revenue codes that are considered packaged for CY 2006 OPPS reimbursement. This listing is unchanged from CY 2005.

Specific Packaged Codes (page 68542 and following)

A number of specific CPT codes have been designated as packaged services. Some codes have been removed from packaged status for 2006, and will be reimbursed separately when reported. These include:

51701 Insertion of non-indwelling bladder catheter (mapped to APC 0340 Minor Ancillary Procedures, reimbursement $36.00, status indicator X). This code will be paid each time that it is reported, not just when it is the only code reported.
51702 Insertion of temporary indwelling Foley catheter, simple (mapped to APC 0340)
51703 Insertion of temporary indwelling Foley catheter, complicated (mapped to APC 0164 Level I Urinary and Anal Procedures, status indicator T, reimbursement $69.00)
The following codes will remain packaged, or will be added to the packaged list for 2006 following discussion of removing them from the list.

76937 Ultrasound guidance for vascular access
75998 Fluoroscopic guidance for VAD placement – added to packaged list for 2006
38792 Injection procedure for identification of sentinel node
42550 Injection procedure for sialography
0069T Acoustic heart sound services
36540 Collection of blood specimen from completely implantable VAD
36600 Arterial puncture, withdrawal of blood for diagnosis
94760 Noninvasive ear or pulse oximetry, single determination
94761 Noninvasive ear or pulse oximetry, multiple determinations
94762 Noninvasive ear or pulse oximetry by continuous overnight monitoring
77790 Supervision, handling and loading of radiation source
36500 Venous catheterization for selective organ blood sampling
75893 Venous sampling through catheter, with or without angiography

During CY 2006 CMS will collect cost data on the following CPT and HCPCS Level II codes with consideration to removing them from packaged status in 2007. For CY 2006, however, despite requests for separate reimbursement, all will remain packaged:

96523 Irrigation of implanted venous access device for drug delivery systems (new code for CY 2006)
76001 Fluoroscopy, physician time more than one hour
76003 Fluoroscopic guidance for needle placement
76005 Fluoroscopic guidance and location of needle or catheter tip
74328 Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation
74329 Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation
74330 Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation
P9612 Catheterization for collection of specimen
G0269 Placement of occlusive device into either a venous or arterial access site, post surgical or interventional procedure

Conversion Factor Update for 2006 (page 68551)

The conversion factor for CY 2006 will be $59.511.

Wage Index Changes for 2006 (page 68551 and following)

Detailed information on wage index changes begins on page 68551. Information on hospital reclassification, methods for calculating wage index changes, etc. are included. The final rule involves adopting the IPPS wage indices and extending them to TEFRA
hospitals that participate in the OPPS but not the IPPS. Any hospitals that were reclassified for IPPS purposes will also be reclassified for OPPS purposes.

**Outlier Thresholds (page 68561)**

The outlier threshold was redefined for CY 2005 as when the cost to a hospital of furnishing a service or procedure exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus a $1,175 fixed-dollar threshold. For CY 2006 this has been modified such that the outlier threshold is triggered when the cost of furnishing a service or procedure exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus a $1,250 fixed-dollar threshold. This recalculation was required to assure that outlier payments would not exceed 1% of total payments, in accordance with a MedPAC recommendation to this effect. Note that the figure of $1,250 is down from the proposed rule figure of $1,575.

The outlier threshold for Community Mental Health Centers (CMHCs) is triggered when the cost of furnishing a service or procedure by a CMHC exceeds 3.4 times the APC payment rate. If a CMHC provider meets this condition, the outlier payment is calculated as 50 percent of the amount by which the cost exceeds 3.4 times the APC payment rate.

**Recognition of New HCPCS Level II and category III CPT Codes (page 68567)**

Beginning in CY 2006, CMS is modifying their process for recognition of new category III codes and recognizing Category III CPT codes that the AMA releases in January to be effective beginning July of the same calendar year in which they are issued, rather than deferring recognition of those codes to the following calendar year update of the OPPS. New HCPCS Level II codes will continue to be implemented with the Final Rule. New 2006 HCPCS codes are designated in Addendum B of the Final Rule with Comment Indicator “NI.” The status indicator and/or APC assignments for all HCPCS codes flagged with Comment Indicator “NI”, which are new 2006 HCPCS codes, are subject to public comment.

