

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



News Flash – The publication titled “How to Search the Medicare Coverage Database” (revised April 2011), is now available in downloadable format from the Medicare Learning Network®. It was designed to provide education about how to use the Medicare Coverage Database (MCD) and includes an explanation of the database and how to use the search, indexes and reports, and download features. The booklet is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedicareCvrgeDatabase_ICN901346.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

MLN Matters® Number: MM7443

Related Change Request (CR) #: CR 7443

Related CR Release Date: May 27, 2011

Effective Date: July 1, 2011

Related CR Transmittal #: R2234CP

Implementation Date: July 5, 2011

July 2011 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Note: This article was updated on August 7, 2012, to reflect current Web addresses. All other content remains the same.

Provider Types Affected

This article is for providers submitting claims to Medicare Contractors (Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries and paid under the Outpatient Prospective Payment System (OPPS).

Provider Action Needed

This article is based on Change Request (CR) 7443 which describes changes to and billing instructions for various payment policies implemented in the July 2011 OPPS update. The July 2011 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common

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Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this Change Request (CR). Be sure your billing staffs are aware of these changes.

Background

Change Request (CR) 7443 describes changes to and billing instructions for various payment policies implemented in the July 2011 OPSS update. The July 2011 Integrated Outpatient Code Editor (I/OCE) and OPSS 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 CR7443. The July 2011 revisions to I/OCE data files, instructions, and specifications are provided in CR7439, "July 2011 Integrated Outpatient Code Editor (I/OCE) Specifications Version 12.2." The related MLN Matters® article can be found at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7439.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

Key OPSS Updates for July 2011

Changes to Device Edits for July 2011

Procedure-to-device edits require that when a particular procedural 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. Procedures for which both a Device A and a Device B are specified, require that at least one each of Device A and Device B be present on the claim (i.e., there must be some combination of a Device A with a Device B in order to pass the edit). Device B can be reported with any Device A for the same procedural HCPCS code.

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.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html> on the CMS website.

New Services

The following new services are assigned for separate payment under the OPSS, effective July 1, 2011:

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Table 1 -- New Services Assigned for Separate Payment under the OPSS Effective July 1, 2011

HCPSCS	Effective date	SI	APC	Short Descriptor	Long descriptor	Payment	Minimum Unadjusted Copayment
C9730	7/1/2011	T	0415	Bronchial thermo, 1 lobe	Bronchoscopic bronchial thermoplasty with imaging guidance (if performed), radiofrequency ablation of airway smooth muscle, 1 lobe	\$1,971.77	\$459.92
C9731	7/1/2011	T	0415	Bronchial thermo, >1 lobe	Bronchoscopic bronchial thermoplasty with imaging guidance (if performed), radiofrequency ablation of airway smooth muscle, 2 or more lobes	\$1,971.77	\$459.92

Effective July 1, 2011, HCPCS code C9729 will be deleted and replaced with new Category III Current Procedural Terminology (CPT) code 0275T. Category III CPT code 0275T will be added to the payable codes in the OPSS and assigned to the same status indicator and APC assignment as its predecessor HCPCS code C9729. Providers reporting the intralaminar decompression procedure should use CPT code 0275T beginning with services rendered on or after July 1, 2011. The table below summarizes the new coding information.

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Table 2 -- Coding Change for the Intralaminar Decompression Procedure Effective July 1, 2011

HCPCS	Effective date	SI	APC	Short Descriptor	Long descriptor	Payment	Minimum Unadjusted Copayment
C9729	7/1/2011	Deleted	Deleted	Percut lumbar lami	Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with ligamentous resection, discectomy, facetectomy and/or foraminotomy, when performed) any method under indirect image guidance, with the use of an endoscope when performed, single or multiple levels, unilateral or bilateral; lumbar	N/A	N/A
0275T	7/1/2011	T	0208	Perq lamot/lam lumbar	Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; lumbar	\$3,535.92	\$707.19

Category III CPT Codes

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

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January. Prior to Calendar Year (CY) 2006, CMS implemented new Category III CPT codes once a year in January of the following year.

