



News Flash – Medicare paid over \$92 million in incentives for 2008 under the Physician Quality Reporting Initiative (PQRI). More than 85,000 physicians and other eligible professionals who successfully reported quality-related data to Medicare under the 2008 PQRI received these payments, which were well above the \$36 million paid in 2007. The number of eligible professionals who earned an incentive payment increased by one-third from 2007, when 56,700 eligible professionals earned an incentive payment. More information about the PQRI program, including participation guidance and the criteria to qualify for an incentive payment is available at <http://www.cms.hhs.gov/PQRI> on the CMS website.

MLN Matters® Number: MM6579

Related Change Request (CR) #: 6579

Related CR Release Date: November 27, 2009

Effective Date: February 26, 2010

Related CR Transmittal #: R6040TN

Implementation Date: February 26, 2010

Payment for Implantable Tissue Markers: Healthcare Common Procedure Coding System (HCPCS) Code A4648

Provider Types Affected

This article is for physicians and other providers who bill Medicare carriers and A/B Medicare Administrative Contractors (A/B MAC) for implantable tissue markers provided Medicare beneficiaries.

What You Need to Know

Change Request (CR) 6579, from which this article is taken, clarifies guidance regarding payment for implantable tissue markers (HCPCS code A4648 -- Tissue marker, implantable, any type, each). When billed on a physician claim and used in conjunction with Current Procedural Terminology (CPT) code 55876 (the placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple), the use of implantable tissue markers (HCPCS code A4648) is separately billable and payable by Medicare. Make sure that your billing staffs are aware of this policy.

Background

Disclaimer

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CR 6579 announces that HCPCS code A4648 is separately billable and payable when billed on a physician claim and when used in conjunction with CPT code 55876. Therefore, in these instances, your carrier or A/B MAC will make a separate payment for HCPCS code A4648. If you bill A4648 on a physician claim and code 55876 is not also billed for that same date of service, Medicare will deny payment for A4648 with a Claim Adjustment Reason Code of B15 indicating “This service /procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.”

Note that there are no changes in CR 6579 to current payment policy for A4648 with regard to payment to hospitals for inpatient or outpatient hospital services or with regard to payment to Ambulatory Surgery Centers.

Additional Information

You can find the official instruction, CR 6579, issued to your carrier or A/B MAC by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R6040TN.pdf> on the Centers for Medicare & Medicaid (CMS) website.

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

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