New category III codes may either be assigned to an existing clinically appropriate APC, assigned to a new technology APC, or designated with a nonpayable status.

**Changes within APCs (page 68567)**

To resolve a 2 times rule violation, CPT codes 88108 (Cytopathology, concentration technique, smears and interpretation) and 88321 (Consultation and report on referred slides prepared elsewhere) will be assigned to a new APC 0433. CPT codes 88112 (Cytopathology, selective cellular enhancement technique with interpretation, except vaginal or cervical) and 88319 (Determinative histochemistry or cytochemistry to identify enzyme constituents) will be assigned to APC 0343.

Codes 45303 (Proctosigmoidoscopy, rigid; with dilation) and 45305 (Proctosigmoidoscopy, rigid; with biopsy, single or multiple) are moved from APC 0146
to a new APC 0428. In addition, 45309 (Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by snare technique) is moved from APC 0147 and assigned to the new APC 0428.

No other changes were made based upon violations of the 2 times rule for CY 2006, although 41 APCs contain 2 times rule violations. Table 8 (page 68570) lists the APCs that are allowed to remain as exceptions to the 2 times rule.

New Technology APCs (page 68571)

For CY 2006, CMS is discontinuing New Technology APCs 1501 and 1538 (the two $0-50 new technology APCs), and reassigning the procedures currently assigned to them to New Technology APCs 1491 through 1500. The New Technology APCs for CY 2006 are contained in table 9 on page 69872.

In the proposed rule with comment period, CMS had proposed that, in order to obtain assignment of a new procedure to a new technology APC, it would require that a CPT coding request be submitted (to the AMA) prior to submission of a New Technology APC application. Because of various issues related to AMA assignment of category I and category III CPT codes, CMS has decided not to enforce this requirement at this time.

Assignment of Procedure Codes to APCs

PET/CT Scans (page 68580)

CPT codes that describe PET/CT scans for attenuation correction were assigned to New Technology APC 1513 and 1514 for CY 2005 and will remain in those APCs for CY 2006.

PET Myocardial Scans (page 68582)

CMS assigned single-study myocardial PET imaging procedures and metabolic evaluation of myocardial PET imaging to APC 0306 (Myocardial Positron Emission Tomography (PET) imaging, single study, metabolic evaluation) with a median cost of $800, based on the CY 2004 hospital claims data for the predecessor G-codes that have been replaced with CPT codes 78459 and 78491. Multiple-study myocardial PET imaging procedures are assigned to APC 0307 (Myocardial Positron Emission Tomography (PET) imaging, multiple studies) with a median cost of $2,482, based upon CY 2004 data.

Proton Beam Therapy Services (page 68582)

Intermediate and complex proton beam therapy services (CPT codes 77523 and 77525) are reassigned from New Technology APC 1510 to clinical APC 0667 (Level II Proton Beam Radiation Therapy), based upon improved cost data and stable frequency of
performance, and simple proton beam therapy services (CPT codes 77520 and 77522) in APC 0664 (Level I Proton Beam Radiation Therapy) for CY 2006.

Smoking Cessation Counseling (page 68583)

Smoking Cessation Counseling (G0375 and G0376) are reassigned to New Technology APC 1491 (payment rate of $5) from their former APC, New Technology APC 1501, with a payment rate of $25. Some commenters had requested that these procedures be assigned to the APC 0600 (Low Level Clinic Visit) but they do not require full evaluation and management services, and CMS believes that hospital resource utilization to provide these services will be very limited. CMS will reassess the reimbursement for these services for CY 2007.

Stereoscopic Kilo X-ray (page 68583)

Newly created code C9722 is no longer needed since AMA created CPT code 77421 to describe “Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy”, which will be effective 01/01/06. It will be mapped to New Technology APC 1502 (Level II $50–$100).

