CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2386	**Date: January 13, 2012**
	Change Request 7672

Transmittal 2376, dated December 29, 2011, is being rescinded and replaced by Transmittal 2386, dated January 13, 2012 to correct an error in the fixed-dollar threshold amount in section 17.d. The correct amount is $2,025. In section 5.c., table 5, HCPCS code Q1079 has been corrected to Q0179. HCPCS code Q1079 doesn't exist. Additionally, Section 18 also has been updated to reflect section 308 of the *Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA)*. All other information remains the same.

SUBJECT: January 2012 Update of the Hospital Outpatient Prospective Payment System (OPPS)

I. SUMMARY OF CHANGES: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the January 2012 OPPS update. It affects Chapter 1, Section 50.3.2, Chapter 4, Sections 10 and 20, and Chapter 18, Section 10.2.1. CMS is updating information in these sections.

The January 2012 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this Change Request (CR).

EFFECTIVE DATE: January 1, 2012
IMPLEMENTATION DATE: January 3, 2012

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/50.3.2/Policy and Billing Instructions for Condition Code 44
R	4/Table of Contents
N	4/10.2.2/Cardiac Resynchronization Therapy
R	4/10.12/Payment Window for Outpatient Services Treated as Inpatient Services
R	4/20.6.4/Use of Modifiers for Discontinued Services

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification

Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 2386	Date: January 13, 2012	Change Request: 7672

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SUBJECT: January 2012 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Effective Date: January 1, 2012

Implementation Date: January 3, 2012

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the January 2012 OPPS update. The January 2012 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this Change Request (CR). The TPTCCA extends the Outpatient Hold-Harmless provision, effective for dates of service on or after January 1, 2012, through February 29, 2012, to rural hospitals with 100 or fewer beds and to all Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs) regardless of bed size and reclassification wage indices originally authorized under section 508 of the MMA. This notification includes instructions addressing hold harmless payment.

The January 2012 revisions to I/OCE data files, instructions, and specifications are provided in CR 7668, "January 2012 Integrated Outpatient Code Editor (I/OCE) Specifications Version 13.0."

B. Policy:

1. New Device Pass-Through Categories

Section 1833(t)(6)(B) of the Social Security Act requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that CMS create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

CMS is establishing one new device pass-through category as of January 1, 2012. The following table provides a listing of new coding and payment information concerning the new device category for transitional pass-through payment.

Table 1 – New Device Pass-Through Code

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	APC for Device Offset from Payment
C1886	01-01-12	H	1886	Catheter, ablation	Catheter, extravascular tissue ablation, any modality (insertable)	0415

a. Device Offset from Payment for C1886

Section 1833(t)(6)(D)(ii) of the Act requires that CMS deduct from pass-through payments for devices an amount that reflects the portion of the APC payment amount that CMS determines is associated with the cost of the device (70 FR 68627-8).

CMS has determined that it is able to identify a portion of the APC payment amount associated with the cost of C1886 (Catheter, extravascular tissue ablation, any modality (insertable)), in APC 0415, Level II, Endoscopy, lower airway. The device offset from payment represents this deduction from pass-through payments for category C1886, when it is billed with a service included in APC 0415. The device offset amount for APC 0415, along with the device offsets for other APCs, is available under "Annual Policy Files" on the CMS OPPS Web site at http://www.cms.gov/HospitalOutpatientPPS/.

b. Revised Device Offset from Payment for Category C1840

Effective January 1, 2012, device pass-through category C1840 must be billed with procedure code C9732 (Insertion of ocular telescope prosthesis including removal of crystalline lens), (see New Procedure Code section below) to receive pass-through payment. C9732 is assigned to APC 0234, Level IV Anterior Segment Eye Procedures. Therefore, as of January 1, 2012, device C1840 will be used with an APC 0234 service. The new device offset for CY 2012 for APC 0234, is available under "Annual Policy Files" on the CMS OPPS Web site at http://www.cms.gov/HospitalOutpatientPPS/.

2. New Procedure Code

CMS is establishing one new procedure code effective January 1, 2012. The following table provides a listing of the descriptor and payment information for this new code.

Table 2 – New Procedure Code

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor
C9732	01-01-12	T	0234	Insert ocular telescope pros	Insertion of ocular telescope prosthesis including removal of crystalline lens

a. Billing Instructions for C9732 and C1840

Pass-through category C1840 (Lens, intraocular (telescopic)), is to be billed and paid for as a pass-through device only when provided with C9732 (Insertion of ocular telescope prosthesis including removal of crystalline lens) beginning on and after the effective date for C9732 of January 1, 2012. These billing instructions supersede prior billing instructions for C1840 provided in the October 2011 Update of the OPPS, Transmittal 2296, CR 7545.

3. Billing for Thermal Anal Lesions by Radiofrequency Energy

For CY 2012, the CPT Editorial Panel created new CPT code 0288T (Anoscopy, with delivery of thermal energy to the muscle of the anal canal (e.g., for fecal incontinence)) to describe the procedure associated with radiofrequency energy creation of thermal anal lesions. Prior to CY 2012, this procedure was described by HCPCS code C9716 (Creations of thermal anal lesions by radiofrequency energy). In Addendum B of the CY 2012 OPPS/ASC final rule, both HCPCS code C9716 and 0288T were assigned to specific APCs. Specifically, HCPCS code C9716 was assigned to APC 0150 (Level IV Anal/Rectal Procedures) and CPT code 0288T was assigned to APC 0148 (Level I Anal/Rectal Procedures). Because HCPCS code C9716 is described by CPT code 0288T, CMS is deleting HCPCS code C9716 on December 31, 2011, since it will be replaced with CPT

code 0288T effective January 1, 2012. In addition, CPT code 0288T is being reassigned from APC 0148 to APC 0150 effective January 1, 2012. This change will be reflected in the January 2012 OPPS I/OCE and OPPS Pricer. Table 3 below lists the final OPPS status indicator and APC assignment for HCPCS codes C9716 and 0288T.

Table 3 – CY 2012 OPPS Status Indicator and APC Assignment for HCPCS Codes C9716 and 0288T

HCPCS Code	Short Descriptor	CY 2012 SI	CY 2012 APC
C9716	Radiofrequency energy to anu	D	N/A
0288T	Anoscopy w/rf delivery	T	0150

4. Cardiac Resynchronization Therapy Payment for CY 2012

Effective for services furnished on or after January 1, 2012, cardiac resynchronization therapy involving an implantable cardioverter defibrillator (CRT-D) will be recognized as a single, composite service combining implantable cardioverter defibrillator procedures and pacing electrode insertion procedures when performed on the same date of service.

CMS also is implementing claims processing edits that will return to providers incorrectly coded claims on which a pacing electrode insertion procedure described by CPT code 33225 (Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (including upgrade to dual chamber system)) is billed without one of the primary CPT codes for insertion of an implantable cardioverter defibrillator or pacemaker as specified in the 2012 CPT code book. CMS is adding new section 10.2.2 to Pub 100-04, Medicare Claims Processing Manual, Chapter 4, to reflect the implementation of this new composite service policy and claims processing edits for CPT code 33225.

5. Billing for Drugs, Biologicals, and Radiopharmaceuticals

a. Reporting HCPCS Codes for All Drugs, Biologicals, and Radiopharmaceuticals

Hospitals are strongly encouraged to report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. It is also of great importance that hospitals billing for these products make certain that the reported units of service of the reported HCPCS codes are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used in the care of the patient.

More complete data from hospitals on the drugs and biologicals provided during an encounter would help improve payment accuracy for separately payable drugs and biologicals in the future. CMS strongly encourages hospitals to report HCPCS codes for all drugs and biologicals furnished, if specific codes are available. CMS realizes that this may require hospitals to change longstanding reporting practices. Precise billing of drug and biological HCPCS codes and units, especially in the case of packaged drugs and biologicals for which the hospital receives no separate payment, is critical to the accuracy of the OPPS payment rates for drugs and biologicals each year.

CMS notes that it makes packaging determinations for drugs and biologicals annually based on charge information reported with specific HCPCS codes on claims, so the accuracy of OPPS payment rates for drugs and biologicals improves when hospitals report charges for all items and services that have HCPCS codes under those HCPCS codes, whether or not payment for the items and services is packaged or not. It is CMS' standard ratesetting methodology to rely on hospital cost and charge information as it is reported to CMS by hospitals through the claims data and cost reports. Precise billing and accurate

cost reporting by hospitals allow CMS to most accurately estimate the hospital costs for items and services upon which OPPS payments are based.

CMS reminds hospitals that under the OPPS, if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used in the care of the patient. The mixing together of two or more products does not constitute a "new" drug as regulated by the Food and Drug Administration (FDA) under the New Drug Application (NDA) process. In these situations, hospitals are reminded that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399 (Unclassified drug or biological) is for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned.

Unless otherwise specified in the long description, HCPCS descriptions refer to the non-compounded, FDA-approved final product. If a product is compounded and a specific HCPCS code does not exist for the compounded product, the hospital should report an appropriate unlisted code such as J9999 or J3490.

b. New CY 2012 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

For CY 2012, several new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. These new codes are listed in Table 4 below.

