



News Flash – The *Swing Bed Fact Sheet* (revised April 2009), which provides information about the requirements hospitals and Critical Access Hospitals must meet in order to enter into a swing bed agreement under which they can use beds, as needed, to provide either acute or Skilled Nursing Facility care, is now available in downloadable format from the Medicare Learning Network at <http://www.cms.hhs.gov/MLNProducts/downloads/SwingBedFactsheet.pdf> on the Centers for Medicare & Medicaid Services website.

MLN Matters® Number: MM6492 **Revised**

Related Change Request (CR) #: 6492

Related CR Release Date: June 23, 2009

Effective Date: July 1, 2009

Related CR Transmittal #: R107BP and R1760CP

Implementation Date: July 6, 2009

July 2009 Update of the Hospital Outpatient Prospective Payment System (OPPS)

NOTE: This article was revised on June 24, 2009, to reflect changes made to CR6492, which was re-issued as Transmittal 1760 on June 23. In the Recurring Update Notification attachment to the original CR6492, Q4115 was incorrectly identified as a newly payable HCPCS in the hospital outpatient setting effective July 1, 2009 in Table 3. HCPCS Code Q4115 is not payable in the hospital outpatient setting. HCPCS Code Q4115 has been removed from Table 3 and the text identifying the number of new drug codes for July, immediately preceding Table 3 has been changed from three to two. All other information remains the same.

Provider Types Affected

Providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries and which are paid under the OPPS.

Provider Action Needed

This article is based on Change Request (CR) 6492 which describes changes to and billing instructions for various payment policies implemented in the July 2009 OPPS update. Be sure billing staffs are aware of these changes.

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Background

CR 6492 describes changes to and billing instructions for various payment policies implemented in the July 2009 OPSS update and it affects the Medicare Claims Processing Manual Chapter 1, Section 50.3; Chapter 4, Sections 10 and 290; and Chapter 17, Section 90.3. It also updates the Medicare Benefits Policy Manual (Chapter 6, Section 20.6) to clarify the existing policy.

July 2009 revisions to the Integrated Outpatient Code Editor (I/OCE) data files, instructions, and specifications are provided in CR 6480 (July 2009 Integrated Outpatient Code Editor (I/OCE) Specifications Version 10.2).” Upon release of CR 6480 a related MLN Matters article will be available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6480.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

Key OPSS Updates for July 2009

1. Changes to Procedure and Device Edits for July 2009

Procedure to device edits require that when a particular procedural Healthcare Common Procedure Coding System (HCPCS) code is billed, the claim must also contain an appropriate device code. Failure to pass these edits will result in the claim being returned to the provider. Device to procedure edits require that a claim that contains one of a specified set of device codes be returned to the provider if it fails to contain an appropriate procedure code. The updated lists of both types of edits can be found under “Device, Radiolabeled Product, and Procedure Edits” at <http://www.cms.hhs.gov/HospitalOutpatientPPS/> on the CMS website.

2. Outlier Reconciliation

CMS updated the Medicare Claims Processing Manual (Chapter 4, Section 10.7.2) to more explicitly identify distinctions between the OPSS outlier reconciliation policy and those of other payment systems. CMS made changes to note that the OPSS outlier reconciliation criteria use OPSS specific-information, specifically 1) the Cost-to-Charge Ratio (CCR) is the OPSS CCR used to make OPSS outlier payments and 2) total outlier payments are total OPSS outlier payments. These changes clarify the manual language to eliminate confusion that the OPSS reconciliation might consider Inpatient Prospective Payment System (IPPS) or other payment system CCRs or total outlier payments across payment systems.

3. Updated Pricer Logic for Certain Blood Products

The January 2009 OPSS Pricer contained a programming error that may result in the underpayment or overpayment of certain blood products that are eligible for the blood deductible when billed together on the same claim. The whole blood and packed red cells described by the following HCPCS codes are eligible for the blood deductible:

HCPCS Codes Eligible for the Blood Deductible
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P9010	P9022	P9040	P9056
P9016	P9038	P9051	P9057
P9021	P9039	P9054	P9058

The blood deductible is applied to these products only when the hospital incurs a charge for the blood product itself, in addition to a charge for processing and storage. The January 2009 OPSS Pricer programming error affects only those claims on which more than one of the blood product HCPCS codes listed above appears, when at least one of those codes is not subject to the blood deductible because the hospital did not incur a charge for the blood product itself.