Stereotactic Radiosurgery (page 68584)

An extensive discussion of the rationale behind the reassignments of several of the stereotactic radiosurgery codes begins on page 68584. Because these procedures, describing linear accelerator based radiosurgery, are not widely performed, details will not be given here but can be found in the Federal Register beginning at the above noted page.

Cardiac and Vascular Procedures (page 68588)

Acoustic heart sound recording (0069T) will remain a packaged service for 2006, as it is never performed alone, but is an add-on code with EKG codes.

CPT code 92973 Percutaneous transluminal coronary thrombectomy (an add-on code) will be reassigned from APC 0676 (Percutaneous thrombectomy and thrombolysis) to APC 0088 (Thrombectomy), with a median reimbursement of $2171 for 2006. Code 37195 Thrombolysis, cerebral, by intravenous infusion, will be assigned to APC 0676, with the actual drugs separately reimbursed under OPPS.

Vascular Access Procedures (page 68592)

A number of new VAD procedures were added to CPT in 2004 and now have one year of history in their original APC assignments. A number of these procedures were reassigned for CY 2006. Table 13 on page 68594 contains a detailed listing of CPT codes for VAD procedures and the APCs to which they are assigned for CY 2006. Table 13 is reproduced below:
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Descriptor</th>
<th>CY 2005 APC</th>
<th>CY 2006 APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>APC 0621</td>
<td>Level I Vascular Access Procedure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36555</td>
<td>Insertion non-tunneled cv cath</td>
<td>0187</td>
<td>0621</td>
</tr>
<tr>
<td>36556</td>
<td>Insertion non-tunneled cv cath</td>
<td>0187</td>
<td>0621</td>
</tr>
<tr>
<td>36568</td>
<td>Insert tunneled cv cath</td>
<td>0187</td>
<td>0621</td>
</tr>
<tr>
<td>36569</td>
<td>Insert tunneled cv cath</td>
<td>0187</td>
<td>0621</td>
</tr>
<tr>
<td>36575</td>
<td>Repair tunneled cv cath</td>
<td>0187</td>
<td>0621</td>
</tr>
<tr>
<td>36576</td>
<td>Repair tunneled cv cath</td>
<td>0187</td>
<td>0621</td>
</tr>
<tr>
<td>36580</td>
<td>Replace tunneled cv cath</td>
<td>0187</td>
<td>0621</td>
</tr>
<tr>
<td>36584</td>
<td>Replace tunneled cv cath</td>
<td>0187</td>
<td>0621</td>
</tr>
<tr>
<td>36589</td>
<td>Remove tunneled cv cath</td>
<td>0109</td>
<td>0621</td>
</tr>
<tr>
<td>36590</td>
<td>Remove tunneled cv cath</td>
<td>0187</td>
<td>0621</td>
</tr>
<tr>
<td>36596</td>
<td>Mech removal tunneled cv cath</td>
<td>0187</td>
<td>0621</td>
</tr>
<tr>
<td>36597</td>
<td>Reposition venous catheter</td>
<td>0187</td>
<td>0621</td>
</tr>
<tr>
<td>APC 0622</td>
<td>Level II Vascular Access Procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36557</td>
<td>Insert tunneled cv cath</td>
<td>0032</td>
<td>0622</td>
</tr>
<tr>
<td>36558</td>
<td>Insert tunneled cv cath</td>
<td>0032</td>
<td>0622</td>
</tr>
<tr>
<td>36578</td>
<td>Replace tunneled cv cath</td>
<td>0187</td>
<td>0622</td>
</tr>
<tr>
<td>36581</td>
<td>Replace tunneled cv cath</td>
<td>0032</td>
<td>0622</td>
</tr>
<tr>