Table 4 – New CY 2012 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2012 HCPCS Code	CY 2012 Long Descriptor	CY 2012 SI	CY 2012 APC
A9585	Injection gadobutrol, 0.1 ml	N	N/A
C9287	Injection, brentuximab vedotin, 1 mg	G	9287
C9366	EpiFix, per square centimeter	G	9366
J0257	Injection, alpha 1 proteinase inhibitor (human), (glassia), 10 mg	K	1415
J7180	Injection, factor xiii (antihemophilic factor, human), 1 i.u.	G	1416
J7326	Hyaluronan or derivative, gel-one, for intra-articular injection, per dose	K	1417
J8561	Everolimus, oral, 0.25 mg	K	1418
Q4122	Dermacell, per square centimeter	K	1419

c. Other Changes to CY 2012 HCPCS for Certain Drugs, Biologicals, and Radiopharmaceuticals

Many HCPCS and CPT codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS and CPT code descriptors that will be effective in CY 2012. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2011, and replaced with permanent HCPCS codes in CY 2012. Hospitals should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the active CY 2012 HCPCS and CPT codes.

Table 5 below notes those drugs, biologicals, and radiopharmaceuticals that have undergone changes in either their HCPCS codes, their long descriptors, or both. Each product's CY 2011 HCPCS code and CY 2011 long descriptor are noted in the two left hand columns, with the CY 2012 HCPCS code and long descriptor are noted in the adjacent right hand columns.

Table 5 – Other CY 2012 HCPCS Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2011 HCPCS code	CY 2011 Long Descriptor	CY 2012 HCPCS Code	CY 2012 Long Descriptor
C9270	Injection, immune globulin (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg	J1557	Injection, immune globulin, (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg
C9272	Injection, denosumab, 1 mg	J0897	Injection, denosumab, 1 mg
C9273***	Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion	Q2043	Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion
C9274	Crotalidae Polyvalent Immune Fab (Ovine), 1 vial	J0840	Injection, crotalidae polyvalent immune fab (ovine), up to 1 gram
C9276	Injection, cabazitaxel, 1 mg	J9043	Injection, cabazitaxel, 1 mg
C9277	Injection, alglucosidase alfa (Lumizyme), 1 mg	J0221	Injection, alglucosidase alfa, (lumizyme), 10 mg
C9278*	Injection, incobotulinumtoxin A, 1 unit	J0588	Injection, incobotulinumtoxin A, 1 unit
Q2040*	Injection, incobotulinumtoxin A, 1 unit	J0588	Injection, incobotulinumtoxin A, 1 unit
C9280	Injection,eribulin mesylate, 1 mg	J9179	Injection, eribulin mesylate, 0.1 mg
C9281	Injection, pegloticase, 1 mg	J2507	Injection, pegloticase, 1 mg
C9282	Injection, ceftaroline fosamil, 10 mg	J0712	Injection, ceftaroline fosamil, 10 mg
C9283	Injection, acetaminophen, 10 mg	J0131	Injection, acetaminophen, 10 mg
C9284	Injection, ipilimumab, 1 mg	J9228	Injection, ipilimumab, 1 mg
C9365	Oasis Ultra Tri-Layer matrix, per square centimeter	Q4124	Oasis ultra tri-layer wound matrix, per square centimeter
C9406	Iodine I-123 ioflupane, diagnostic, per study dose, up to 5 millicuries	A9584	Iodine i-123 ioflupane, diagnostic, per study dose, up to 5 millicuries
J0220	Injection, alglucosidase alfa, 10 mg	J0220	Injection, alglucosidase alfa, 10 mg, not otherwise classified
J0256	Injection, alpha 1 - proteinase inhibitor - human, 10 mg	J0256	Injection, alpha 1 proteinase inhibitor (human), not otherwise specified, 10mg
J1561**	'Injection, immune globulin, (Gamunex), intravenous, non-lyophilized (e.g. liquid), 500 mg	J1561	Injection, immune globulin, (Gamunex/Gamunex-c/Gammaked), non-lyophilized (e.g., liquid), 500 mg
Q2044	Injection, belimumab, 10 mg	J0490	Injection, belimumab, 10 mg
Q2042	Injection, hydroxyprogesterone	J1725	Injection, hydroxyprogesterone

CY 2011 HCPCS code	CY 2011 Long Descriptor	CY 2012 HCPCS Code	CY 2012 Long Descriptor
	caproate, 1 mg		caproate, 1 mg
J7130	Hypertonic saline solution, 50 or 100 meq, 20 cc vial	J7131	Hypertonic saline solution, 1 ml
Q2041	Injection, von willebrand factor complex (human), wilate, 1 i.u. vwf:rco	J7183	Injection, von willlebrand factor complex (human), wilate, 1 i.u. vwf:rco
Q0179	Ondansetron hydrochloride 8 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	Q0162	Ondansetron 1 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen

* HCPCS code C9278 was replaced with HCPCS code Q2040 effective April 1, 2011. HCPCS code Q2040 was subsequently replaced with HCPCS code J0588, effective January 1, 2012.

** The short descriptor for HCPCS code J1561 has been revised from "Gamunex/Gamunex C" to "Gamunex, Gamunex-C, Gammaked" effective January 1, 2012.

*** HCPCS code C9273 was replaced with HCPCS code Q2043 effective July 1, 2011.

d. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective January 1, 2012

For CY 2012, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 4 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2012, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. CMS notes that for the first quarter of CY 2012, payment for drugs and biologicals with pass-through status is not made at the Part B Drug Competitive Acquisition Program (CAP) rate, as the CAP program was postponed beginning January 1, 2009. Should the Part B Drug CAP program be reinstituted sometime during CY 2012, CMS would again use the Part B drug CAP rate for pass-through drugs and biologicals if they are a part of the Part B drug CAP program, as required by the statute.

In the CY 2012 OPPS/ASC final rule with comment period, CMS stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Effective January 1, 2012, payment rates for many drugs and biologicals have changed from the values published in the CY 2012 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2011. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2012 release of the OPPS Pricer. CMS is not publishing the updated payment rates in this instruction implementing the January 2012 update of the OPPS. However, the updated payment rates effective January 1, 2012 can be found in the January 2012 update of the OPPS Addendum A and Addendum B on the CMS Web site at http://www.cms.gov/HospitalOutpatientPPS/.

e. Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2011 through December 31, 2011

The payment rates for several HCPCS codes were incorrect in the October 2011 OPPS Pricer. The corrected payment rates are listed in Table 6 below and have been installed in the January 2012 OPPS Pricer, effective for services furnished on October 1, 2011, through implementation of the January 2012 update.

Table 6 – Updated payment Rates for Certain HCPCS Codes Effective October 1, 2011 through December 31, 2011

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J9600	K	0856	Porfimer sodium injection	$19,143.46	$3,828.69
Q4121	K	1345	Theraskin	$20.77	$4.15

f. Correct Reporting of Biologicals When Used As Implantable Devices

When billing for biologicals where the HCPCS code describes a product that is only surgically implanted or inserted, whether the HCPCS code is identified as having pass-through status or not, hospitals are to report the appropriate HCPCS code for the product. Units should be reported in multiples of the units included in the HCPCS descriptor. Providers and hospitals should not bill the units based on the way the implantable biological is packaged, stored, or stocked. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the implantable biological. Therefore, before submitting Medicare claims for biologicals that are used as implantable devices, it is extremely important to review the complete long descriptors for the applicable HCPCS codes. In circumstances where the implanted biological has pass-through status as a device, separate payment for the device is made. In circumstances where the implanted biological does not have pass-through status, the OPPS payment for the implanted biological is packaged into the payment for the associated procedure.

When billing for biologicals where the HCPCS code describes a product that may either be surgically implanted or inserted or otherwise applied in the care of a patient, hospitals should not separately report the biological HCPCS codes, with the exception of biologicals with pass-through status, when using these items as implantable devices (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures. Under the OPPS, hospitals are provided a packaged APC payment for surgical procedures that includes the cost of supportive items, including implantable devices without pass-through status. When using biologicals during surgical procedures as implantable devices, hospitals may include the charges for these items in their charge for the procedure, report the charge on an uncoded revenue center line, or report the charge under a device HCPCS code (if one exists) so these costs would appropriately contribute to the future median setting for the associated surgical procedure.

Hospitals are reminded that HCPCS codes describing skin substitutes (Q4100 – Q4130) should only be reported when used with one of the CPT codes describing application of a skin substitute (15271-15278). These Q codes for skin substitutes should not be billed when used with any other procedure besides the skin substitute application procedures.

g. Payment for Therapeutic Radiopharmaceuticals

Beginning in CY 2010, nonpass-through separately payable therapeutic radiopharmaceuticals are paid under the OPPS based upon the ASP. If ASP data are unavailable, payment for therapeutic radiopharmaceuticals will be provided based on the most recent hospital mean unit cost data. Therefore,

for January 1, 2012, the status indicator for separately payable therapeutic radiopharmaceuticals is "K" to reflect their separately payable status under the OPPS. Similar to payment for other separately payable drugs and biologicals, the payment rates for nonpass-through separately payable therapeutic radiopharmaceuticals will be updated on a quarterly basis.

