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Related Change Request (CR) #: 6751

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Effective Date: January 1, 2010

Related CR Transmittal #: R1873CP and R116BP

Implementation Date: January 4, 2010

## January 2010 Update of the Hospital Outpatient Prospective Payment System (OPPS)

**Note:** This article was revised on December 22, 2009 to reflect a revised CR 6751 that was issued on December 21, 2009. In this article, the CR release date, transmittal number, and Web address for accessing CR 6751 were revised. All other information is the same. The revised CR 6751 also has a new Table 12 with correct wage index values for providers. The revised CR is at <http://www.cms.hhs.gov/Transmittals/downloads/R1882CP.pdf> on the CMS website.

### Provider Types Affected

Providers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for outpatient services provided to Medicare beneficiaries and paid under the OPPS.

### Provider Action Needed

This article is based on Change Request (CR) 6751, which describes changes to the OPPS to be implemented in the January 2010 OPPS update. Be sure billing staffs are aware of these changes.

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## Background

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CR 6751 describes changes to and billing instructions for various payment policies implemented in the January 2010 OPPS update. The January 2010 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 notification.

The January 2010 revisions to the I/OCE data files, instructions, and specifications are provided in CR 6761, "January 2010 Integrated Outpatient Code Editor (I/OCE) Specifications Version 11.0." Once CR 6761 is issued, a related MLN Matters® will be available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6761.pdf> on the Centers for Medicare & Medicaid Services (CMS) website. The remainder of this article provides details on the changes conveyed by CR 6751.

### *Changes to Device Edits for January 2010*

Claims for OPPS services must pass two types of device edits to be accepted for processing: procedure-to-device edits and device-to-procedure edits. Procedure-to-device edits, which have been in place for many procedures since 2005, continue to be in place. These edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code.

Since January 1, 2007, CMS also has required 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 device-to-procedure edits are designed to ensure that the costs of these devices are assigned to the appropriate APC in OPPS ratesetting.

The most current edits for both types of device edits can be found at <http://www.cms.hhs.gov/HospitalOutpatientPPS/> on the CMS website. Failure to pass these edits will result in the claim being returned to the provider.

### *Billing for "Sometimes Therapy" Services that May be Paid as Non-Therapy Services for Hospital Outpatients*

Section 1834(k) of the Act, as added by Section 4541 of the Balanced Budget Act (BBA), allows payment at 80 percent of the lesser of the actual charge for the services or the applicable fee schedule amount for all outpatient therapy services; that is, physical therapy services, speech-language pathology services, and occupational therapy services. As provided under Section 1834(k)(5) of the Social Security Act (or the Act), a therapy code list was created based on a uniform coding system (that is, the HCPCS) to identify and track these outpatient therapy services paid under the Medicare Physician Fee Schedule (MPFS).

The list of therapy codes, along with their respective designation, can be found at [http://www.cms.hhs.gov/TherapyServices/05\\_Annual\\_Therapy\\_Update.asp#TopOfPage](http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage) on the CMS website. Two of the designations that are used for therapy services are: "always therapy" and "sometimes therapy." An "always therapy" service must be performed by a qualified

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therapist under a certified therapy plan of care, and a “sometimes therapy” service may be performed by an individual outside of a certified therapy plan of care.

Under the OPFS, separate payment is provided for certain services designated as “sometimes therapy” services if these services are furnished to hospital outpatients as a non-therapy service, that is, without a certified therapy plan of care. Specifically, to be paid under the OPFS for a non-therapy service, hospitals SHOULD NOT append the therapy modifier GP (physical therapy), GO (occupational therapy), or GN (speech language pathology), or report a therapy revenue code 042x, 043x, or 044x in association with the “sometimes therapy” codes listed in the table below.

To receive payment under the MPFS, when “sometimes therapy” services are performed by a qualified therapist under a certified therapy plan of care, providers should append the appropriate therapy modifier GP, GO, or GN, and report the charges under an appropriate therapy revenue code, specifically 042x, 043x, or 044x. This instruction does not apply to claims for “sometimes therapy” codes furnished as therapy services in the hospital outpatient department and paid under the MPFS.

Effective January 1, 2010, CPT code 92520 (Laryngeal function studies (ie, aerodynamic testing and acoustic testing)), is newly designated as a “sometimes therapy” service under the MPFS. CPT code 92520 is not a new code, however, its “sometimes therapy” designation is new and effective January 1, 2010. Under the OPFS, hospitals will receive separate payment when they bill CPT code 92520 as a non-therapy service.

The list of HCPCS codes designated as “sometimes therapy” services that may be paid as non-therapy services when furnished to hospital outpatients as of January 1, 2010 is displayed in the following table.