<td>36585</td>
<td>Replace tunneled cv cath</td>
<td>0032</td>
<td>0622</td>
</tr>
<tr>
<td>36570</td>
<td>Insert tunneled cv cath</td>
<td>0032</td>
<td>0622</td>
</tr>
<tr>
<td>36571</td>
<td>Insert tunneled cv cath</td>
<td>0032</td>
<td>0622</td>
</tr>
<tr>
<td>36595</td>
<td>Mech removal tunneled cv cath</td>
<td>0187</td>
<td>0622</td>
</tr>
<tr>
<td>36262</td>
<td>Removal intra-arterial inf. Pump</td>
<td>0124</td>
<td>0622</td>
</tr>
<tr>
<td>APC 0623</td>
<td>Level III Vascular Access Procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36560</td>
<td>Insert tunneled cv cath</td>
<td>0115</td>
<td>0623</td>
</tr>
<tr>
<td>36561</td>
<td>Insert tunneled cv cath</td>
<td>0115</td>
<td>0623</td>
</tr>
<tr>
<td>36563</td>
<td>Insert tunneled cv cath</td>
<td>0119</td>
<td>0623</td>
</tr>
<tr>
<td>36565</td>
<td>Insert tunneled cv cath</td>
<td>0115</td>
<td>0623</td>
</tr>
<tr>
<td>36582</td>
<td>Replace tunneled cv cath</td>
<td>0115</td>
<td>0623</td>
</tr>
<tr>
<td>36583</td>
<td>Insertion of access device</td>
<td>0119</td>
<td>0623</td>
</tr>
<tr>
<td>36640</td>
<td>Insertion catheter, artery</td>
<td>0032</td>
<td>0623</td>
</tr>
<tr>
<td>36260</td>
<td>Insertion of infusion pump</td>
<td>0119</td>
<td>0623</td>
</tr>
<tr>
<td>36261</td>
<td>Revision of infusion pump</td>
<td>0124</td>
<td>0623</td>
</tr>
<tr>
<td>APC 0115</td>
<td>Cannula/Access Device Procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36835</td>
<td>Artery to vein shunt</td>
<td>0115</td>
<td>0115</td>
</tr>
<tr>
<td>35903</td>
<td>Excision, graft, extremity</td>
<td>0115</td>
<td>0115</td>
</tr>
<tr>
<td>36815</td>
<td>Insertion of cannula</td>
<td>0115</td>
<td>0115</td>
</tr>
<tr>
<td>36861</td>
<td>Cannula declotting</td>
<td>0115</td>
<td>0115</td>
</tr>
<tr>
<td>35761</td>
<td>Exploration of artery/vein</td>
<td>0115</td>
<td>0115</td>
</tr>
<tr>
<td>49419</td>
<td>Insert abdominal cath for chemo</td>
<td>0115</td>
<td>0115</td>
</tr>
<tr>
<td>36800</td>
<td>Insertion of cannula</td>
<td>0115</td>
<td>0115</td>
</tr>
<tr>
<td>37204</td>
<td>Transcatheter occlusion</td>
<td>0115</td>
<td>0115</td>
</tr>
<tr>
<td>36810</td>
<td>Insertion of cannula</td>
<td>0115</td>
<td>0115</td>
</tr>
<tr>
<td>APC 0109</td>
<td>Removal of Implanted Devices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33284</td>
<td>Remove pt-activated heart recorder</td>
<td>0109</td>
<td>0109</td>
</tr>
<tr>
<td>63746</td>
<td>Removal of spinal shunt</td>
<td>0109</td>
<td>0109</td>
</tr>
</tbody>
</table>
CPT code 76362 CT guidance for, and monitoring of, visceral tissue ablation is reassigned to APC 0333 (Computerized Axial Tomography and Computerized Angiography Without Contrast Followed by Contrast) with an APC median cost of $303 for CY 2006. This code was originally proposed to be assigned to APC 0332 (Computerized Axial Tomography and Computerized Angiography without Contrast). This will be the case even where the procedure is not performed without and with contrast because of the extended CT time required for the tissue ablation procedure. Code 76362 will continue to have a status indicator of S.