Specifically, an underpayment or overpayment may occur when the following conditions are met:

- 1) More than one blood product that is eligible for the blood deductible (i.e., whole blood and packed red cells) appears on the claim;
- 2) At least one of the blood products appearing on the claim that is eligible for the blood deductible is not subject to the blood deductible due to the absence of payment adjustment flag (PAF) 5 and 6 indicating the hospital incurred a charge for the blood itself (the Integrated Outpatient Code Editor applies PAF 5 or 6 to blood lines eligible for the blood deductible when the hospital reports charges for the blood product itself using Revenue Code series 038X (excluding 0380) in addition to charges for processing and storage services using Revenue Code 0390, 0392, or 0399);
- 3) The dates of service fall on or after January 1, 2009, but prior to July 1, 2009; and
- 4) The claim was processed for payment prior to the installation of the July 2009 OPSS Pricer on July 6, 2009.

This programming error has been corrected in the July 2009 OPSS Pricer. Providers who think they may have received an incorrect payment as a result of this programming error may voluntarily submit claims to their contractors for repayment following the implementation of the July 2009 OPSS Pricer on July 6, 2009.

4. Category III CPT Codes

The American Medical Association (AMA) releases Category III Current Procedural Terminology (CPT) codes in January, for implementation beginning the following July, and in July, for implementation beginning the following January.

As discussed in the CY 2006 OPSS final rule with comment period (70 FR 68567; see <http://www.gpoaccess.gov/fr/retrieve.html> on the Internet), CMS modified their process for implementing the Category III codes that the AMA releases each January for implementation in July to ensure timely collection of data pertinent to the services described by the codes; to ensure patient access to the services the codes describe; and to eliminate potential redundancy between

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Category III CPT codes and some of the C-codes that are payable under the OPSS and were created by us in response to applications for new technology services. Therefore, on July 1, 2009, CMS will implement in the OPSS four Category III CPT codes that the AMA released in January 2009 for implementation in July 2009. The codes, along with their status indicators and Ambulatory Payment Classifications (APCs), are shown in Table 1 below. Payment rates for these services can be found in Addendum B of the July 2009 OPSS Update that is posted at <http://www.cms.hhs.gov/HospitalOutpatientPPS/> on the CMS website.

Table 1--Category III CPT Codes Implemented as of July 1, 2009

HCPCS	Long Descriptor	APC	SI
0199T	Physiologic recording of tremor using accelerometer(s) and gyroscope(s), (including frequency and amplitude) including interpretation and report	0215	S
0200T	Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device (if utilized), one or more needles	0049	T
0201T	Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device (if utilized), two or more needles	0050	T
0202T	Posterior vertebral joint(s) arthroplasty (e.g., facet joint[s] replacement) including facetectomy, laminectomy, foraminotomy and vertebral column fixation, with or without injection of bone cement, including fluoroscopy, single level, lumbar spine		C

5. Billing for 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.

CMS reminds hospitals that under the OPSS, 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 code descriptors refer to the non-compounded, FDA-approved final product. If a product is compounded and a specific HCPCS code

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does not exist for the compounded product, the hospital should report an appropriate unlisted code such as J9999 or J3490.

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective July 1, 2009

For CY 2009, payment for nonpass-through drugs and biologicals 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 or biological. In CY 2009, a single payment of ASP+6 percent for pass-through drugs and biologicals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. CMS notes that for the third quarter of CY 2009, 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 suspended beginning January 1, 2009. Should the Part B Drug CAP program be reinstated sometime during CY 2009, 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 2009 OPPS/ASC final rule with comment period, it was stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the July 2009 release of the OPPS PRICER. The updated payment rates, effective July 1 2009 will be included in the July 2009 update of the OPPS Addendum A and Addendum B, which will be posted at <http://www.cms.hhs.gov/HospitalOutpatientPPS/> on the CMS website.

b. Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2009

Nine drugs and biologicals have been granted OPPS pass-through status effective July 1, 2009. These items, along with their descriptors and APC assignments, are identified in Table 2 below.