**Table 1- Services Designated as “Sometimes Therapy” that May be Paid as Non-Therapy Services for Hospital Outpatients as of January 1, 2010**

HCPCS Code	Long Descriptor
92520	Laryngeal function studies (ie, aerodynamic testing and acoustic testing)
97597	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters
97598	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area greater than 20 square centimeters

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HCPCS Code	Long Descriptor
97602	Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session
97605	Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters
97606	Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters
0183T	Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day

### ***Partial Hospitalization APCs (APC 0172 and APC 0173)***

For CY 2010, CMS is updating the two Partial Hospitalization Program (PHP) per diem payment rates: APC 0172 (Level I Partial Hospitalization (3 services)) and APC 0173 (Level II Partial Hospitalization (4 or more services)). When a community mental health center (CMHC) or hospital outpatient department provides three units of partial hospitalization services and meets all other partial hospitalization payment criteria, the CMHC or hospital would be paid through APC 0172. When the CMHC or hospital outpatient department provides four or more units of partial hospitalization services and meets all other partial hospitalization payment criteria, the hospital would be paid through APC 0173. The following table provides the updated per diem payment rates.

**Table 2-Updated Per Diem Payment Rates for Partial Hospitalization APCs**

2010 APC	2010 Long Descriptor	Payment Rate
0172	(Level I Partial Hospitalization (3 units of service))	\$149.84
0173	(Level II Partial Hospitalization (4 units or more units of service))	\$210.89

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### ***Payment for Multiple Imaging Composite APCs***

Effective for services furnished on or after January 1, 2009, multiple imaging procedures performed during a single session using the same imaging modality are paid by applying a composite APC payment methodology. The services are paid with one composite APC payment each time a hospital bills for second and subsequent imaging procedures described by the HCPCS codes in one imaging family on a single date of service. The I/OCE logic determines the assignment of the composite APCs for payment. Prior to January 1, 2009, hospitals received a full APC payment for each imaging service on a claim, regardless of how many procedures were performed during a single session.

The composite APC payment methodology for multiple imaging services utilizes three imaging families (Ultrasound, CT and CTA, and MRI and MRA) and five composite APCs: APC 8004 (Ultrasound Composite); APC 8005 (CT and CTA without Contrast Composite); APC 8006 (CT and CTA with Contrast Composite); APC 8007 (MRI and MRA without Contrast Composite); and APC 8008 (MRI and MRA with Contrast Composite). When a procedure is performed with contrast during the same session as a procedure without contrast, and the two procedures are within the same family, the "with contrast" composite APC (either APC 8006 or 8008) is assigned.

CMS has updated the list of specified HCPCS codes within the three imaging families and five composite APCs to reflect HCPCS coding changes for CY 2010. Specifically, we added CPT code 74261 (Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material) and CPT code 74262 (Computed tomographic (CT) colonography, diagnostic, including image postprocessing, with contrast materials(s) including non-contrast images, if performed) to the CT and CTA family, and removed CPT code 0067T (Computed tomographic (CT) colonography (ie, virtual colonoscopy); diagnostic), which was replaced by these CPT codes.

The specified HCPCS codes within the three imaging families and five composite APCs for CY 2010 are provided in Table 3 of CR 6751, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1882CP.pdf> on the CMS website.

### ***Cardiac Rehabilitation Services***

CMS deleted Section 200.5 of Chapter 4 of the Medicare Claims Processing Manual and reserved it for future use. The coding requirements for cardiac rehabilitation services have been moved to Chapter 32 (Billing Requirements for Special Services), Section 140 (Cardiac Rehabilitation Programs, Intensive Cardiac Rehabilitation Programs, and Pulmonary Rehabilitation Programs). Section 140.1 contains coverage and coding requirements for cardiac rehabilitation services furnished on or before December 31, 2009. Sections 140.2 and 140.3 have been added and include coverage and coding requirements for cardiac rehabilitation and intensive cardiac rehabilitation services beginning January 1, 2010. The revised manual chapters are available as an attachment to CR 6751.

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### ***Pulmonary Rehabilitation Services***

CMS added Section 140.4 to Chapter 32 (Billing Requirements for Special Services), Section 140 (Cardiac Rehabilitation Programs, Intensive Cardiac Rehabilitation Programs, and Pulmonary Rehabilitation Programs). It includes coverage and coding requirements for pulmonary rehabilitation services beginning January 1, 2010.

### ***Outpatient Observation Services***

CMS deleted Section 290.3 of Chapter 4 of the Medicare Claims Processing Manual and reserved it for future use. This section, "Billing and Payment for Observation Services Furnished Prior to January 1, 2006," is no longer relevant for claims processing purposes. In addition, CMS is making minor revisions to Section 290.5.2 (Billing and Payment for Direct Referral for Observation Care Furnished Beginning January 1, 2008) to reflect the change in the code descriptor of HCPCS code G0379 (Direct referral for hospital observation care), which is effective January 1, 2010.