Table 7 – Nonpass-Through Separately Payable Therapeutic Radiopharmaceuticals for January 1, 2012

CY 2012 HCPCS Code	CY 2012 Long Descriptor	Final CY 2012 APC	Final CY 2012 SI
A9517	Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie	1064	K
A9530	Iodine I-131 sodium iodide solution, therapeutic, per millicurie	1150	K
A9543	Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries	1643	K
A9545	Iodine I-131 tositumomab, therapeutic, per treatment dose	1645	K
A9563	Sodium phosphate P-32, therapeutic, per millicurie	1675	K
A9564	Chromic phosphate P-32 suspension, therapeutic, per millicurie	1676	K
A9600	Strontium Sr-89 chloride, therapeutic, per millicurie	0701	K
A9604	Samarium SM-153 lexidronam, therapeutic, per treatment dose, up to 150 millicuries	1295	K

h. Payment Offset for Pass-Through Diagnostic Radiopharmaceuticals

Effective for nuclear medicine services furnished on and after April 1, 2009, CMS implemented a payment offset for pass-through diagnostic radiopharmaceuticals under the OPPS. As discussed in the April 2009 OPPS CR 6416 (Transmittal 1702), pass-through payment for a diagnostic radiopharmaceutical is the difference between the payment for the pass-through product and the payment for the predecessor product that, in the case of diagnostic radiopharmaceuticals, is packaged into the payment for the nuclear medicine procedure in which the diagnostic radiopharmaceutical is used.

Effective July 1, 2011, the diagnostic radiopharmaceutical reported with HCPCS code A9584 (Iodine i-123 ioflupane, diagnostic, per study dose, up to 5 millicuries) was granted pass-through status under the OPPS and assigned status indicator "G." HCPCS code A9584 will continue on pass-through status for CY 2012 and therefore, when HCPCS code A9584 is billed on the same claim with a nuclear medicine procedure, CMS will reduce the amount of payment for the pass-through diagnostic radiopharmaceutical reported with HCPCS code A9584 by the corresponding nuclear medicine procedure's portion of its APC payment associated with "policy-packaged" drugs (offset amount) so no duplicate radiopharmaceutical payment is made.

The "policy-packaged" portions of the CY 2012 APC payments for nuclear medicine procedures may be found on the CMS Web site at: http://www.cms.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage in the download file labeled 2012 OPPS Offset Amounts by APC.

CY 2012 APCs to which nuclear medicine procedures are assigned and for which CMS expects a diagnostic radiopharmaceutical payment offset could be applicable in the case of a pass-through diagnostic radiopharmaceutical are displayed in Table 8 below.

Table 8 - APCs to Which Nuclear Medicine Procedures are Assigned for CY 2012

CY 2012 APC	CY 2012 APC Title
0308	Positron Emission Tomography (PET) Imaging.
0377	Level II Cardiac Imaging.
0378	Level II Pulmonary Imaging.
0389	Level I Non-imaging Nuclear Medicine.
0390	Level I Endocrine Imaging.
0391	Level II Endocrine Imaging.
0392	Level II Non-imaging Nuclear Medicine.
0393	Hematologic Processing & Studies.
0394	Hepatobiliary Imaging.
0395	GI Tract Imaging.
0396	Bone Imaging.
0397	Vascular Imaging.
0398	Level I Cardiac Imaging.
0400	Hematopoietic Imaging.
0401	Level I Pulmonary Imaging.
0402	Level II Nervous System Imaging.
0403	Level I Nervous System Imaging.
0404	Renal and Genitourinary Studies.
0406	Level I Tumor/Infection Imaging.
0408	Level III Tumor/Infection Imaging.
0414	Level II Tumor/Infection Imaging.

i. Payment Offset for Pass-Through Contrast Agents

Effective for contrast-enhanced procedures furnished on or after January 1, 2010, CMS implemented a payment offset for pass-through contrast agents, for when a contrast-enhanced procedure that is assigned to a procedural APC with a "policy-packaged" drug amount greater than $20.00 (that is not an APC containing nuclear medicine procedures) is billed on the same claim with a pass-through contrast agent on the same date of service. As discussed in the January 2010 OPPS CR 6751 (Transmittal 1882), CMS will reduce the amount of payment for the contrast agent by the corresponding contrast-enhanced procedure's portion of its APC payment associated with "policy-packaged" drugs (offset amount) so no duplicate contrast agent payment is made.

CY 2012 procedural APCs for which CMS expects a contrast agent payment offset could be applicable in the case of a pass-through contrast agent are identified in Table 9 below. Pass-through payment for a contrast agent is the difference between the payment for the pass-through product and the payment for the predecessor product that, in the case of a contrast agent, is packaged into the payment for the contrast-enhanced procedure in which the contrast agent is used. For CY 2012, when a contrast agent with pass-through status is billed with a contrast-enhanced procedure assigned to any procedural APC listed in Table 9 on the same date of service, a specific pass-through payment offset determined by the

procedural APC to which the contrast-enhanced procedure is assigned will be applied to payment for the contrast agent to ensure that duplicate payment is not made for the contrast agent.

For CY 2012, HCPCS code C9275 (Injection, hexaminolevulinate hydrochloride, 100 mg, per study dose) will continue on pass-through status and will be subject to the payment offset methodology for contrast agents. HCPCS code C9275 is assigned a status indicator of "G". Therefore, in CY 2012, CMS will reduce the payment that is attributable to the predecessor contrast agent that is packaged into payment for the associated contrast enhanced procedure reported on the same claim on the same date as HCPCS code C9275 if the contrast-enhanced procedure is assigned to one of the APCs listed in Table 9 below. The "policy-packaged" portions of the CY 2012 APC payments that are the offset amounts may be found on the CMS Web site at: http://www.cms.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage in the download file labeled 2012 OPPS Offset Amounts by APC.

Table 9 – APCs to Which a Pass-Through Contrast Agent Offset May Be Applicable for CY 2012

CY 2012 APC	CY 2012 APC Title
0080	Diagnostic Cardiac Catheterization
0082	Coronary or Non-Coronary Atherectomy
0083	Coronary Angioplasty, Valvuloplasty, and Level I Endovascular Revascularization
0093	Vascular Reconstruction/Fistula Repair without Device
0104	Transcatheter Placement of Intracoronary Stents
0128	Echocardiogram with Contrast
0152	Level I Percutaneous Abdominal and Biliary Procedures
0229	Level II Endovascular Revascularization of the Lower Extremity
0278	Diagnostic Urography
0279	Level II Angiography and Venography
0280	Level III Angiography and Venography
0283	Computed Tomography with Contrast
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast
0333	Computed Tomography without Contrast followed by Contrast
0334	Combined Abdomen and Pelvis CT with Contrast
0337	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast followed by Contrast
0375	Ancillary Outpatient Services When Patient Expires
0383	Cardiac Computed Tomographic Imaging
0388	Discography
0442	Dosimetric Drug Administration
0653	Vascular Reconstruction/Fistula Repair with Device
0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents
0662	CT Angiography
0668	Level I Angiography and Venography
8006	CT and CTA with Contrast Composite
8008	MRI and MRA with Contrast Composite

6. Clarification of Coding for Drug Administration Services

As noted in CR 7271, Transmittal 2141, in 2011 CMS revised Pub. 100-04, Medicare Claims Processing Manual, chapter 4, section 230.2, to clarify the correct coding of drug administration services. Drug administration services are to be reported with a line-item date of services on the day they are provided. In

addition, CMS noted that beginning in CY 2007, hospitals should report only one initial drug administration service, including infusion services, per encounter for each distinct vascular access site, with other services through the same vascular access site being reported via the sequential, concurrent or additional hour codes. CMS has subsequently become aware of new CPT guidance regarding the reporting of initial drug administration services in the event of a disruption in service; however, Medicare contractors are to continue to follow the guidance given in this manual.

7. Provenge Administration

Effective July 1, 2010, the autologous cellular immunotherapy treatment reported with HCPCS code C9273 (Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion) was granted pass-through status under OPPS and assigned status indicator "G." Effective July 1, 2011, this product was assigned to HCPCS code Q2043 (Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion) with status indicator "G." HCPCS code Q2043 will continue on pass-through status for CY 2012.

CMS notes that the HCPCS long descriptor for CY 2012 for HCPCS code Q2043 includes payment for the drug itself, as well as "all other preparatory procedures," referring to the transportation process of collecting immune cells from a patient during a non-therapeutic leukapheresis procedure, subsequently sending the immune cells to the manufacturing facility, and then transporting the immune cells back to the site of service to be administered to the patient. Payment for Q2043 does not include OPPS payment for drug administration.