As discussed in the CY 2006 OPPS final rule with comment period (70 FR 68567), 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 Category III CPT codes and some of the C-codes that are payable under the OPPS and were created by CMS in response to applications for new technology services.

For the July 2011 update, CMS is implementing in the OPPS 14 Category III CPT codes that the AMA released in January 2011 for implementation on July 1, 2011. Of the 14 Category III CPT codes, 12 are separately payable under the hospital OPPS. The Category III CPT codes, status indicators, and APCs are shown in Table 3 below. Payment rates for these services can be found in Addendum B of the July 2011 OPPS Update that is posted on the CMS website.

Table 3 -- Category III CPT Codes Implemented as of July 1, 2011

CPT Code	Long Descriptor	SI	APC
0262T	Implantation of catheter-delivered prosthetic pulmonary valve, endovascular approach	C	NA
0263T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure including unilateral or bilateral bone marrow harvest	S	0112
0264T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure excluding bone marrow harvest	S	0112
0265T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; unilateral or bilateral bone marrow harvest only for intramuscular autologous bone marrow cell therapy	S	0112
0266T	Implantation or replacement of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)	C	NA

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CPT Code	Long Descriptor	SI	APC
0267T	Implantation or replacement of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)	T	0687
0268T	Implantation or replacement of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)	S	0039
0269T	Revision or removal of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)	T	0221
0270T	Revision or removal of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)	T	0687
0271T	Revision or removal of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)	T	0688
0272T	Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (eg, battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day)	S	0218
0273T	Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (eg, battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day); with programming	S	0218
0274T	Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; cervical or thoracic	T	0208

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CPT Code	Long Descriptor	SI	APC
0275T	Percutaneous laminotomy/laminectomy (intradiscal approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; lumbar	T	0208

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 an item described by a reported HCPCS code 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 OPPIs, 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 only for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, and for which a specific HCPCS code has not been assigned.

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective July 1, 2011

For CY 2011, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 5 percent, which provides payment for both the acquisition cost and pharmacy overhead cost associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2011, 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 cost of these pass-through items. CMS notes that for the third quarter of CY 2011, 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, CMS would again use the Part B drug CAP rate for pass-through drugs and biologicals that are a part of the Part B drug CAP program, as required by the statute.

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In the CY 2011 OPSS/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. 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 2011 release of the OPSS Pricer. The updated payment rates, effective July 1, 2011, will be included in the July 2011 update of the OPSS Addendum A and Addendum B, which will be posted on the CMS Web site. The Addendums are at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html> on the CMS website.

b. Drugs and Biologicals with OPSS Pass-Through Status Effective July 1, 2011

Seven drugs and biologicals have been granted OPSS pass-through status effective July 1, 2011. These items, along with their descriptors and APC assignments, are identified in Table 4 below.

Table 4 -- Drugs and Biologicals with OPSS Pass-Through Status Drugs and Biologicals with OPSS Pass-Through Status Effective July 1, 2011

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 7/1/11
C9283*	Injection, acetaminophen, 10 mg	9283	G
C9284*	Injection, ipilimumab, 1 mg	9284	G
C9285*	Lidocaine 70 mg/tetracaine 70 mg, per patch	9285	G
C9365*	Oasis Ultra Tri-Layer Matrix, per square centimeter	9365	G
C9406*	Iodine I-123 ioflupane, diagnostic, per study dose, up to 5 millicuries	9406	G
J1572	Injection, immune globulin, (flebogamma/flebogamma dif), intravenous, non-lyophilized (e.g. liquid), 500 mg	0947	G
Q2044*	Injection, belimumab, 10 mg	1353	G

NOTE: The HCPCS codes identified with an "*" indicate that these are new codes effective July 1, 2011.

c. New HCPCS Codes Effective July 1, 2011, for Certain Drugs and Biologicals

Three new HCPCS codes have been created for reporting certain drugs and biologicals (other than new pass-through drugs and biologicals listed above in Table 4) in the hospital outpatient

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setting for July 1, 2011. These codes are listed in Table 5 below and are effective for services furnished on or after July 1, 2011. HCPCS code Q2041 is replacing HCPCS code J7184 beginning on July 1, 2011, and HCPCS code Q2043 is replacing HCPCS code C9273 beginning on July 1, 2011.