### ***Kidney Disease Education***

Section 152(b) of MIPPA added kidney disease education (KDE) as a Medicare Part B covered benefit effective January 1, 2010, for beneficiaries diagnosed with Stage IV chronic kidney disease (CKD). Medicare will cover up to and including six KDE sessions for beneficiaries referred by the physician managing the beneficiary's kidney condition when the beneficiary has been diagnosed with Stage IV CKD. To be covered, these services must be furnished by a "qualified person". A qualified person is a physician, physician assistant, nurse practitioner, or clinical nurse specialist or a provider of services located in a rural area; or a hospital or critical access hospital (CAH) that is treated as being located in a rural area under Section 412.103 of the Code of Federal Regulations (CFR). Renal dialysis facilities and providers of services located outside a rural area, except for hospitals or CAHs that are treated as being located in a rural area under CFR Section 412.103, are excluded from the definition of a "qualified person."

KDE services furnished by rural providers of services, including a hospital or CAH that is treated as being located in a rural area under CFR Section 412.103, are paid under the Medicare Physician Fee Schedule. KDE services should be reported using the HCPCS codes G0420 (Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour) and G0421 (Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour). Further information on billing, coverage, and payment of KDE services can be found in the Medicare Benefit Policy Manual, Chapter 15, Section 310 and the Medicare Claims Processing Manual, Chapter 32, Section 20, as discussed in CR 6557.

### ***Billing for Allogeneic and Autologous Stem Cell Transplant Procedures***

CMS added Section 231.11 to the Medicare Claims Processing Manual, Chapter 4, to clarify billing for allogeneic stem cell transplant procedures when provided in the outpatient setting. Allogeneic stem cell transplant procedures are payable under Part A or Part B depending upon whether the transplant takes place in the inpatient or outpatient setting. Payment for allogeneic stem cell acquisition services (including harvesting procedures) is packaged into the payment for the

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transplant procedure when provided in the outpatient setting. CMS also updated Chapter 4, Section 231.10 and Chapter 3, Section 90.3.3 to reflect that allogeneic stem cell transplant procedures may be billed and paid under Part B when provided in the hospital outpatient setting.

### ***Payment for Brachytherapy Sources***

For CY 2010, CMS proposed and finalized payment for brachytherapy sources using prospective rates based on Medicare claims data. For CY 2009 and most previous years, brachytherapy sources have been paid based on charges adjusted to a hospital's cost. The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) requires CMS to pay for brachytherapy sources for the period of July 1, 2008 through December 31, 2009 at hospitals' charges adjusted to the costs. CMS, therefore, has continued paying brachytherapy sources based on charges adjusted to cost for CY 2009. The status indicators of separately payable brachytherapy source HCPCS codes (except HCPCS code C2637) that were previously paid at charges adjusted to cost remain "U," which is the status indicator for separately payable brachytherapy sources irrespective of the payment methodology applied. CMS established status indicator "U" effective January 1, 2009.

These changes are reflected in the table below for all sources (with the exception of HCPCS code C2637, which is non-payable). In addition, because they will be paid prospectively beginning on January 1, 2010, brachytherapy sources will be eligible for outlier payments and for the rural sole community hospital (SCH) adjustment. The HCPCS codes for brachytherapy sources, long descriptors, status indicators, and APCs for CY 2010 are listed in Table 4, the comprehensive brachytherapy source table below.

**NOTE:** When billing for stranded sources, providers should bill the number of units of the appropriate source HCPCS C-code according to the number of brachytherapy sources in the strand, and should not bill as one unit per strand. See Transmittal 1259, CR 5623, issued June 1, 2007, for further information on billing for brachytherapy sources and the OPPS coding changes made for brachytherapy sources effective July 1, 2007. The MLN Matters® article related to CR 5623 is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5623.pdf> on the CMS website.