8. Billing for Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse – National Coverage Determination (NCD)

Effective for claims with dates of service on and after October 14, 2011, CMS will cover annual alcohol screening, and for those who screen positive, up to four, brief, face-to-face behavioral counseling interventions per year for Medicare beneficiaries, including pregnant women: 1) who misuse alcohol, but whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence (defined as at least three of the following: tolerance, withdrawal symptoms, impaired control, preoccupation with acquisition and/or use, persistent desire or unsuccessful efforts to quit, sustains social, occupational, or recreational disability, use continues despite adverse consequences); and 2) who are competent and alert at the time that counseling is provided; and 3) whose counseling is furnished by qualified primary care physicians or other primary care practitioners in a primary care setting. In outpatient hospital settings, as in any other setting, services covered under this NCD must be provided by a primary care provider.

To implement this recent coverage determination, CMS created two new G-codes to report annual alcohol screening and brief, face-to-face behavioral counseling interventions. The long descriptors for both G-codes appear in Table 10.

Table 10 – Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse

CY 2012 HCPCS Code	CY 2012 Long Descriptor	CY 2012 Status Indicator	CY 2012 APC
G0442	Annual alcohol misuse screening, 15 minutes	S	0432
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	S	0432

Both HCPCS codes G0442 and G0443 have been assigned to APC 0432, Health and Behavior Services, and given a status indicator assignment of "S."

Further reporting guidelines on Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse can be found in Pub. 100-03, Medicare National Coverage Determinations Manual, chapter 1, section 210.8 and Pub. 100-04, Medicare Claims Processing Manual, chapter 18, section 180, as well as in Transmittals 138, and 2358, CR 7633 that was published on November 23, 2011.

9. Screening for Depression in Adults – NCD

Effective for claims with dates of service on and after October 14, 2011, Medicare covers annual screening for adults for depression in the primary care setting that have staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up. For the purposes of this NCD, a primary care setting is defined as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, and hospice are not considered primary care settings under this definition.

To implement this recent coverage determination, CMS created a new G-code to report the annual depression screening. The long descriptor for the G-code appears in Table 11.

Table 11 – Annual Depression Screening

CY 2012 HCPCS Code	CY 2012 Long Descriptor	CY 2012 Status Indicator	CY 2012 APC
G0444	Annual Depression Screening, 15 minutes	S	0432

HCPCS code G0444 has been assigned to APC 0432 and given a status indicator assignment of "S."

Further reporting guidelines on depression screening can be found in Pub. 100-03, Medicare National Coverage Determinations Manual, chapter 1, section 210.9 and Pub. 100-04, Medicare Claims Processing Manual, Chapter 18, section 190, as well as in Transmittals 139 and 2359, CR 7637 that was published on November 23, 2011.

10. Billing for Sexually Transmitted Infections (STIs) Screening and High Intensity Behavioral Counseling (HIBC) to Prevent STIs – NCD

Effective for claims with dates of service on and after November 8, 2011, CMS will cover screening for chlamydia, gonorrhea, syphilis and hepatitis B with the appropriate FDA approved/cleared laboratory tests, used consistent with FDA approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations, when ordered by the primary care provider, and performed by an eligible Medicare provider for these services. Also effective for claims with dates of service on and after November 8, 2011, CMS will cover up to two individual - 20 to 30 minute, face to face counseling sessions annually for Medicare beneficiaries for HIBC to prevent STIs for all sexually active adolescents and for adults at increased risk for STIs, if referred for this service by a primary care provider and provided by a Medicare eligible primary care provider in a primary care setting. For the purposes of this NCD, a primary care setting is defined as the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical

centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, clinics providing a limited focus of health care services, and hospice are examples of settings not considered primary care settings under this definition.

To implement this recent coverage determination, CMS created a new G-code to report HIBC to Prevent STIs. The long descriptor for the G-code appears in Table 12.

Table 12 –STIs Screening and HIBC to Prevent STIs

CY 2012 HCPCS Code	CY 2012 Long Descriptor	CY 2012 Status Indicator	CY 2012 APC
G0445	High intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes	S	0432

HCPCS code G0445 has been assigned to APC 0432 and given a status indicator assignment of "S." Further reporting guidelines on HIBC to Prevent STIs will be provided in a future CR.

CMS is deleting screening code G0450 (Screening for sexually transmitted infections, includes laboratory tests for Chlamydia, Gonorrhea, Syphilis, and Hepatitis B) previously released on the 2012 HCPCS tape, from the OPPS addenda, effective November 8, 2011. This screening service will now be identified using ICD-9 screening and diagnosis codes. Coding and billing instructions will be issued in an upcoming CR.

11. Billing for Intensive Behavioral Therapy for Cardiovascular Disease – NCD

Effective for claims with dates of service on and after November 8, 2011, CMS will cover intensive behavioral therapy for cardiovascular disease (referred to below as a CVD risk reduction visit), which consists of the following three components: 1) encouraging aspirin use for the primary prevention of cardiovascular disease when the benefits outweigh the risks for men age 45-79 years and women 55-79 years; 2) screening for high blood pressure in adults age 18 years and older; and 3) intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age, and other known risk factors for cardiovascular and diet-related chronic disease. Effective for claims with dates of service on and after November 8, 2011, CMS covers one face-to-face CVD risk reduction per year for Medicare beneficiaries who are competent and alert at the time that counseling is provided, and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting. For the purposes of this NCD , a primary care setting is defined as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, and hospices are not considered primary care settings under this definition.

To implement this recent coverage determination, CMS created a new G-code to report the CVD risk reduction visit. The long descriptor for the G-code appears in Table 13.

Table 13 – Intensive Behavioral Therapy for Cardiovascular Disease

CY 2012 HCPCS Code	CY 2012 Long Descriptor	CY 2012 Status Indicator	CY 2012 APC
G0446	Intensive behavioral therapy to reduce cardiovascular disease risk, individual, face-to-face, annual, 15 minutes	S	0432

HCPCS code G0446 has been assigned to APC 0432 and given a status indicator assignment of "S."

Further reporting guidelines on intensive behavioral therapy for cardiovascular disease can be found in Pub. 100-03, Medicare National Coverage Determinations Manual, chapter 1, section 210.11 and Pub. 100-04, Medicare Claims Processing Manual, chapter 18, section 160, as well as in Transmittals 137 and 2357, CR 7636 that was published on November 23, 2011.

12. Intensive Behavioral Therapy for Obesity – NCD

Effective for claims with dates of service on and after November 29, 2011, Medicare beneficiaries with obesity (BMI $\geq$ 30 kg/m^2), who are competent and alert at the time that counseling is provided and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting are eligible for: 1) One face to face visit every week for the first month; 2) One face to face visit every other week for months 2-6; and 3) One face to face visit every month for months 7-12.

To implement this recent coverage determination, CMS created a new G-code to report counseling for obesity. The long descriptor for the G-code appears in Table 14.

Table 14 – Intensive Behavioral Therapy for Obesity

CY 2012 HCPCS Code	CY 2012 Long Descriptor	CY 2012 Status Indicator	CY 2012 APC
G0447	Face-to-face behavioral counseling for obesity, 15 minutes	S	0432

HCPCS code G0447 has been assigned to APC 0432 and given a status indicator assignment of "S." Further reporting guidelines on intensive behavioral therapy for obesity will be provided in a future CR.

CMS is deleting screening code G0449 (Annual face to face obesity screening, 15 minutes) previously released on the 2012 HCPCS tape, from the OPPS addenda, effective November 29, 2011. This screening service will now be identified using ICD-9 screening and diagnosis codes. Coding and billing instructions will be issued in an upcoming CR.

13. Payment Window for Outpatient Services Treated as Inpatient Services

CMS is revising its billing instructions to clarify that in situations where there is no Part A coverage for the inpatient stay, there is no inpatient service into which outpatient services (i.e., services provided to a beneficiary on the date of an inpatient admission or during the 3 calendar days (or 1 calendar day for a non-IPPS hospital) prior to the date of an inpatient admission) must be bundled. Therefore services provided to the beneficiary prior to the point of admission (i.e., the admission order) may be separately billed to Part B as the outpatient services that they were. See Pub. 100-04, Medicare Claims Processing Manual, chapter 4, section 10.12 and chapter 1, section 50.3.2 for the updated billing guidelines.

14. Partial Hospitalization APCs

For CY 2012, CMS is updating the four partial hospitalization program (PHP) per diem payment rates based on the median costs calculated using the most recent claims data for each provider type: two for community mental health centers (CMHCs) (for Level I and Level II PH services based on only CMHC data), and two for hospital-based PHPs (for Level I and Level II services based on only hospital-based data). The APCs for the CMHCs are: APC 0172 (Level I Partial Hospitalization (3 services)) and APC 0173 (Level II Partial Hospitalization (4 or more services)). The APCs for the hospital-based PHPs are: APC 0175 (Level I Partial Hospitalization (3 services)) and APC 0176 (Level Level II Partial Hospitalization (4 or more services)).