Table 5 -- New HCPCS Codes Effective for Certain Drugs and Biologicals Effective July 1, 2011

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 7/1/11
Q2041	Injection, von willebrand factor complex (human), Wilate, 1 i.u. vwf:rco	1352	G
Q2042	Injection, hydroxyprogesterone caproate, 1 mg	1354	K
Q2043	Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion	9273	G

Supplemental Information on HCPCS code Q2043 (Provenge)

HCPCS code Q2043 is replacing HCPCS code C9273 beginning on July 1, 2011. In CR 7117, Transmittal 2050, dated September 17, 2010, CMS clarified the reporting of HCPCS code C9273. Since HCPCS code Q2043 is a replacement code for HCPCS code C9273, the reporting instructions for HCPCS code C9273 also apply to HCPCS code Q2043. That is, the language in the long descriptor of HCPCS code Q2043 that states "all other preparatory procedures" refers to the entire process of collecting immune cells from a patient during a non-therapeutic leukapheresis procedure, sending the immune cells to the facility that prepares the immunotherapy product, and then transporting the immune cells back to the site of service to be administered to the patient.

d. Updated Payment Rate for HCPCS Code J2505 Effective April 1, 2010, through June 30, 2010

The payment rate for HCPCS code J2505 was incorrect in the April 2010 OPPS Pricer. The corrected payment rate is listed in Table 6 below and has been installed in the July 2011 OPPS Pricer, effective for services furnished on April 1, 2010, through implementation of the July 2010 update. Medicare contractors shall adjust as appropriate claims brought to their attention that have dates of service that fall on or after April 1, 2010, but prior to July 1, 2010, contain HCPCS Code J2505, and were originally processed prior to the installation of the July 2011 OPPS Pricer.

Table 6 -- Updated Payment Rates for HCPCS Code J2505 Effective April 1, 2010 through June 31, 2010

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HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J2505	K	9119	Injection, pegfilgrastim 6mg	\$2,386.39	\$477.28

e. Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2010, through September 30, 2010

The payment rates for several HCPCS codes were incorrect in the July 2010 OPSS Pricer. The corrected payment rates are listed in Table 7 below and have been installed in the July 2011 OPSS Pricer, effective for services furnished on July 1, 2010, through implementation of the October 2010 update. Medicare contractors shall adjust as appropriate claims brought to their attention that have dates of service that fall on or after July 1, 2010, but prior to October 1, 2010, contain a HCPCS Code from Table 7, and were originally processed prior to the installation of the July 2011 OPSS Pricer.

Table 7 -- Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2010 through September 30, 2010

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J0150	K	0379	Injection adenosine 6 MG	\$11.47	\$2.29
J2430	K	0730	Pamidronate disodium /30 MG	\$15.12	\$3.02
J2505	K	9119	Injection, pegfilgrastim 6mg	\$2,423.91	\$484.78
J9065	K	0858	Inj cladribine per 1 MG	\$25.61	\$5.12
J9178	K	1167	Inj, epirubicin hcl, 2 mg	\$2.19	\$0.44
J9200	K	0827	Floxuridine injection	\$34.99	\$7.00
J9206	K	0830	Irinotecan injection	\$3.36	\$0.67
J9208	K	0831	Ifosfomide injection	\$29.83	\$5.97
J9209	K	0732	Mesna injection	\$4.15	\$0.83
J9211	K	0832	Idarubicin hcl injection	\$41.14	\$8.23
J9263	K	1738	Oxaliplatin	\$4.35	\$0.87
J9293	K	0864	Mitoxantrone hydrochl / 5 MG	\$44.38	\$8.88

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f. Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2010, through December 31, 2010

The payment rates for several HCPCS codes were incorrect in the October 2010 OPSS Pricer. The corrected payment rates are listed in Table 8 below and have been installed in the July 2011 OPSS Pricer, effective for services furnished on October 1, 2010, through implementation of the January 2011 update. Medicare contractors shall adjust as appropriate claims brought to their attention that have dates of service that fall on or after October 1, 2010, but prior to January 1, 2011, contain a HCPCS Code from Table 8, and were originally processed prior to the installation of the July 2011 OPSS Pricer.