**Table 4- Comprehensive List of Brachytherapy Source HCPCS Codes as of January 1, 2010**

CY 2010 HCPCS Code	CY 2010 Long Descriptor	CY 2010 SI	CY 2010 APC
A9527	Iodine I-125, sodium iodide solution, therapeutic, per millicurie	U	2632
C1716	Brachytherapy source, non-stranded, Gold-198, per source	U	1716
C1717	Brachytherapy source, non-stranded, High Dose Rate Iridium-192, per source	U	1717

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CY 2010 HCPCS Code	CY 2010 Long Descriptor	CY 2010 SI	CY 2010 APC
C1719	Brachytherapy source, non-stranded, Non-High Dose Rate Iridium-192, per source	U	1719
C2616	Brachytherapy source, non-stranded, Yttrium-90, per source	U	2616
C2634	Brachytherapy source, non-stranded, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source	U	2634
C2635	Brachytherapy source, non-stranded, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source	U	2635
C2636	Brachytherapy linear source, non-stranded, Palladium-103, per 1MM	U	2636
C2637	Brachytherapy source, non-stranded, Ytterbium-169, per source	B	N/A
C2638	Brachytherapy source, stranded, Iodine-125, per source	U	2638
C2639	Brachytherapy source, non-stranded, Iodine-125, per source	U	2639
C2640	Brachytherapy source, stranded, Palladium-103, per source	U	2640
C2641	Brachytherapy source, non-stranded, Palladium-103, per source	U	2641
C2642	Brachytherapy source, stranded, Cesium-131, per source	U	2642
C2643	Brachytherapy source, non-stranded, Cesium-131, per source	U	2643
C2698	Brachytherapy source, stranded, not otherwise specified, per source	U	2698
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source	U	2699

### ***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.

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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' longstanding policy under the OPPS is to refrain from instructing hospitals on the appropriate revenue code to use to charge for specific services. While CMS does not require hospitals to use revenue code 0636 (Pharmacy-Extension of 025x; Drugs Requiring Detailed coding (a)) when billing for drugs and biologicals that have HCPCS codes, whether they are separately payable or packaged, CMS believes that a practice of billing all drugs and biologicals with HCPCS codes under revenue code 0636 would be consistent with National Uniform Billing Committee (NUBC) billing guidelines and would provide it with the most complete and detailed information for future ratesetting. CMS' standard ratesetting methodology is to rely on hospital cost and charge information as it is reported to us by hospitals through the claims data and cost reports.

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 2010 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals**

For CY 2010, 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 5 below.

**Table 5-New CY 2010 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals**

CY 2010 HCPCS Code	CY 2010 Long Descriptor	CY 2010 SI	CY 2010 APC
A9583	Injection, gadofosveset trisodium, 1 ml	G	1299
C9254	Injection, lacosamide, 1 mg	K	9254
C9255	Injection, paliperidone palmitate, 1 mg	G	9255

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CY 2010 HCPCS Code	CY 2010 Long Descriptor	CY 2010 SI	CY 2010 APC
C9256	Injection, dexamethasone intravitreal implant, 0.1 mg	G	9256
J0586	Injection, abobotulinumtoxintypeA, 5 units	K	1289
J1680*	Injection, human fibrinogen concentrate, 100 mg	G	1290
J2793	Injection, Riloncept	K	1291
J9155	Injection, degarelix, 1 mg	G	1296
Q0138	Injection, Ferumoxytol, for treatment of iron deficiency anemia, 1 mg	G	1297

\*Note: HCPCS code J1680 is identified as a blood clotting factor and, as such, is subject to the CY 2010 blood clotting factor furnishing fee.

**c. Other Changes to CY 2010 HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals**

Many HCPCS codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS code descriptors that will be effective in CY 2010. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2009 and replaced with permanent HCPCS codes in CY 2010. 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 2010 HCPCS codes.

**Table 6-Other CY 2010 HCPCS Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals**

CY 2009 HCPCS code	CY 2009 Long Descriptor	CY 2010 HCPCS Code	CY 2010 Long Descriptor
90378	Respiratory syncytial virus immune globulin (RSV-IgM), for intramuscular use, 50 mg, each	90378	Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each
90663	Influenza virus vaccine, pandemic formulation	90663	Influenza virus vaccine, pandemic formulation, H1N1
90669	Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use	90669	Pneumococcal conjugate vaccine, 7 valent, for intramuscular use
A9500	Technetium tc-99m sestamibi,	A9500	Technetium tc-99m sestamibi, diagnostic,