When a CMHC provides three services of partial hospitalization services and meets all other partial hospitalization payment criteria, the CMHCs would be paid through APC 0172. Similarly, when a hospital-based PHP provides three services of partial hospitalization services and meets all other partial hospitalization payment criteria, the hospital-based PHP would be paid through APC 0175. When the CMHCs provide four or more services of partial hospitalization services and meet all other partial hospitalization payment criteria, the CMHC would be paid through APC 0173 and the hospital-based PHP providing four or more services would be paid through APC 0176.

The tables below provide the updated per diem payment rates:

Table 15– CY 2012 Median Per Diem Costs for CMHC PHP Services Plus Transition

APC	Group Title	Median Per Diem Costs Plus Transition
0172	Level I Partial Hospitalization (3 services) for CMHCs	$97.64
0173	Level II Partial Hospitalization (4 or more services) for CMHCs	$113.83

Table 16 – CY 2012 Median Per Diem Costs for Hospital-Based PHP Services

APC	Group Title	Median Per Diem Costs
0175	Level I Partial Hospitalization (3 services) for hospital-based PHPs	$160.74
0176	Level II Partial Hospitalization (4 or more services) for hospital-based PHPs	$191.16

15. Molecular Pathology Procedure Test Codes

The AMA's CPT Editorial Panel created 101 new molecular pathology procedure test codes for CY 2012. These new codes are in the following CPT code range: 81200-81299, 81300-81383, and 81400-81408. For payment purposes under the hospital OPPS these test codes will be assigned to status indicator "E" (Not recognized by Medicare for outpatient claims; alternate code for the same item or service may be available) effective January 1, 2012. These new codes will be listed in the January 2012 OPPS Addendum B, which can be downloaded from this CMS Website: https://www.cms.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage.

CMS notes that each of the new molecular pathology procedure test codes represent a test that is currently being utilized and which may be billed to Medicare. When these types of tests are billed to Medicare, CMS understands that existing CPT test codes are "stacked" to represent a given test. For example, Laboratory A has a genetic test that is generally billed to Medicare in the following manner – 83891 (one time) + 83898 (multiple

times) + 83904 (multiple times) + 83909 (multiple times) + 83912 (one time) – in order to represent the performance of the entire test. If the new CPT test coding structure were active, Laboratory A would bill Medicare the new, single CPT test code that corresponds to the test represented by the "stacked" codes in the example above rather than billing each component of the test separately.

Effective January 1, 2012, under the hospital OPPS, hospitals are advised to report both the existing CPT "stacked" test codes that are required for payment and the new single CPT test code that would be used for payment purposes if the new CPT test codes were active. Referring to the example above, Laboratory A would report the existing stacked set of codes that are required to receive payment [i.e., 83891 (one time) + 83898 (multiple times) + 83904 (multiple times) + 83909 (multiple times) + 83912 (one time)] along with the new, single CPT test code that corresponds to the test represented by the "stacked" test codes.

16. Use of Modifiers for Discontinued Services (Modifiers 52, 53, 73, and 74)

CMS is revising the guidance related to use of modifiers for discontinued services in Pub. 100-04, Medicare Claims Processing Manual, chapter 4, section 20.6.4.

17. Changes to OPPS Pricer Logic

a. Rural sole community hospitals and essential access community hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in CY 2012. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with section 1833(t)(13)(B) of the Act, as added by section 411 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

b. New OPPS payment rates and copayment amounts will be effective January 1, 2012. All copayment amounts will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the CY 2012 inpatient deductible.

c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2012. This threshold of 1.75 is multiplied by the total line-item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount. The payment formula is (cost-(APC payment x 1.75))/2.

d. There will be no change in the fixed-dollar threshold in CY 2012. The estimated cost of a service must be greater than the APC payment amount plus $2,025.in order to qualify for outlier payments.

e. For outliers for Community Mental Health Centers (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2012. This threshold of 3.4 is multiplied by the total line-item APC payment for APC 0173 to determine eligibility for outlier payments. This multiple amount is also used to determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment formula is (cost-(APC 0173 payment x 3.4))/2.

f. Effective January 1, 2012, 4 devices are eligible for pass-through payment in the OPPS Pricer logic. Categories C1749 (Endoscope, retrograde imaging/illumination colonoscope device (implantable)) and C1830 (Powered bone marrow biopsy needle) have an offset amount of $0 because CMS is not able to identify portions of the APC payment amounts associated with the cost of the devices. Category C1840 (Lens, intraocular (implantable)) and C1886 (Catheter, extravascular tissue ablation, any modality (insertable)) have offset amounts included in the Pricer for CY 2012. Pass-through offset amounts are

adjusted annually. For outlier purposes, when C1749 is billed with a service included in APC 0143 or APC 0158 it will be associated with specific HCPCS in those APCs for outlier eligibility and payment.

g. Effective January 1, 2012, the OPPS Pricer will apply a reduced update ratio of 0.980 to the payment and copayment for hospitals that fail to meet their hospital outpatient quality data reporting requirements or that fail to meet CMS validation edits. The reduced payment amount will be used to calculate outlier payments.

h. Effective January 1, 2012, there will be 1 diagnostic radiopharmaceutical receiving pass-through payment in the OPPS Pricer logic. For APCs containing nuclear medicine procedures, Pricer will reduce the amount of the pass-through diagnostic radiopharmaceutical payment by the wage-adjusted offset for the APC with the highest offset amount when the radiopharmaceutical with pass-through appears on a claim with a nuclear procedure. The offset will cease to apply when the diagnostic radiopharmaceutical expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals are the "policy-packaged" portions of the CY 2012 APC payments for nuclear medicine procedures and may be found on the CMS Web site.

i. Effective January 1, 2012, there will be 1 contrast agent receiving pass-through payments in the OPPS Pricer logic. For a specific set of APCs identified elsewhere in this update, Pricer will reduce the amount of the pass-through contrast agent by the wage-adjusted offset for the APC with the highest offset amount when the contrast agent with pass-through status appears on a claim on the same date of service with a procedure from the identified list of APCs with procedures using contrast agents. The offset will cease to apply when the contrast agent expires from pass-through status. The offset amounts for contrast agents are the "policy-packaged" portions of the CY 2012 APC payments for procedures using contrast agents and may be found on the CMS Web site.

j. Pricer will update the payment rates for drugs, biologicals, therapeutic radiopharmaceuticals, and diagnostic radiopharmaceuticals with pass-through status when those payment rates are based on ASP on a quarterly basis.

k. Effective January 1, 2012, CMS is adopting the FY 2012 IPPS post-reclassification wage index values with application of out-commuting adjustment authorized by Section 505 of the MMA to non-IPPS hospitals discussed below.

18. Update the Outpatient Provider Specific File (OPSF)

For January 1, 2012, contractors shall maintain the accuracy of the provider records in the Outpatient Provider Specific File (OPSF) as changes occur in data element values.

Update the OPSF for New Core-Based Statistical Area (CBSA) and Wage Indices for Non-IPPS Hospitals Eligible for the Out-Commuting Adjustment Authorized by Section 505 of the MMA

This includes updating the CBSA in the provider records, as well as updating the "special wage index" value for those providers who qualify for the Section 505 adjustment as annotated in Table 17. CMS notes that reclassification wage index values under Section 508 of the MMA expired on September 30, 2011. As always, the OPPS applies the IPPS fiscal year 2012 post-reclassification wage index values to all hospitals and community mental health centers participating in the OPPS for the 2012 calendar year.

Contractors shall do the following to update the OPSF (effective January 1, 2012):

1. Update the CBSA value for each provider in Table 17;

2. For non-IPPS providers who qualify for the 505 adjustment in CY 2012 (Table 17.);

   a) Create a new provider record, effective January 1, 2012 and

   b) Enter a value of "1" in the Special Payment Indicator field on the OPSF; and

   c) Enter the final wage index value (given for the provider in Table 17.) in the Special Wage Index field in the OPSF.

3. For non-IPPS providers who received a special wage index in CY 2011, but no longer receive it in CY 2012;

   a) Create a new provider record, effective January 1, 2012 and

   b) Enter a blank in the Special Payment Indicator field; and

   c) Enter zeroes in the special wage index field.

NOTE: Although the Section 505 adjustment is static for each qualifying county for 3 years, the special wage index will need to be updated (using the final wage index in Table 17) because the post-reclassification CBSA wage index has changed.

NOTE: Payment for Distinct Part Units (DPUs) located in an acute care hospital is based on the wage index for the labor market area where the hospital is located, even if the hospital has a reclassified wage index. If the DPU falls in a CBSA eligible to receive the section 505 out-commuting adjustment, the DPU's final wage index should consist of the geographic wage index plus the appropriate out-commuting adjustment.