CPT 0067T Diagnostic computed tomographic colonography (CTC-Dx) will be reassigned to APC 0333 (CT and CTA without contrast followed by contrast) for CY 2006, from APC 0332 in 2005 (CT and CTA without contrast).

Category III CPT codes 0071T Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue, and 0072T Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater or equal to 200 cc of tissue will be assigned to APC 0195 (Level IX Female Reproductive Procedures) and 0202 (Level X Female Reproductive Procedures), respectively for CY 2006.

Nonimaging nuclear medicine studies have been split into two APCs for 2006, as follows:

In conjunction with this change, changes are also made to the HCPCS codes for the radiopharmaceuticals used in these studies. HCPCS code C9013 will be deleted, HCPCS code A9546 (Cobalt CO–57/58, cyanocobalamin, diagnostic, per study dose, up to 1 microcurie) will replace HCPCS code C1079, and HCPCS code A9559 (Cobalt CO–57 cyanocobalamin, oral, diagnostic, per study dose, up to 1 microcurie) will replace HCPCS code Q3012. These codes, of course, will be reimbursed in addition to the APC for the study itself.

Kyphoplasty codes will be reassigned and modified somewhat for CY 2006. The new Category I codes include the bone biopsy when performed, so no separate reimbursement will be available for that procedure. However, hospitals will bill separately for the fluoroscopic guidance used during the procedure. CPT codes 22523 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy
included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation; thoracic 22524; lumbar and 22525 each additional thoracic or lumbar vertebral body (add-on code) will be assigned to APC 0052 (Level IV Musculoskeletal Procedures Except Hand and Foot) for CY 2006.

Neurostimulator electrode implantation codes have also been reassigned for CY 2006. CPT codes 63655 Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural (from APC 0225), 64575 Incision for implantation of neurostimulator electrodes; peripheral nerve (includes sacral nerve) (from APC 0040), 64577 Incision for implantation of neurostimulator electrodes; autonomic nerve (from APC 0225), 64580 Incision for implantation of neurostimulator electrodes; neuromuscular (from APC 0225) and 64581 Incision for implantation of neurostimulator electrodes; sacral nerve, transforaminal placement (from APC 0040) have been reassigned to newly created APC 0061 (Laminectomy or incision for implantation of neurostimulator).

CPT code 32019 Insertion of indwelling tunneled pleural catheter with cuff (a new category I code in 2005) will be reassigned to APC 0427 (Level III tube changes and repositioning) for the CY 2006, transferred from CPT 0070 (Thoracentesis/Lavage).

For CY 2006, CMS will reassign CPT code 47370 Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency to APC 0132 (Level III Laparoscopy) from APC 0131 because the costs far exceed the median cost for APC 0131.

**Allergy Testing (page 68610)**

The fact that some allergy tests are reported “per test” and others are reported “per visit” has led to confusion. All the allergy tests have been divided into two APCs as follows:

The existing APC 0370 (Allergy Tests) will now be used to report “per visit” allergy tests, and a new APC 0381 will be created for Single Allergy Tests.

**Aphaeresis (page 68611)**

An issue of concern for hospital compliance officers was raised in reference to code 36515 Therapeutic aphaeresis; with extracorporeal immunoadsorption and plasma reinfusion, which is apparently in some instances being reported in place of code 36415 Collection of venous blood by venipuncture. Clearly, there are significantly different
procedures. All chargemaster teams should review their CDMs to assure that the correct code is being reported. Some claims reported costs less than $200 for this procedure, for which the median is $1597.

**Bone marrow harvest for transplantation (page 68613)**

Another code which may be consistently misreported is 38230 Bone marrow harvesting for transplantation. Costs reported with his code ranged from $140 to $66.770! Again, all hospitals should review the CDM and coding guidelines to assure than this code is being reported appropriately.

**Computer Assisted Navigational Procedures (page 68613)**

Category III CPT codes 0054T, 0055T, and 0056T, used to report computer assisted navigation during musculoskeletal procedures, along with category I code 61795 Stereotactic computer assisted volumetric procedure, intracranial, extracranial and spinal will be placed in APC 0302 with for CY 2006, and APC 0302 will receive a new name, “Computer Assisted Navigational Procedures”. All these codes are add-on codes.