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CY 2009 HCPCS code	CY 2009 Long Descriptor	CY 2010 HCPCS Code	CY 2010 Long Descriptor
	diagnostic, per study dose, up to 40 millicuries		per study dose
A9535	Injection, methylene blue, 1 ml	Q9968	Injection, non-radioactive, non-contrast, visualization adjunct (e.g., methylene blue, isosulfan blue), 1 mg
A9605	Samarium sm-153 lexidronamm, therapeutic, per 50 millicuries	A9604	Samarium SM-153 lexidronam, therapeutic, per treatment dose, up to 150 millicuries
C9245	Injection, romiplostim, 10 mcg	J2796	Injection, Romiplostim, 10 micrograms
C9246	Injection, gadoxetate disodium, per ml	A9581	Injection, gadoxetate disodium, 1 ml
C9247	Iobenguane, I-123, diagnostic, per study dose, up to 10 millicuries	A9582	Iodine I-123 iobenguane, diagnostic, per study dose, up to 15 millicuries
C9249	Injection, certolizumab pegol, 1 mg	J0718	Injection, certolizumab pegol, 1 mg
C9251	Injection, C1 esterase inhibitor (human), 10 units	J0598	Injection, C1 esterase inhibitor (human), 10 units
C9252	Injection, plerixafor, 1 mg	J2562	Injection, Plerixafor, 1 mg
C9253	Injection, temozolomide, 1 mg	J9328	Injection, temozolomide, 1 mg
C9358	Dermal substitute, native, nondenatured collagen (SurgiMend Collagen Matrix), per 0.5 square cm	C9358	Dermal substitute, native, non-denatured collagen, fetal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters
C9359	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Putty, Integra OS Osteoconductive Scaffold Putty), per 0.5 cc	C9359	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Putty, Integra OS Osteoconductive Scaffold Putty), per 0.5 cc
J0460	Injection, atropine sulfate, up to 0.3 mg	J0461	Injection, atropine sulfate, 0.01 mg
J0530	Injection, penicillin g benzathine and penicillin g procaine, up to 600,000 units	J0559	Injection, penicillin G benzathine and penicillin G procaine, 2500 units
J0540	Injection, penicillin g benzathine and penicillin g procaine, up to 1,200,000	J0559	Injection, penicillin G benzathine and penicillin G procaine, 2500 units

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CY 2009 HCPCS code	CY 2009 Long Descriptor	CY 2010 HCPCS Code	CY 2010 Long Descriptor
	units		
J0550	Injection, penicillin g benzathine and penicillin g procaine, up to 2,400,000 units	J0559	Injection, penicillin G benzathine and penicillin G procaine, 2500 units
J0585	Botulinum toxin type a, per unit.	J0585	Injection, onabotulinumtoxin, 1 unit
J0587	Botulinum toxin type b, per 100 units	J0587	Injection, rimabotulinumtoxinb, 100 units
J0835	Injection, cosyntropin, per 0.25 mg	J0833	Injection, cosyntropin, not otherwise specified, 0.25 mg
J0835	Injection, cosyntropin, per 0.25 mg	J0834	Injection, cosyntropin (cortrosyn), 0.25 mg
J1565	Injection, respiratory syncytial virus immune globulin, intravenous, 50 mg	90379	Respiratory syncytial virus immune globulin (rsv-igiv), human, for intravenous use
J7192	Factor viii (antihemophilic factor, recombinant) per i.u.	J7192	Factor viii (antihemophilic factor, recombinant) per i.u., not otherwise specified
J7322	Hyaluronan or derivative, synvisc, for intra-articular injection, per dose	J7325	Hyaluronan or derivative, synvisc or synvisc-one, for intra-articular injection, 1 mg
J9170	Injection, docetaxel, 20 mg	J9171	Injection, docetaxel, 1 mg
Q2009	Injection, fosphenytoin, 50 mg	Q2009	Injection, Fosphenytoin, 50 mg phenytoin equivalent
Q2023	Injection, factor viii (antihemophilic factor, recombinant) (Xyntha), per i.u.	J7185	Injection, factor viii (antihemophilic factor, recombinant) (xyntha), per i.u.
Q2024	Injection, bevacizumab, 0.25 mg	C9257	Injection, bevacizumab, 0.25 mg

**d. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective January 1, 2010**

For CY 2010, 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 2010, a single payment of ASP+6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition

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cost and pharmacy overhead costs of these pass-through items. CMS notes that for the first quarter of CY 2010, 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 was suspended beginning January 1, 2009. Should the Part B Drug CAP be reinstated sometime during CY 2010, we 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, as required by the statute.

In the CY 2010 OPPTS/ASC final rule with comment period, CMS states that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as subsequent quarter ASP submissions become available. Effective January 1, 2010, payment rates for many drugs and biologicals have changed from the values published in the CY 2010 OPPTS/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 2009. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2010 release of the OPPTS Pricer. CMS is not publishing the updated payment rates in CR 6751. However, the updated payment rates effective January 1, 2010 can be found in the January 2010 update of the OPPTS Addendum A and Addendum B at <http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp> on the CMS Web site.

**e. Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2009 through June 30, 2009**

The payment rates for several HCPCS codes were incorrect in the April 2009 OPPTS Pricer. The corrected payment rates are listed below and have been installed in the January 2010 OPPTS Pricer, effective for services furnished on April 1, 2009 through implementation of the July 2009 update. Claims processed with the incorrect rates will be adjusted if you bring such claims to the attention of your contractor.