**Table 8 -- Updated Payment Rates for Certain HCPCS Codes
Effective October 1, 2010 through December 31, 2010**

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J0150	K	0379	Injection adenosine 6 MG	\$9.59	\$1.92
J2430	K	0730	Pamidronate disodium /30 MG	\$11.81	\$2.36
J9065	K	0858	Inj cladribine per 1 MG	\$24.97	\$4.99
J9178	K	1167	Inj, epirubicin hcl, 2 mg	\$9.17	\$1.83
J9185	K	0842	Fludarabine phosphate inj	\$158.16	\$31.63
J9200	K	0827	Floxuridine injection	\$32.17	\$6.43
J9206	K	0830	Irinotecan injection	\$4.68	\$0.94
J9208	K	0831	Ifosfomide injection	\$31.54	\$6.31
J9209	K	0732	Mesna injection	\$4.62	\$0.92
J9211	K	0832	Idarubicin hcl injection	\$84.06	\$16.81
J9263	K	1738	Oxaliplatin	\$4.60	\$0.92
J9266	K	0843	Pegaspargase injection	\$2,675.40	\$535.08
J9293	K	0864	Mitoxantrone hydrochl / 5 MG	\$33.48	\$6.70

g. Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2011, through March 31, 2011

The payment rates for several HCPCS codes were incorrect in the January 2011 OPSS Pricer. The corrected payment rates are listed in Table 9 below and have been installed in the July 2011 OPSS Pricer, effective for services furnished on January 1, 2011, through implementation of the April 2011 update. Medicare contractors shall adjust as appropriate

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claims brought to their attention that have dates of service that fall on or after January 1, 2011, but prior to April 1, 2011, contain a HCPCS Code from Table 9, and were originally processed prior to the installation of the July 2011 OPSS Pricer.

**Table 9 -- Updated Payment Rates for Certain HCPCS Codes
Effective January 1, 2011 through March 31, 2011**

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J9065	K	0858	Inj cladribine per 1 MG	\$24.93	\$4.99
J9178	K	1167	Inj, epirubicin hcl, 2 mg	\$1.90	\$0.38
J9200	K	0827	Floxuridine injection	\$37.92	\$7.58
J9206	K	0830	Irinotecan injection	\$5.31	\$1.06
J9208	K	0831	Ifosfomide injection	\$33.40	\$6.68
J9211	K	0832	Idarubicin hcl injection	\$118.41	\$23.68
J9265	K	1309	Paclitaxel injection	\$6.95	\$1.39
J9266	K	0843	Pegaspargase injection	\$2,701.13	\$540.23
J9293	K	0864	Mitoxantrone hydrochl / 5 MG	\$33.36	\$6.67

h. Correct Reporting of 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. 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, either as a biological or a device, a separate payment for the biological or device 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

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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.

i. Correct Reporting of Units for Drugs

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 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 descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient; hospitals should bill 10 units, even though only 1 vial was administered. The HCPCS 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.

As discussed in the "Medicare Claims Processing Manual," Pub.100-04, Chapter 17, Section 40 (see <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf> on the CMS website), CMS encourages hospitals to use drugs efficiently and in a clinically appropriate manner. However, CMS also recognizes that hospitals may discard some drug and biological product when administering from a single use vial or package. In that circumstance, Medicare pays for the amount of drug or biological discarded *as well as* the *dose* administered, up to the amount of the drug or biological as indicated on the vial or package label. Multi-use vials are not subject to payment for discarded amounts of drug or biological.

j. Reporting of Outpatient Diagnostic Nuclear Medicine Procedures

With the specific exception of HCPCS code C9898 (Radiolabeled product provided during a hospital inpatient stay) to be reported by hospitals on outpatient claims for nuclear medicine procedures to indicate that a radiolabeled product that provides the radioactivity necessary for the reported diagnostic nuclear medicine procedure was provided during a hospital inpatient stay, hospitals should only report HCPCS codes for products they provide in the hospital

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outpatient department and should not report a HCPCS code and charge for a radiolabeled product on the nuclear medicine procedure-to-radiolabeled product edit list solely for the purpose of bypassing those edits present in the I/OCE.