**Wound Care (page 68617)**

CPT codes 97602 Nonselective debridement of wounds, 97605 Negative pressure wound therapy 50 cm sq, and 97606 Negative pressure wound therapy greater than 50 cm sq had been previously classified as “always therapy” services, that would always be provided under a PT or OT plan of care, and, as such would be reimbursed under the Physician Fee Schedule and carry a status indicator of A. On the other hand, CPT codes 97597 Selective wound care 20 sq cm and 97598 Selective wound care greater than 20 sq cm were designated as “sometimes therapy” codes, which could be performed both under a PT/OT plan of care and by an advanced practice nurse or physician. For CY 2006, all five codes will be designated as “sometimes therapy” and will be assigned to the following APCs when NOT performed as a part of a PT/OT plan of care:

- 97602 – APC 0340 Minor Ancillary Procedures (status indicator X)
- 97597 – APC 0012 Level I Debridement and Destruction (status indicator T)
- 97605 – APC 0012 Level I Debridement and Destruction (status indicator T)
- 97598 – APC 0013 Level II Debridement and Destruction (status indicator T)
- 97606 – APC 0013 Level II Debridement and Destruction (status indicator T)

When performed as a part of a PT/OT plan of care, the codes should be reported in the usual way with the GP or GO modifier, and reimbursement will be made per the Physicians Fee Schedule.

**Payment Changes for Devices – Device Dependent APCs (page 68618)**

The reporting of device codes for so-called device dependent APCs was made mandatory for CY 2005. Changes for CY 2006 primarily relate to adjustments to costs based upon a
year’s worth of data. For CY 2006, CMS has set the medians for device-dependent APCs at the highest of: the median cost of all single bills; the median cost calculated using only claims that contain pertinent device codes and for which the device cost is greater than $1; or 90 percent of the payment median that was used to set the CY 2005 payment rates. Although some commenters had requested additional reimbursement for so-called high-cost devices, no special calculations will be used for them. Table 16 on page 68624-68625 lists the median cost adjustments for the device-dependent APCs.

**Pass-through Devices**

Categories C1814 (Retinal tamponade device, silicone oil), C1818 (Integrated keratoprosthesis), and C1819 (Tissue localization excision device) will expire from pass-through status effective 12/31/05, although the codes are still active and should be reported as usual. There are no established categories that would continue for pass-through status in CY 2006.

**Surgical Insertion and Implantation Criterion (page 68624)**

An important change in the definition of implants occurs with CY 2006, in that a device now may be inserted through a natural orifice, not just a surgically created incision.

**Payment Changes for Drugs, Biologicals, and Radiopharmaceuticals (page 68631)**

Next follows 100+ pages of discussion regarding specific drugs, radiopharmaceuticals and biologicals. These will not be reported in detail here. On page 68635, table 19 lists the 19 drugs eligible for pass-through payment in CY 2006, along with their HCPCS codes and APCs. These are the only drugs with current pass-through status. Table 19 is reproduced here.

There is also an extensive discussion of calculations for reimbursement rates for drugs in this section. This discussion begins on approximately page 68639 of the Final Rule.

A number of C codes will be deleted effective 12/31/05 and replaced with A and J codes. These are enumerated on table 25 on page 68645. Included are several skin substitutes
(Dermagraft and Apligraf) as well as a number of radiopharmaceuticals and echocardiography contrast agents.

**IVIG (page 68649)**

The reimbursement for intravenous immunoglobulin was reduced for CY 2006. To prevent hardship on patients in need of this agent, code G0332 Preadministration-related services for intravenous infusion of immunoglobulin, per infusion encounter, has been developed, and should be reported along with the code for the drug. G0332 will map to APC 1502, a new technology APC with a payment rate of $75.