**Table 7-Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2009 through June 30, 2009**

CY 2009 HCPCS Code	CY 2009 SI	CY 2009 APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9245	G	9245	Injection, romiplostim	\$44.81	\$8.79
J1260	K	0750	Dolasetron mesylate	\$4.54	\$0.91
J2778	K	9233	Ranibizumab injection	\$399.55	\$79.91

**f. Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2009 through September 30, 2009**

The payment rates for several HCPCS codes were incorrect in the July 2009 OPPTS Pricer. The corrected payment rates are listed below and have been installed in the January 2010 OPPTS Pricer, effective for services furnished on July 1, 2009 through implementation of the October 2009

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update. Claims processed with the incorrect rates will be adjusted if you bring such claims to the attention of your contractor.

**Table 8-Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2009 through September 30, 2009**

CY 2009 HCPCS Code	CY 2009S I	CY 2009 APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9354	G	9354	Veritas collagen matrix, cm2	\$11.77	\$2.31
C9364	G	9364	Porcine implant, Permacol	\$18.46	\$3.62
J1520	K	0921	Gamma globulin 7 CC inj	\$102.15	\$20.43

#### **g. 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. 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 OPPS 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 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.

#### **h. 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. 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. If

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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.

**i. 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, effective January 1, 2010, 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 9-Non-pass-Through Separately Payable Therapeutic Radiopharmaceuticals Effective January 1, 2010**

CY 2010 HCPCS Code	CY 2010 Long Descriptor	Final CY 2010 APC	Final CY 2010 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

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**j. Reporting of Outpatient Diagnostic Nuclear Medicine Procedures**

CMS applies nuclear medicine procedure-to-radiolabeled product edits in the I/OCE effective January 2008 that require a radiolabeled product to be present on the same claim as a nuclear medicine procedure for payment under the OPSS to be made. These edits have been revised quarterly, based on information provided to us by members of the public with regard to certain clinical scenarios. CMS is updating the lists of nuclear medicine procedures and radiolabeled products for CY 2010. The complete list of updated nuclear medicine procedure-to-radiolabeled product edits can be found at

[http://www.cms.hhs.gov/HospitalOutpatientPPS/02\\_device\\_procedure.asp#TopOfPage](http://www.cms.hhs.gov/HospitalOutpatientPPS/02_device_procedure.asp#TopOfPage) on the CMS website.

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 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 stated in the October 2009 OPSS 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 we expect that the majority of hospitals will not encounter this situation.

**k. 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 OPSS. As discussed in Transmittal 1702, CR 6416, issued March 13, 2009, 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. The MLN Matters® article related to CR 6416 is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6416.pdf> on the CMS website.

Effective April 1, 2009, the diagnostic radiopharmaceutical reported with HCPCS code C9247 (Iobenguane, I-123, diagnostic, per study dose, up to 10 millicuries) was granted pass-through status under the OPSS and assigned status indicator "G." Therefore, in CY 2009, when HCPCS code C9247 is billed on the same claim with a nuclear medicine procedure, CMS reduces the amount of payment for the pass-through diagnostic radiopharmaceutical reported with HCPCS code C9247 by the corresponding nuclear medicine procedure's portion of its APC payment

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associated with “policy-packaged” drugs (offset amount) so no duplicate radiopharmaceutical payment is made.

For CY 2010, HCPCS code C9247 is being replaced with HCPCS code A9582 (Iodine I-123 iobenguane, diagnostic, per study dose, up to 15 millicuries) and HCPCS code A9582 will continue on pass-through status for CY 2010. Therefore, for CY 2010, HCPCS code A9582 will be assigned status indicator “G” and will be subject to the pass-through payment offset for pass-through diagnostic radiopharmaceuticals. The offset will cease to apply when this diagnostic radiopharmaceutical expires from pass-through status.

The “policy-packaged” portions of the CY 2010 APC payments for nuclear medicine procedures may be found on the CMS website at <http://www.cms.hhs.gov/HospitalOutpatientPPS/APF/list.asp#TopOfPage> in the download file labeled 2010 OPPS Offset Amounts by APC.

CY 2010 APCs to which nuclear medicine procedures are assigned and for which we expect a diagnostic radiopharmaceutical payment offset could be applicable in the case of a pass-through diagnostic radiopharmaceutical are displayed in the following table.

**Table 10-APCs to Which Nuclear Medicine Procedures are Assigned for CY 2010**

CY 2010 APC	CY 2010 APC Title
0307	Myocardial Positron Emission Tomography (PET) imaging
0308	Non-Myocardial 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

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CY 2010 APC	CY 2010 APC Title
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. Introduction of Payment Offset for Pass-Through Contrast Agents

As discussed in the CY 2010 OPPTS/ASC final rule with comment period, effective for pass-through contrast agents furnished on and after January 1, 2010, when a contrast-enhanced procedure that is assigned to a procedural APC with a “policy-packaged” drug amount greater than \$20 (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, 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 2010 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 the table below this section. 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 2010, when a contrast agent with pass-through status is billed with a contrast-enhanced procedure assigned to any procedural APC listed in this section’s table 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.