As CMS stated in the October 2009 OPPS update, in the rare instance when a diagnostic radiopharmaceutical may be administered to a beneficiary in a given Calendar Year prior to a hospital furnishing an associated nuclear medicine procedure in the subsequent Calendar Year, hospitals are instructed to report the date the radiolabeled product is furnished to the beneficiary as the same date that the nuclear medicine procedure is performed. CMS believes that this situation is extremely rare and expects that the majority of hospitals will not encounter this situation.

Where a hospital or a nonhospital location, administers a diagnostic radiopharmaceutical product for a different hospital providing the nuclear medicine scan, hospitals should comply with the OPPS policy that requires that radiolabeled products be reported and billed with the nuclear medicine scan. In these cases, the first hospital or nonhospital location may enter into an arrangement under the Social Security Act (section 1861(w)(1); see http://www.ssa.gov/OP_Home/ssact/title18/1861.htm on the Internet), and as discussed in 42 CFR 410.28(a)(1) (see http://edocket.access.gpo.gov/cfr_2010/octqtr/pdf/42cfr410.28.pdf on the Internet) and defined in 42 CFR 409.3 (see http://edocket.access.gpo.gov/cfr_2010/octqtr/pdf/42cfr409.3.pdf on the Internet), where the second hospital that administers the nuclear medicine scan both bills Medicare for the administration of the nuclear medicine scan with diagnostic radiopharmaceutical and pays the first hospital or nonhospital location that administers the diagnostic radiopharmaceutical some amount for administration of the diagnostic radiopharmaceutical. CMS notes that it considers the radiolabeled product and the nuclear medicine scan to be part of one procedure and would expect both services to be performed together.

k. Use of HCPCS Code C9399

As stated in the "Medicare Claims Processing Manual," Pub. 100-04, Chapter 17, Section 90.3 (see <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf> on the CMS website), hospitals are to report HCPCS code C9399, Unclassified drug or biological, solely for new outpatient drugs or biologicals that are approved by the FDA on or after January 1, 2004 and that are furnished as part of covered outpatient department services for which a product-specific HCPCS code has not been assigned. It is not appropriate to report HCPCS code C9399 for drugs and biologicals that are defined as usually self-administered drugs by the patient as defined in the "Medicare Benefit Policy Manual," Pub. 100-02, Chapter 15, Section 50.2 (see <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf> on the CMS website).

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Reporting Hours of Observation

Under current OPSS payment policy, observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy). CMS is revising billing instructions to state that in situations where such a procedure interrupts observation services, hospitals may determine the most appropriate way to account for this time. For example, a hospital may record for each period of observation services the beginning and ending times during the hospital outpatient encounter and add the length of time for the periods of observation services together to reach the total number of units reported on the claim for the hourly observation services HCPCS code G0378 (Hospital observation service, per hour). A hospital may also deduct the average length of time of the interrupting procedure, from the total duration of time that the patient receives observation services. CMS is updating the "Medicare Claims Processing Manual," Pub.100-04, Chapter 4, Section 290.2.2 (which is included as an attachment to CR7443) to reflect the revised observation reporting guidelines.