Table 17 – Wage Index by CBSA for Non-IPPS Hospitals that are Eligible for the Section 505 Out-Commuting Adjustment

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2012
013027	01	YES	0.7430
013032	23460	YES	0.8013
014006	23460	YES	0.8013
014016	01	YES	0.7497
042007	38220	YES	0.7960
042011	04	YES	0.7569
052034	36084	YES	1.5553
052035	42044	YES	1.1981
052039	42044	YES	1.1981
052053	42044	YES	1.1981
053034	42044	YES	1.1981
053301	36084	YES	1.5553
053304	42044	YES	1.1981
053306	42044	YES	1.1981
053308	42044	YES	1.1981
054074	46700	YES	1.4435
054110	36084	YES	1.5553

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2012
054122	34900	YES	1.4431
054135	42044	YES	1.1981
054141	46700	YES	1.4435
054146	36084	YES	1.5553
063033	24540	YES	0.9885
064007	14500	YES	1.0133
073026	07	YES	1.2218
114018	11	YES	0.7892
132001	13	YES	0.9486
134010	13	YES	0.8448
153040	15	YES	0.8836
154014	15	YES	0.8751
154035	15	YES	0.8633
154047	15	YES	0.8836
183028	21060	YES	0.8646
184012	21060	YES	0.8646
192022	19	YES	0.7959
192026	19	YES	0.8183
192034	19	YES	0.8061
192036	19	YES	0.8142
192040	19	YES	0.8142
192050	19	YES	0.8120
193036	19	YES	0.8061
193044	19	YES	0.8142
193047	19	YES	0.8061
193049	19	YES	0.8061
193055	19	YES	0.7954
193058	19	YES	0.7979
193063	19	YES	0.8142
193067	19	YES	0.8012
193068	19	YES	0.8142
193069	19	YES	0.7979
193073	19	YES	0.8061
193079	19	YES	0.8142
193081	19	YES	0.8120
193088	19	YES	0.8120
193091	19	YES	0.7975
194047	19	YES	0.8183
194065	19	YES	0.7959
194075	19	YES	0.8012
194077	19	YES	0.7959
194081	19	YES	0.7961

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2012
194082	19	YES	0.8012
194083	19	YES	0.7979
194085	19	YES	0.8120
194087	19	YES	0.7959
194091	19	YES	0.8142
194092	19	YES	0.7935
194095	19	YES	0.8061
194097	19	YES	0.8061
212002	25180	YES	0.9420
214001	12580	YES	1.0030
214003	25180	YES	0.9420
222000	15764	YES	1.3890
222003	15764	YES	1.3890
222024	15764	YES	1.3890
222026	37764	YES	1.3759
222044	37764	YES	1.3759
222047	37764	YES	1.3759
223026	15764	YES	1.3890
223028	37764	YES	1.3759
224007	15764	YES	1.3890
224033	37764	YES	1.3759
224038	15764	YES	1.3890
224039	37764	YES	1.3759
232019	19804	YES	0.9527
232020	13020	YES	0.9084
232023	47644	YES	0.9623
232025	35660	YES	0.8834
232027	19804	YES	0.9527
232028	12980	YES	1.0002
232030	47644	YES	0.9626
232031	19804	YES	0.9527
232032	19804	YES	0.9527
232036	27100	YES	0.9186
232038	19804	YES	0.9527
233025	12980	YES	1.0002
233027	19804	YES	0.9527
233028	47644	YES	0.9626
233300	19804	YES	0.9527
234011	47644	YES	0.9626
234021	47644	YES	0.9623
234023	47644	YES	0.9626
234028	19804	YES	0.9527

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2012
234034	19804	YES	0.9527
234035	19804	YES	0.9527
234038	19804	YES	0.9527
234039	47644	YES	0.9623
234040	19804	YES	0.9527
252011	25	YES	0.7997
264005	26	YES	0.8134
303026	30	YES	1.1789
304001	40484	YES	1.1789
312018	20764	YES	1.1503
313025	35084	YES	1.1579
313300	20764	YES	1.1503
314010	35084	YES	1.1579
314011	20764	YES	1.1503
314020	35084	YES	1.1579
323025	32	YES	0.9328
334017	39100	YES	1.1796
334049	10580	YES	0.8656
334061	39100	YES	1.1796
342019	34	YES	0.8446
344001	39580	YES	0.9481
344011	39580	YES	0.9481
344014	39580	YES	0.9481
362016	15940	YES	0.8725
362032	15940	YES	0.8725
363026	49660	YES	0.8414
364031	15940	YES	0.8725
364040	44220	YES	0.8758
364042	36	YES	0.8415
364043	36	YES	0.8474
372017	37	YES	0.7971
372019	37	YES	0.8187
373032	37	YES	0.7971
392030	39	YES	0.9021
392031	27780	YES	0.8899
392034	10900	YES	0.9627
393026	39740	YES	0.9340
393050	10900	YES	0.9627
394014	39740	YES	0.9340
394020	30140	YES	0.8699
394052	39740	YES	0.9340
422004	42	YES	0.9086

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2012
423029	11340	YES	0.8723
424011	11340	YES	0.8723
444006	27740	YES	0.7801
444008	44	YES	0.8074
444019	17300	YES	0.8369
452018	23104	YES	0.9436
452019	23104	YES	0.9436
452028	23104	YES	0.9436
452088	23104	YES	0.9436
452099	23104	YES	0.9436
452110	23104	YES	0.9436
453040	23104	YES	0.9436
453041	23104	YES	0.9436
453042	23104	YES	0.9436
453089	45	YES	0.8099
453094	23104	YES	0.9436
453300	23104	YES	0.9436
453303	23104	YES	0.9436
454009	45	YES	0.8121
454012	23104	YES	0.9436
454051	23104	YES	0.9436
454052	23104	YES	0.9436
454061	23104	YES	0.9436
454072	23104	YES	0.9436
454086	23104	YES	0.9436
454101	45	YES	0.8207
462005	39340	YES	0.9233
493026	49	YES	0.8167
494029	49	YES	0.7952
522005	39540	YES	0.9230
523302	36780	YES	0.9193
524002	36780	YES	0.9193
524025	22540	YES	0.9438
673035	23104	YES	0.9436
673044	23104	YES	0.9436

a) Updating the OPSF for Expiration of Transitional Outpatient Payments (TOPs)

Section 3121 of the Affordable Care Act extended the hold harmless provision for small rural hospitals with 100 or fewer beds through December 31, 2010, at 85 percent of the hold harmless amount. Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs) are no longer limited to those with 100 or fewer beds effective January 1, 2010, and these providers will receive TOPs payments at 85 percent of the hold harmless amount through December 31, 2011. Cancer and children's hospitals are permanently held

harmless under section 1833(t)(7)(D)(ii) of the Social Security Act and continue to receive TOPs payments in CY 2011.

NOTE: EACHs are considered SCHs for purposes of the TOPs adjustment.

Section 308 of the *Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA)* extends the Outpatient Hold-Harmless provision, effective for dates of service on or after January 1, 2012, through February 29, 2012, to rural hospitals with 100 or fewer beds and to all Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs) **regardless of bed size**.

For CY 2012, contractors shall enter a "Y" in the TOPs Indicator field within the Outpatient Provider Specific File (OPSF) for all providers that previously had a "Y" in the TOPs Indicator. Additionally, contractors shall enter a "Y" in the TOPs Indicator field for **all** SCHs and EACHs (Provider Type 16, 17, 21, or 22) regardless of the value in the Bed Size field for CY 2012.

Cancer and children's hospitals continue to receive hold harmless TOPs permanently. For CY 2012, cancer hospitals will receive an additional payment adjustment that will be provided at cost report settlement. The details of this specific adjustment for cancer hospitals are forthcoming in a separate CR.

Unless otherwise instructed, by February 29, 2012, contractors shall create an additional OPSF for all providers listed in the attachment with a March 1, 2012, effective date that does not contain a "Y" in the TOPs Indicator.

b) Updating the OPSF for the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) Requirements

Effective for OPPS services furnished on or after January 1, 2009, Subsection (d) hospitals that have failed to submit timely hospital outpatient quality data as required in Section 1833(t)(17)(A) of the Act will receive payment under the OPPS that reflects a 2 percentage point deduction from the annual OPPS update for failure to meet the HOP QDRP requirements. This reduction will not apply to hospitals not required to submit quality data or hospitals that are not paid under the OPPS.

For January 1, 2012, contractors shall maintain the accuracy of the provider records in the OPSF by updating the Hospital Quality Indicator field. CMS will release a Technical Direction Letter that lists Subsection (d) hospitals that are subject to and fail to meet the HOP QDRP requirements. Once this list is released, FIs/MACs will update the OPSF by removing the '1', (that is, ensure that the Hospital Quality Indicator field is blank) for all hospitals identified on the list and will ensure that the OPSF Hospital Quality Indicator field contains '1' for all hospitals that are not on the list. CMS notes that if these hospitals are later determined to have met the HOP QDRP requirements, FIs/MACs shall update the OPSF. For greater detail regarding updating the OPSF for the HOP QDRP requirements, see Transmittal 368, CR 6072, issued on August 15, 2008.

c) Updating the OPSF for the Outpatient Cost to Charge Ratio (CCR)

As stated in Pub. 100-04, Medicare Claims Processing Manual, chapter 4, section 50.1, contractors must maintain the accuracy of the data and update the OPSF as changes occur in data element values, including changes to provider cost–to-charge ratios. The file of OPPS hospital upper limit CCRs and the file of Statewide CCRs are located on the CMS Web site at www.cms..gov/HospitalOutpatientPPS/ under "*Annual Policy Files*." A spreadsheet listing the Statewide CCRs also can be found in the file containing the preamble tables that appears in the most recent OPPS/ASC final rule.