Effective January 1, 2009, contrast agent HCPCS code C9246 (Injection, gadoxetate disodium, per ml) was granted pass-through status under the OPPTS and was assigned status indicator “G.” As the pass-through offset methodology was not in place for contrast agents in CY 2009, payments for HCPCS code C9246 were not reduced by the corresponding contrast-enhanced procedure’s portion of its APC payment associated with “policy-packaged” drugs (offset amount).

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For CY 2010, HCPCS code C9246 is being replaced with HCPCS code A9581 (Injection, gadoxetate disodium, 1 ml) and HCPCS code A9581 will continue on pass-through status for CY 2010. In addition, HCPCS code A9583 (Injection, gadofosveset trisodium, 1 ml) describes a contrast agent that has been granted pass-through status beginning January 1, 2010. Both HCPCS codes A9581 and A9583 will be assigned status indicator "G" and will be subject to the payment offset methodology for contrast agents. Therefore, in CY 2010 CMS will reduce the payment for HCPCS codes A9581 and A9583 by the estimated amount of 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 A9581 or A9583 if the contrast-enhanced procedure is assigned to one of the APCs listed in the table below. The "policy-packaged" portions of the CY 2010 APC payments that are the offset amounts may be found on the CMS website at [http://www.cms.gov/apps/ama/license.asp?file=/HospitalOutpatientPPS/Downloads/CMS\\_1414\\_FC\\_Offset\\_Amounts\\_by\\_APC.zip](http://www.cms.gov/apps/ama/license.asp?file=/HospitalOutpatientPPS/Downloads/CMS_1414_FC_Offset_Amounts_by_APC.zip) on the CMS website.

When HCPCS code A9581 or A9583 is billed on a claim on the same date of service as one or more procedures assigned to an APC listed in the following table, the OPSS Pricer will identify the offset amount or amounts that apply to the contrast-enhanced procedures that are reported on the claim. Where there is a single contrast-enhanced procedure reported on the claim with a single occurrence of either HCPCS code A9581 or A9583, the OPSS Pricer will identify a single offset amount for the procedure billed and adjust the offset by the wage index value that applies to the hospital submitting the claim. Where there are multiple contrast procedures on the claim with a single occurrence of the pass-through contrast agent, the OPSS Pricer will select the contrast-enhanced procedure with the single highest offset amount and adjust the selected offset amount by the wage index value of the hospital submitting the claim. When a claim has more than one occurrence of either HCPCS code A9581 or A9583, the OPSS Pricer will rank potential offset amounts associated with the units of contrast-enhanced procedures on the claim and identify a total offset amount that takes into account the number of occurrences of the pass-through contrast agent on the claim and adjust the total offset amount by the wage index value of the hospital submitting the claim. The adjusted offset amount will be subtracted from the APC payment for the pass-through contrast agent reported with either HCPCS code A9581 or A9583. The offset will cease to apply when each of these contrast agents expires from pass-through status.

**Table 11-APCs to Which a Pass-Through Contrast Agent Offset May Be Applicable for CY 2010**

CY 2010 APC	CY 2010 APC Title
0080	Diagnostic Cardiac Catheterization
0082	Coronary or Non-Coronary Atherectomy
0083	Coronary or Non-Coronary Angioplasty and Percutaneous Valvuloplasty
0093	Vascular Reconstruction/Fistula Repair without Device

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CY 2010 APC	CY 2010 APC Title
0104	Transcatheter Placement of Intracoronary Stents
0128	Echocardiogram with Contrast
0152	Level I Percutaneous Abdominal and Biliary Procedures
0229	Transcatheter Placement of Intravascular Shunts
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
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
0418	Insertion of Left Ventricular Pacing Elect.
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

### ***Drug Administration Services***

As discussed in the CY 2010 OPPI/ASC final rule with comment period, drug administration services will continue to be reported using the full set of drug administration CPT codes with the

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following exception. CMS note that new CPT code 90470 (H1N1 immunization administration (intramuscular, intranasal), including counseling when performed) has been created by CPT for administration of the H1N1 vaccine for CY 2010. We are assigning this code status indicator "E" for OPPS payment purposes in CY 2010. Hospitals that administer the H1N1 vaccine should continue to use HCPCS code G9141 (Influenza A (H1N1) drug administration (includes the physician counseling the patient/family) for services furnished on or after September 1, 2009. Further information related to H1N1 codes can be found in Transmittal 547, CR 6633, issued August 28, 2009.