Reporting Critical Care Services under the OPSS

Beginning January 1, 2011, under revised AMA CPT Editorial Panel guidance, hospitals that report in accordance with the CPT guidelines will begin reporting all of the ancillary services and their associated charges separately when they are provided in conjunction with critical care (CPT codes 99291 and 99292). CMS continues to recognize the existing CPT codes for critical care services and has established a payment rate based on its historical data, into which the cost of the ancillary services is intrinsically packaged. The I/OCE logic conditionally packages payment for the ancillary services that are reported on the same date of service as critical care services in order to avoid overpayment. The payment status of the ancillary services does not change when they are not provided in conjunction with critical care services. Hospitals may use HCPCS modifier -59 to indicate when an ancillary procedure or service is distinct or independent from critical care when performed on the same day but in a different encounter.

Effective January 1, 2011, National Correct Coding Initiative edits for the hospital OPSS that disallow the reporting of critical care services with ancillary services will be deleted retroactive to January 1, 2011. The I/OCE generates Correct Coding Initiative (CCI) edits for OPSS hospitals. Providers whose claims contained lines that were denied or rejected due to the critical care CCI edits for ancillary services from January 1, 2011, through June 30, 2011, may request contractor adjustment of the previously processed claims.

Payment Window for Outpatient Services Treated as Inpatient Services

The payment window for outpatient services treated as inpatient services policy, specifically described in Transmittal 796, CR7142, issued on October 29, 2010, (see the corresponding MLN Matters article for CR7142 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7142.pdf> on the CMS website), states that a hospital (or an entity that is wholly owned or wholly operated by the hospital) must include on the claim for a beneficiary's inpatient stay, the diagnoses, procedures, and charges for all outpatient diagnostic

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services and admission-related outpatient non-diagnostic services provided during the payment window. Hospitals may attest to specific non-diagnostic services as being unrelated to the inpatient stay (that is, the preadmission non-diagnostic services are clinically distinct or independent from the reason for the beneficiary's admission) by adding condition code 51 (definition "51 – Attestation of Unrelated Outpatient Non-diagnostic Services) to the separately billed outpatient non-diagnostic services claim starting April 1, 2011, for outpatient claims that have a date of service on or after June 25, 2010.

CMS is adding section 10.12 to the "Medicare Claims Processing Manual," Pub. 100-04, Chapter 4, (which is included as an attachment to CR7443) to reflect the regulatory and statutory policy changes outlined in CR7142. CMS is also revising section 180.7 of the Claims Processing Manual, Pub. 100-04, Chapter 4, (which is included as an attachment to CR7443) to clarify that CMS will not pay for "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.

Billing for Linear Accelerator (Robotic Image-Guided and Non-Robotic Image-Guided) SRS Planning and Delivery

CMS is updating the "Medicare Claims Processing Manual," Pub. 100-04, Chapter 4, Section 200.3.4 (which is included as an attachment to CR7443) to correct a typographical error citing HCPCS code G0039 rather than G0339.

Changes to OPPS Pricer Logic

- a. Rural Sole Community Hospitals (SCH) and Essential Access Community Hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in CY 2011. The 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 Social Security Act, as added by Section 411 of Pub. L. 108-173. However, the rural SCH and EACH 7.1 percent payment increase does not apply to services billed on a non-patient bill type 014X.
- b. Effective for claims with a date of service on or after January 1, 2011, the OPPS Pricer will not apply Deductible and Coinsurance amounts for Preventive care services waived by Section 4104 of the Patient Protection and Affordable Care Act (the Affordable Care Act) as appropriate.

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Additional Items

Medicare contractors will adjust as appropriate claims brought to their attention that have dates of service that fall on or after January 1, 2011, but prior to July 1, 2011, include CPT codes 99291 and/or 99292, and were originally processed prior to the installation of the revised July 2011 I/OCE.

Medicare contractors will also adjust as appropriate claims brought to their attention that have dates of service that fall on or after January 1, 2006, but prior to July 1, 2011, where the provider is a rural Sole-Community Hospital that received the 7.1% add-on for laboratory services, contain a type of bill 14X, and were originally processed prior to the installation of the revised July 2011 I/OCE.

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.

Additional Information

The official instruction, CR7443, issued to your FIs, A/B MACs, and RHHs regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2234CP.pdf> on the CMS website.

If you have any questions, please contact your FIs, A/B MACs, or RHHs at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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