19. Coverage Determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS 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. Fiscal Intermediaries (FIs)/Medicare Administrative Contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, FIs/MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7672.04.1	Medicare contractors shall install the January 2012 OPPS Pricer.	X		X		X	X				COBC
7672.04.2	Medicare contactors shall manually delete C9716 from their systems effective December 31, 2011. They should also delete G0449 effective November 29, 2011, and G0450 effective November 8, 2011. **Note:** These deletions will be reflected in the January 2012 IOCE update and in the January 2012 Update of the OPPS Addendum A and Addendum B on the CMS Web site at https://www.cms.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage	X		X		X	X				COBC
7672.04.3	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service that fall on or after October 1, 2011, but prior to January 1, 2012; 2) Contain HCPCS codes listed in Table 6; and 3) Were originally processed prior to the installation of the January 2012 OPPS Pricer.	X		X		X					COBC
7672.04.4	As specified in chapter 4, section 50.1, Medicare contractors shall maintain the accuracy of the data and	X		X		X					COBC

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	update the OPSF file as changes occur in data element values. For CY 2012, this includes all changes to the OPSF identified in Section 18 of this Change Request.										

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7672.04.5	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X		X					COBC

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Marina Kushnirova at marina.kushnirova@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirement.

Medicare Claims Processing Manual
Chapter 1 - General Billing Requirements

50.3.2 - Policy and Billing Instructions for Condition Code 44
(Rev.2386, Issued: 01-13-12, Effective: 01-01-12, Implementation: 01-03-12)

In cases where a hospital or a CAH's UR committee determines that an inpatient admission does not meet the hospital's inpatient criteria, the hospital or CAH may change the beneficiary's status from inpatient to outpatient and submit an outpatient claim (bill type 13x or 85x) for medically necessary Medicare Part B services that were furnished to the beneficiary, provided all of the following conditions are met:

1. The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital;

2. The hospital has not submitted a claim to Medicare for the inpatient admission;

3. The practitioner responsible for the care of the patient and the UR committee concur with the decision; and

4. The concurrence of the practitioner responsible for the care of the patient and the UR committee is documented in the patient's medical record.

While typically the full UR committee makes the decision for the committee that a change in patient status under Condition Code 44 is warranted, in accordance with §482.30(d)(1) one physician member of the UR committee may make the decision for the committee, provided he or she is a different person from the concurring practitioner who is responsible for the care of the patient.

When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be billed as an outpatient episode of care on a 13x or 85x bill type and outpatient services that were ordered and furnished should be billed as appropriate.

Refer to Pub. 100-04, Medicare Claims Processing Manual; Chapter 30, Financial Liability Protections; Section 20, Limitation On Liability (LOL) Under §1879 Where Medicare Claims Are Disallowed, for information regarding financial liability protections.

When the hospital submits a 13x or 85x bill for services furnished to a beneficiary whose status was changed from inpatient to outpatient, the hospital is required to report Condition Code 44 on the outpatient claim in one of Form Locators 24-30, or in the ANSI X12N 837 I in Loop 2300, HI segment, with qualifier BG, on the outpatient claim. Additional information may be found in Chapter 25 of this manual, (Completing and Processing the Form CMS-1450 Data Set). Condition Code 44 is used by CMS and QIOs

to track and monitor these occurrences. The reporting of Condition Code 44 on a claim does not affect the amount of hospital outpatient payment that would otherwise be made for a hospital outpatient claim that did not require the reporting Condition Code 44.

One of the requirements for the use of Condition Code 44 is concurrence by the practitioner who is responsible for the care of the patient with the determination that an inpatient admission does not meet the hospital's admission criteria and that the patient should have been registered as an outpatient. This prerequisite for use of Condition Code 44 is consistent with the requirements in the CoP in §482.30 (d) of the regulations. This paragraph provides that the practitioner or practitioners responsible for the care of the patient must be consulted and allowed to present their views before the UR committee or QIO makes its determination that an admission is not medically necessary. It may also be appropriate to include the practitioner who admitted the patient if this is a different person than the practitioner responsible for the care of the patient.

If the conditions for use of Condition Code 44 are not met, the hospital may submit a 12x bill type for covered "Part B Only" services that were furnished to the inpatient. Medicare may still make payment for certain Part B services furnished to an inpatient of a hospital when payment cannot be made under Part A because an inpatient admission is determined not to be medically necessary. Information about "Part B Only" services is located in Pub. 100-02, Medicare Benefit Policy Manual, chapter 6, section 10. Examples of such services include, but are not limited to, diagnostic x-ray tests, diagnostic laboratory tests, surgical dressings and splints, prosthetic devices, and certain other services. The Medicare Benefit Policy Manual includes a complete list of the payable "Part B Only" services. *See Pub. 100-04, Medicare Claims Processing Manual, chapter 4, section 10.12 for a discussion of the billing and payment rules regarding services furnished within the payment window for outpatient services treated as inpatient services.*

Entries in the medical record cannot be expunged or deleted and must be retained in their original form. Therefore, all orders and all entries related to the inpatient admission must be retained in the record in their original form. If a patient's status changes in accordance with the requirements for use of Condition Code 44, the change must be fully documented in the medical record, complete with orders and notes that indicate why the change was made, the care that was furnished to the beneficiary, and the participants in making the decision to change the patient's status.

When Condition Code 44 is appropriately used, the hospital reports on the outpatient bill the services that were ordered and provided to the patient for the entire patient encounter. However, in accordance with the general Medicare requirements for services furnished to beneficiaries and billed to Medicare, even in Condition Code 44 situations, hospitals may not report observation services using HCPCS code G0378 (Hospital observation service, per hour) for observation services furnished during a hospital encounter prior to a physician's order for observation services. Medicare does not permit retroactive orders or the inference of physician orders. Like all hospital outpatient services, observation services must be ordered by a physician. The clock time begins at the time that observation services are initiated in accordance with a physician's order.

While hospitals may not report observation services under HCPCS code G0378 for the time period during the hospital encounter prior to a physician's order for observation services, in Condition Code 44 situations, as for all other hospital outpatient encounters, hospitals may include charges on the outpatient claim for the costs of all hospital resources utilized in the care of the patient during the entire encounter. For example, a beneficiary is admitted as an inpatient and receives 12 hours of monitoring and nursing care, at which point the hospital changes the status of the beneficiary from inpatient to outpatient and the physician orders observation services, with all criteria for billing under Condition Code 44 being met. On the outpatient claim on an uncoded line with revenue code 0762, the hospital could bill for the 12 hours of monitoring and nursing care that were provided prior to the change in status and the physician order for observation services, in addition to billing HCPCS code G0378 for the observation services that followed the change in status and physician order for observation services. For other rules related to billing and payment of observation services, see chapter 4, section 290 of this manual, and Pub.100-02, Medicare Benefit Policy Manual, chapter 6, Section 20.6.

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

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(Rev.2386,Issued: 01-13-12)

10.2.2 – Cardiac Resynchronization Therapy

(Rev.2386, Issued: 01-13-12, Effective: 01-01-12, Implementation: 01-03-12)

Effective for services furnished on or after January 1, 2012, cardiac resynchronization therapy involving an implantable cardioverter defibrillator (CRT-D) will be recognized as a single, composite service combining implantable cardioverter defibrillator procedures (described by CPT code 33249 (Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator)) and pacing electrode insertion procedures (described by CPT code 33225 (Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (including upgrade to dual chamber system))) when performed on the same date of service. When these procedures appear on the same claim but with different dates of service, or appear on the claim without the other procedure, the standard APC assignment for each service will continue to be applied.

Medicare will make a single payment for those procedures that qualify for composite service payment, as well as any packaged services furnished on the same date of service. Because CPT codes 33225 and 33249 may be treated as a composite service for payment purposes, CMS is assigning them status indicator "Q3" (Codes that may be paid through a composite APC) in Addendum B.

Hospitals will continue to use the same CPT codes to report CRT-D procedures, and the I/OCE will evaluate every claim received to determine if payment as a composite service is appropriate. Specifically, the I/OCE will determine whether payment will be made through a single, composite payment when the procedures are done on the same date of service, or through the standard APC payment methodology when they are done on different dates of service.