### *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 2010. 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 Pub. L. 108-173.
- b. New OPPS payment rates and copayment amounts will be effective January 1, 2010. All coinsurance rates will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the inpatient deductible of \$1,100.
- c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2010. 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  $(\text{cost} - (\text{APC payment} \times 1.75)) / 2$ .
- d. However, there will be a change in the fixed-dollar threshold in CY 2010. The estimated cost of a service must be greater than the APC payment amount plus \$2,175 in order to qualify for outlier payments. The previous fixed-dollar threshold for CY 2009 was \$1,800.
- e. For outliers for Community Mental Health Centers (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2010. 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  $(\text{cost} - (\text{APC 0173 payment} \times 3.4)) / 2$ .
- f. Effective January 1, 2010, MIPPA provisions authorizing payment for brachytherapy sources (status indicator "U") at charges reduced to cost expire, and Pricer will make payment based on final CY 2010 prospective payment rates. Note that the payment and copayment reduction for the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) (section j.) will apply to brachytherapy sources beginning January 1, 2010. Brachytherapy sources are eligible to receive outlier payments. Brachytherapy sources are not subject to the wage adjustment, but

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- do receive the adjustment for rural sole community hospitals and essential access community hospitals.
- g. Effective January 1, 2010, MIPPA provisions authorizing payment for therapeutic radiopharmaceuticals at charges reduced to cost expire, and Pricer will make prospective payment based either on the ASP for those therapeutic radiopharmaceuticals for which manufacturers submit ASP data or on mean unit cost. Therapeutic radiopharmaceuticals without pass-through status will have a status indicator of "K" beginning in CY 2010. Like other drugs and biologicals, therapeutic radiopharmaceuticals are not eligible to receive outlier payments or the adjustment for rural sole community hospitals and essential access hospitals, and are not wage-adjusted.
  - h. Effective January 1, 2009, status indicator "R" is used to denote blood and blood products for payment purposes. Blood and blood products are eligible to receive outlier payments. Blood and blood products are not subject to wage adjustment, but do receive the adjustment for rural sole community hospitals and essential access community hospitals.
  - i. Effective January 1, 2010, no devices are eligible for pass-through payment in the OPSS Pricer logic. There are no associated APC offset amounts or specific logic assigning device payment to associated APC payment for determining outlier eligibility and payment.
  - j. Effective January 1, 2010, the OPSS Pricer will apply a reduced update ratio of 0.980 to the payment and copayment for hospitals that fail to meet their HOP QDRP reporting requirements or that fail to meet CMS validation edits. The reduced payment amount will be used to calculate outlier payments.
  - k. Effective January 1, 2010 there will be 1 diagnostic radiopharmaceutical receiving pass-through payment in the OPSS 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 2010 APC payments for nuclear medicine procedures and may be found at <http://www.cms.hhs.gov/HospitalOutpatientPPS/APF/list.asp#TopOfPage> in the download file labeled 2010 OPSS Offset Amounts by APC.
  - l. Effective January 1, 2010 there will be 2 contrast agents receiving pass-through payment in the OPSS 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-

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- packaged” portions of the CY 2010 APC payments for procedures using contrast agents and may be found on the CMS website.
- m. Pricer will update the payment rates for drugs, biologicals, and therapeutic radiopharmaceuticals when those payment rates are based on ASP on a quarterly basis.
  - n. Effective January 1, 2010, CMS is adopting the FY 2010 Inpatient Prospective Payment System (IPPS) post-reclassification wage index values with application of out-commuting adjustment authorized by section 505 of Pub. L. 108-173 to non-IPPS hospitals discussed below.

### ***Wage Indices for Non-IPPS Hospitals Eligible for the Out-Commuting Adjustment Authorized by Section 505 of Pub. L. 108-173***

Wage indexes for Non-IPPS hospitals eligible for the Out-Commuting Adjustment authorized by Section 505 of Public Law 108-173 can be found in Table 12 of CR 6751.

### ***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**

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If you have questions, please contact your Medicare A/B MAC or fiscal intermediary at their toll-free number which may be found at:

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

The official instruction (CR6751) was issued to your Medicare A/B MAC and/or fiscal intermediary via two transmittals. The first transmittal, R1882CP, modifies the Medicare Claims Processing Manual and is located at <http://www.cms.hhs.gov/Transmittals/downloads/R1882CP.pdf> on the CMS website. The second transmittal, R116BP, provides the revisions to the Medicare Benefit Policy Manual and that transmittal is located at <http://www.cms.hhs.gov/Transmittals/downloads/R116BP.pdf> on that same site.

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