**LOCM (page 68652)**

The new Q codes (Q9945-Q9951) created for LOCM in 2005 will be activated on 01/01/06, replacing codes A4644-A4646. The final rule did not mention documentation of medical necessity for low osmolar contrast media with the new codes.

**Handling Fee APCs and Final Reimbursement Calculation**

There will be no handling fee APCs implemented for CY 2006. Three classes of handling C codes had been proposed, but will not be enacted at this time. The final reimbursement for separately paid drugs will be average sales price (ASP) plus 6%. Clotting factors will also be paid at ASP +6%, as will intrathecal drugs and single-indication orphan drugs.

Table 26 on page 66867 contains a listing of new drugs, biologicals, and radiopharmaceuticals without pass-through status, and their APCs. Included in this list for the first time are codes for high osmolar contrast media.

**Newly Approved Drugs (page 68669)**

Drugs given as a part of a covered outpatient procedure that have been approved by the Food and Drug Administration but not yet received a HCPCS code should be reported with code C9399 Unclassified drug or biological. This will result in claim suspension and individual pricing by the FI. Reimbursement will be at 95% of Red Book average wholesale price (AWP) or equivalent.

**Brachytherapy Sources (page 68674)**

Table 28, page 68676, lists all brachytherapy sources that will be separately paid in 2006, as follows:
Drug Administration Injections and Infusions (page 68676)

CPT 2006 contains 33 new codes for injections and infusions. CMS is adopting 20 of these codes for APC reimbursement purposes, while choosing not to adopt 13 more at this time. Thus, hospitals will bill for infusions and injections with a combination of new CPT codes and new HCPCS Level II codes. CMS created six new HCPCS Level II C codes to replace the 13 CPT codes they did not adopt, plus an additional two codes for use in reporting infusions performed via a pump. The 13 codes that CMS chose not to adopt are those that include the terms “sequential”, “initial” or “concurrent” in their code descriptions.

Table 20 on page 68679 lists the CPT codes that CMS will recognize for CY 2006.
Table 26 on page 68680 lists the new HCPCS codes that will replace the 13 CPT codes that CMS is not recognizing.
In addition, two codes have been developed to report nonchemo services requiring a pump:

**Hospital Coding for Evaluation and Management Services (page 68684)**

Unfortunately, no new codes or guidelines are issued with the final rule regarding facility coding for E&M services.

**Blood and Blood Products (page 68684)**

Payment for blood and blood products will continue in CY 2006. Table 33 on page 68687 lists the products, their codes, APCs and adjusted median costs. Guidelines for billing issued in 2005 will continue to be in effect.

**Observation Services (page 68688)**

The existing G codes (G0244, G0263, and G0264) will be discontinued and replaced with two new G codes: G0378: Hospital observation services, per hour and G0379: Direct admission of patient for hospital observation care. Hospitals can bill G0379 when they admit a patient directly to observation status without an ED, critical care, or clinic visit at the hospital on the day of or day before observation admission.

The criteria for APC payment of observation services are unchanged. The patient must have congestive heart failure, asthma, or chest pain as an admitting or principal diagnosis, and eight or more hours of observation for the hospital to qualify for observation APC 0339. There must be documentation that the patient was managed by a physician during his or her stay. There is a complete list of eligible ICD-9-CM codes in Table 34 of the final rule on page 68692. Although there had been requests for expansion of this list to include diagnoses such as dehydration, there is no change at this time.

**Inpatient Only List**
Once again, CMS declined to eliminate the inpatient only list entirely, although it did remove an additional 26 codes from the list. The Final Rule also includes a discussion of the inappropriate use of modifier CA with procedures on the inpatient only list. CMS reiterates that modifier CA is to be reported only when the procedure is performed to resuscitate or stabilize a patient with an emergent or life-threatening condition who expires prior to admission. As in the proposed rule, CMS cited several procedures which could not have matched these criteria (e.g. thyroidectomy, repair of nonunion of fracture) reported with modifier CA. When modifier CA is appended to an inpatient procedure, reimbursement is made under APC 0375 (Ancillary Outpatient Services When Patient Expires) at a payment rate of $3,217.47. Thus, this represents a significant compliance issue.