CMS is also implementing claims processing edits that will return to providers incorrectly coded claims on which a pacing electrode insertion procedure described by CPT code 33225 is billed without one of the following CPT codes for insertion of an implantable cardioverter defibrillator or pacemaker:

- *33206 (Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial);*
- *33207 (Insertion or replacement of permanent pacemaker with transvenous electrode(s); ventricular);*
- *33208 (Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular);*
- *33212 (Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular);*
- *33213 (Insertion or replacement of pacemaker pulse generator only; dual chamber, atrial or ventricular);*

- *33214 (Upgrade of implanted pacemaker system, conversion of single chamber system to dual chamber system (includes removal of previously placed pulse generator, testing of existing lead, insertion of new lead, insertion of new pulse generator));*

- *33216 (Insertion of a single transvenous electrode, permanent pacemaker or cardioverter-defibrillator);*

- *33217 (Insertion of 2 transvenous electrodes, permanent pacemaker or cardioverter-defibrillator);*

- *33221(Insertion of pacemaker pulse generator only; with existing multiple leads);*

- *33222 (Revision or relocation of skin pocket for pacemaker);*

- *33230 (Insertion of pacing cardioverter-defibrillator pulse generator only; with existing dual leads);*

- *33231 (Insertion of pacing cardioverter-defibrillator pulse generator only; with existing multiple leads)*

- *33233 (Removal of permanent pacemaker pulse generator);*

- *33234 (Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular);*

- *33235 (Removal of transvenous pacemaker electrode(s); dual lead system, atrial or ventricular);*

- *33240 (Insertion of single or dual chamber pacing cardioverter-defibrillator pulse generator); or*

- *33249 (Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator).*

10.12 – Payment Window for Outpatient Services Treated as Inpatient Services

(Rev. 2386, Issued: 01-13-12, Effective: 01-01-12, Implementation: 01-03-12)

The policy for the payment window for outpatient services treated as inpatient services is discussed in section 40.3, of chapter 3 of the Medicare Claims Processing Manual. The policy requires payment for certain outpatient services provided to a beneficiary on the date of an inpatient admission or during the 3 calendar days (or 1 calendar day for a non-IPPS hospital) prior to the date of an inpatient admission to be bundled (i.e., included) with the payment for the beneficiary‘s inpatient admission if those outpatient services are provided by the admitting hospital or an entity that is wholly owned or wholly operated by the admitting hospital. The policy applies to all diagnostic outpatient services and non-diagnostic (i.e., therapeutic) that are

related to the inpatient stay. Ambulance and maintenance renal dialysis services are not subject to the payment window.

All diagnostic services provided to a Medicare beneficiary by a hospital (or an entity wholly owned or wholly operated by the hospital) on the date of the beneficiary's inpatient admission or during the 3 calendar days (or, in the case of a non-subsection (d) hospital, 1 calendar day) immediately preceding the date of admission are required to be included on the bill for the inpatient stay.

Outpatient non-diagnostic services that are related to an inpatient admission must be bundled with the billing for the inpatient stay. An outpatient service is related to the admission if it is clinically associated with the reason for a patient's inpatient admission. In accordance with section 102 of Pub. L. 111-192, for services furnished on or after June 25, 2010, all outpatient non-diagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the date of a beneficiary's inpatient admission are deemed related to the admission, and thus, must be billed with the inpatient stay. Also, outpatient non-diagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the first, second, and third calendar days for a subsection (d) hospital paid under the IPPS (first calendar day for non-subsection (d) hospitals) preceding the date of a beneficiary's inpatient admission are deemed related to the admission, and thus, must be billed with the inpatient stay, unless the hospital attests to specific non-diagnostic services as being unrelated to the hospital claim (that is, the preadmission non-diagnostic services are clinically distinct or independent from the reason for the beneficiary's admission). Outpatient non-diagnostic services provided during the payment window that are unrelated to the admission, and are covered by Part B, may be separately billed to Part B. The June 25, 2010 effective date of section 102 of Pub. L. 111-192 applies to outpatient services provided on or after June 25, 2010.

In the event that there is no Part A coverage for the inpatient stay, there is no inpatient service into which outpatient services (i.e., services provided to a beneficiary on the date of an inpatient admission or during the 3 calendar days (or 1 calendar day for a non-IPPS hospital) prior to the date of an inpatient admission) must be bundled. Therefore, services provided to the beneficiary prior to the point of admission (i.e., the admission order) may be separately billed to Part B as the outpatient services that they were.

A hospital may attest to specific non-diagnostic services as being unrelated to the hospital claim (that is, the preadmission non-diagnostic services are clinically distinct or independent from the reason for the beneficiary's admission) by adding a condition code 51 (definition "51 - Attestation of Unrelated Outpatient Non-diagnostic Services") to the separately billed outpatient non-diagnostic services claim. Providers may submit outpatient claims with condition code 51 starting April 1, 2011, for outpatient claims that have a date of service on or after June 25, 2010. Outpatient claims with a date of service on or after June 25, 2010, that did not contain condition code 51 received prior to April, 1, 2011, will need to be adjusted by the provider if they were rejected by FISS or CWF.

As stated in section 180.7, "inpatient-only" procedures that are provided to a patient in the outpatient setting on the date of the patient's inpatient admission or during the 3 calendar days (or 1 calendar day for a non-subsection (d) hospital) preceding the date of the inpatient admission that would otherwise be deemed related to the admission are not paid for by CMS. Providers should bill for these services on a no-pay claim (Type of Bill (TOB) 110). If there are covered services/procedures provided during the same outpatient encounter as the non-covered inpatient-only procedure (see the two exceptions listed in section 180.7), providers are then required to submit two claims:

- One claim with covered service(s)/procedure(s) on a TOB 11X (with the exception of 110), and,

- The other claim with the non-covered service(s)/procedure(s) on a TOB 110 (no-pay claim).

NOTE: Both the covered and non-covered claim must have a matching Statement Covers Period.

20.6.4 - Use of Modifiers for Discontinued Services

(Rev2386, Issued: 01-13-12, Effective: 01-01-12, Implementation: 01-03-12)

A. General

Modifiers provide a way for hospitals to report and be paid for expenses incurred in preparing a patient for a procedure and scheduling a room for performing the procedure where the service is subsequently discontinued. This instruction is applicable to both outpatient hospital departments and to ambulatory surgical centers.

Modifier -73 is used by the facility to indicate that a procedure requiring anesthesia was terminated due to extenuating circumstances or to circumstances that threatened the well being of the patient after the patient had been prepared for the procedure (including procedural pre-medication when provided), and been taken to the room where the procedure was to be performed, but prior to administration of anesthesia. For purposes of billing for services furnished in the hospital outpatient department, anesthesia is defined to include local, regional block(s), moderate sedation/analgesia ("conscious sedation"), deep sedation/analgesia, or general anesthesia. This modifier code was created so that the costs incurred by the hospital to prepare the patient for the procedure and the resources expended in the procedure room and recovery room (if needed) could be recognized for payment even though the procedure was discontinued.

Modifier -74 is used by the facility to indicate that a procedure requiring anesthesia was terminated after the induction of anesthesia or after the procedure was started (e.g., incision made, intubation started, scope inserted) due to extenuating circumstances or circumstances that threatened the well being of the patient. *This modifier may also be used to indicate that a planned surgical or diagnostic procedure was discontinued, partially reduced or cancelled at the physician's discretion after the administration of anesthesia.* For purposes of billing for services furnished in the hospital outpatient department, anesthesia is defined to include local, regional

block(s), moderate sedation/analgesia ("conscious sedation"), deep sedation/analgesia, and general anesthesia. This modifier code was created so that the costs incurred by the hospital to initiate the procedure (preparation of the patient, procedure room, recovery room) could be recognized for payment even though the procedure was discontinued prior to completion.

Coinciding with the addition of the modifiers -73 and -74, modifiers -52 and -53 were revised. Modifier -52 is used to indicate partial reduction, *cancellation,* or discontinuation of services for which anesthesia is not planned. The modifier provides a means for reporting reduced services without disturbing the identification of the basic service. Modifier -53 is used to indicate discontinuation of physician services and is not approved for use for outpatient hospital services.

The elective cancellation of a procedure should not be reported.

Modifiers -73 and -74 are only used to indicate discontinued procedures for which anesthesia is planned or provided.

B. Effect on Payment

Procedures that are discontinued after the patient has been prepared for the procedure and taken to the procedure room but before anesthesia is provided will be paid at 50 percent of the full OPPS payment amount. Modifier -73 is used for these procedures.

Procedures that are discontinued*, partially reduced or cancelled* after the procedure has been initiated and/or the patient has received anesthesia will be paid at the full OPPS payment amount. Modifier -74 is used for these procedures.

Procedures for which anesthesia is not planned that are discontinued*, partially reduced or cancelled* after the patient is prepared and taken to the room where the procedure is to be performed will be paid at 50 percent of the full OPPS payment amount. Modifier -52 is used for these procedures.

C. Termination Where Multiple Procedures Planned

When one or more of the procedures planned is completed, the completed procedures are reported as usual. The other(s) that were planned, and not started, are not reported. When none of the procedures that were planned are completed, and the patient has been prepared and taken to the procedure room, the first procedure that was planned, but not completed is reported with modifier -73. If the first procedure has been started (scope inserted, intubation started, incision made, etc.) and/or the patient has received anesthesia, modifier -74 is used. The other procedures are not reported.

If the first procedure is terminated prior to the induction of anesthesia and before the patient is wheeled into the procedure room, the procedure should not be reported. The patient has to be taken to the room where the procedure is to be performed in order to report modifier -73 or -74.