Table 2-Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2009

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 7/1/09
C9250*	Human plasma fibrin sealant, vapor-heated, solvent-detergent (Artiss), 2ml	9250	G
C9251*	Injection, C1 esterase inhibitor (human), 10 units	9251	G
C9252*	Injection, plerixafor, 1 mg	9252	G
C9253*	Injection, temozolomide, 1 mg	9253	G
C9360*	Dermal substitute, native, non-denatured collagen, neonatal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters	9360	G

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C9361*	Collagen matrix nerve wrap (NeuroMend Collagen Nerve Wrap), per 0.5 centimeter length	9361	G
C9362*	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Strip), per 0.5 cc	9362	G
C9363*	Skin substitute, Integra Meshed Bilayer Wound Matrix, per square centimeter	9363	G
C9364*	Porcine implant, Permacol, per square centimeter	9364	G

NOTE: The HCPCS codes identified with an "*" indicate that these are new codes effective July 1, 2009.

c. New HCPCS Codes Effective for Certain Drugs and Biologicals

Two new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting for July 2009. These codes are listed in Table 3 below and are effective for services furnished on or after July 1, 2009.

Table 3- New HCPCS Codes Effective for Certain Drugs and Biologicals Effective July 1, 2009

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 7/1/09
Q2023	Injection, factor viii (antihemophilic factor, recombinant) (Xyntha), per i.u.	1268	K
Q4116	Skin substitute, alloderm, per square centimeter	1270	K

d. Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2009 through March 31, 2009

The payment rates for several HCPCS codes were incorrect in the January 2009 OPSS PRICER. The corrected payment rates are listed in Table 4 below and have been installed in the July 2009 OPSS PRICER, effective for services furnished on January 1, 2009, through implementation of the April 2009 update. If you have claims that were processed prior to April 1, 2009 with these codes for services on or after January 1, 2009, but prior to April 1, 2009, you may ask your Medicare contractor to adjust the claims.

Table 4-Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2009 Through March 31, 2009

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HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J1441	K	7049	Filgrastim 480 mcg injection	\$304.27	\$60.85
J1740	K	9229	Ibandronate sodium injection	\$136.35	\$27.27
J2505	K	9119	Injection, pegfilgrastim 6mg	\$2,135.12	\$427.02
J7513	K	1612	Daclizumab, parenteral	\$341.09	\$68.22

e. Recognition of Multiple HCPCS Codes For Drugs

Prior to January 1, 2008, the OPSS generally recognized only the lowest available administrative dose of a drug if multiple HCPCS codes existed for the drug; for the remainder of the doses, the OPSS assigned a status indicator "B" indicating that another code existed for OPSS purposes. For example, if drug X has 2 HCPCS codes, one for a 1 ml dose and a second for a 5 ml dose, the OPSS would assign a payable status indicator to the 1 ml dose and status indicator "B" to the 5 ml dose. Hospitals then were required to bill the appropriate number of units for the 1 ml dose in order to receive payment under the OPSS. However, beginning January 1, 2008, the OPSS has recognized each HCPCS code for a Part B drug, regardless of the units identified in the drug descriptor. Hospitals may choose to report multiple HCPCS codes for a single drug, or to continue billing the HCPCS code with the lowest dosage descriptor available.

f. Correct Reporting of Drugs and Biologicals When Used As Implantable Devices

When billing for biologicals where the HCPCS code describes a product that is solely 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. In circumstances where the implanted biological has pass-through status, a separate payment for the biological is made. In circumstances where the implanted biological does not have pass-through status, the OPSS payment for the 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 code, 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 OPSS, 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.

g. Correct Reporting of Units for Drugs

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Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS code descriptor. For example, if the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be 1. As another example, if the description for the drug code is 50 mg, but 200 mg of the drug was administered to the patient, the units billed should be 4. Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS code descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, bill 10 units, even though only 1 vial was administered. The HCPCS code short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

h. Unit Correction – HCPCS code J9181, *Etoposide, 10 mg*

Table 5 'HCPCS Code Changes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals in CY 2008' listed in Transmittal 1657, Change Request (CR) 6320, issued December 31, 2008, incorrectly listed the number of units in the long code descriptor for HCPCS code J9181, *Etoposide, 10 mg*. HCPCS code J9181 which is assigned status indicator 'N' in CY 2009 under the OPPS, is the code for 10 mg of etoposide, while HCPCS code J9182 was discontinued effective January 1, 2009. Providers may review the short and long HCPCS code descriptors in the HCPCS file that is available at <http://www.cms.hhs.gov/HCPCSReleaseCodeSets/> on the CMS website.