Coding professionals need to be sure that they are assigning modifier CA only when appropriate. This is a significant compliance issue, as CMS does not intend to reimburse hospitals for inpatient only procedures when performed on an outpatient basis. Coding departments should carefully review the guidelines for use of modifier CA on page 68700 of the final rule to assure that they are applying this modifier correctly.

Table 36 on page 68699 lists the codes that were removed from the inpatient only list for CY 2006.

**Status Indicators (page 68701)**

- **A** Services that are billable to fiscal intermediaries but are paid under some payment method other than OPPS (such as fee schedule)
- **B** Services that are billable to fiscal intermediaries but are not payable under OPPS when submitted on an outpatient hospital Part B bill type, but that may be payable by fiscal intermediaries to other provider types when submitted on an appropriate bill type
- **C** Inpatient services that are not payable under OPPS
- **D** Code is discontinued, effective January 1, 2006
- **E** Item or service not covered by Medicare or codes that are not recognized by Medicare.
- **F** Acquisition of corneal tissue paid on a reasonable cost basis, certain CRNA services, and hepatitis B vaccines that are paid on a reasonable cost basis
- **G** Drugs and biologicals that are paid under the OPPS transitional pass-through rules
- **H** Pass-through devices, brachytherapy sources, and separately payable radiopharmaceuticals that are paid on a cost basis
- **K** Drugs and biologicals (including blood and blood products) that are paid in separate APCs under OPPS, but that are not paid under the OPPS transitional pass-through rules
- **L** Influenza and pneumococcal immunizations that are paid at reasonable cost but to which no coinsurance or copayment apply
- **M** Services that are only billable to carriers and not to fiscal intermediaries and that are not payable under the OPPS
- **N** Services that are paid under OPPS, but for which payment is packaged into another service or APC group
P Services that are paid under the OPPS, but only in partial hospitalization programs
Q Packaged services subject to separate payment under OPPS payment criteria.
S Significant procedures that are not discounted when multiple and that are subject to separate APC payment under OPPS
T Significant services that are paid under OPPS and to which the multiple procedure payment discount under the OPPS applies
V Medical visits (including emergency department or clinic visits) that are paid under OPPS
X Ancillary services that are paid under the OPPS
Y Nonimplantable durable medical equipment that must be billed directly to the durable medical equipment regional carrier rather than to the fiscal intermediary

The list on page 68701 includes all active status indicators for CY 2006.

**Imaging Families (page 68703)**

In the proposed rule, CMS had listed a number of diagnostic imaging procedures that logically grouped into “families”, where significant economies of scale could be expected if additional procedures from the same “family” were performed in addition to the initial procedure. The original proposal was to reduce reimbursement for each of the additional procedures by 50%. In the Final Rule, CMS abandoned this plan for CY 2006 and will continue to reimburse such procedures at 100%.

**Interrupted Procedure Payment Policies (page 68708)**

Reimbursement will continue unchanged for procedures modifier with 73 (reimbursed at 50% of allowable) and 74 (reimbursed at 100% of allowable), but reimbursement for those procedures modifier with 52 will be reduced by 50%.

**Physician Oversight of Nonphysician Practitioners in Critical Access Hospitals (page 68712)**

Physicians must review and sign a sample of nonphysician practitioner outpatient records periodically, but not less than every two weeks, only if State law requires such record reviews or cosignatures, or both, by a collaborating physician.

**List of APCs**

A complete list of APCs for CY 2006, with status indicators, relative weights, copayment amounts and payment rates, can be found on pages 68729-68751 (Addendum A).

**List of CPT/HCPCS Codes**
A complete list of CPT/HCPCS codes with status indicators, APCs, relative weights, copayment amounts and payment rates can be found on pages 68752-68913 (Addendum B).

**Inpatient Only Procedures**

Addendum E, pages 68916-68964 contains a complete list of CPT codes, with descriptors, that are paid only on an inpatient basis.