6. Clarification Related to the Appropriate Use of HCPCS Code C9399

CMS revised the Medicare Claims Processing Manual (Chapter 17, Section 90.3) to clarify the appropriate use of HCPCS code C9399. Specifically, HCPCS code C9399 should be used by hospitals when billing a new drug or biological that has been approved by the FDA on or after January 1, 2004 and for which a product-specific HCPCS code has not been assigned. Beginning on or after the date of FDA approval, hospitals may bill for the drug or biological using C9399, Unclassified drug or biological. Hospitals will report in the ANSI ASC X-12 837 I in specific locations, or in the "Remarks" section of the CMS 1450:

- The National Drug Code (NDC);
- The quantity of the drug that was administered (expressed in the unit of measure applicable to the drug or biological); and
- The date the drug was furnished to the beneficiary.

Medicare contractors will manually price the drug or biological at 95 percent of the Average Wholesale Price (AWP). They will pay hospitals 80 percent of the calculated price and will bill beneficiaries 20 percent of the calculated price, after the deductible is met. Drugs and biological that are manually priced at 95 percent of AWP are not eligible for outlier payment.

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7. Changes to Nuclear Medicine Procedure-to-Radiolabeled Product Edits for July 2009

Nuclear medicine procedure-to-radiolabeled product edits require that when a nuclear medicine procedure HCPCS code is billed, the claim must also contain an appropriate radiolabeled product. Failure to pass these edits will result in the claim being returned to the provider. Nuclear medicine procedure-to-radiolabeled product edits require that a claim that contains one of a specified set of nuclear medicine codes be returned to the provider if it fails to contain an appropriate radiolabeled product code. The updated lists of both types of edits can be found under "Device, Radiolabeled Product, and Procedure Edits" at <http://www.cms.hhs.gov/HospitalOutpatientPPS/> on the CMS website.

8. Clarification Related to Observation Services

CMS updated the Medicare Claims Processing Manual (Chapter 4, Section 290) and the Medicare Benefit Policy Manual (Chapter 6, Section 20.6) to clarify that a hospital begins billing for observation services, reported with HCPCS code G0378, at the clock time documented in the patient's medical record, which coincides with the time that observation services are initiated in accordance with a physician's order for observation services. Editorial changes to the manuals remove references to "admission" and "observation status" in relation to outpatient observation services and direct referrals for observation services. These terms may have been confusing to hospitals. The term "admission" is typically used to denote an inpatient admission and inpatient hospital services. For payment purposes, there is no payment status called "observation". Observation care is an outpatient service, ordered by a physician and reported with a HCPCS code.

9. Clarification Related to Condition Code 44

The changes to the Medicare Claims Processing Manual (Chapter 1, Section 50.3) incorporate information and guidance published in MLN Matters article SE0622, published March, 2006, which you can review at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0622.pdf> on the CMS website. MLN Matters article SE0622 provided clarification to Transmittal 299, CR 3444, issued September 10, 2004. You can also review the revised Chapter 1 (Section 50.3) of the Medicare Claims Processing Manual, which is included as an attachment to CR 6492, which is at <http://www.cms.hhs.gov/Transmittals/downloads/R1760CP.pdf> on the CMS website.

10. Coverage Determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPSS 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. FIs/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.

Additional Information

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The official instruction, CR6480, was issued to your FI, MAC, and RHHI in two transmittals. The first transmittal modifies the Medicare Benefit Policy Manual and is at <http://www.cms.hhs.gov/Transmittals/downloads/R107BP.pdf> on the CMS website. The second transmittal modifies the Medicare Claims Processing Manual and it is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1760CP.pdf> on the CMS website.

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

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