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Information for Medicare Fee-For-Service Health Care Professionals

News Flash – The transcript of the Centers for Medicare & Medicaid Services (CMS) ICD-10-CM/PCS National Provider Conference Call for Physicians that was held on November 17, 2008 is now available at http://www.cms.gov/Medicare/Coding/ICD10/downloads/November17calltranscript.pdf on the Centers for Medicare & Medicaid Services website.

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

Note: This article was updated on December 17, 2012, to reflect current Web addresses. This article was previously revised on January 21, 2009 to reflect that CR 6320 (Transmittal R101BP only) was revised to make minor changes to two of the sections of the Medicare Benefit Policy Manual, attached to CR 6320. Specifically, the third CFR citation in Section 20.3 was corrected by deleting one of the "i's" and Section 70.3.3 was amended to add the word "imminent" to the italicized sentence in that subsection. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6320, which describes changes to the OPPS to be implemented in the January 2009 OPPS update. Be sure billing staffs are aware of these changes.

Background

CR 6320 describes changes to and billing instructions for various payment policies implemented in the January 2009 OPPS update. The January 2009 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.

January 2009 revisions to I/OCE data files, instructions, and specifications are provided in CR 6315, "January 2009 Integrated Outpatient Code Editor (I/OCE) Specifications Version 10.0." Upon release of CR 6315, a related MLN Matters article will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6315.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

Key OPPS Updates for January 2009

1. New Status Indicators for the Calendar Year (CY) 2009

For CY 2009, CMS is replacing current status indicator "Q" with three new separate status indicators: "Q1," "Q2," and "Q3." Status indicator "Q1" is assigned to all "STVX-packaged codes;" status indicator "Q2" is assigned to all "T-packaged codes;" and status indicator "Q3"is assigned to all codes that may be paid through a composite APC-based on composite-specific criteria or separately through single code APCs when the criteria are not met. The change to establish new status indicators "Q1," "Q2," and "Q3" helps to make Medicare policies more transparent to hospitals and facilitates the use of status indicator-driven logic in CMS ratesetting calculations, and in hospital billing and accounting systems.

For CY 2009, CMS is using new payment status indicator "R" for all blood and blood product APCs. This new status indicator was created in order to facilitate implementation of the reduced market basket conversion factor that applies to payments to hospitals that are required to report quality data but fail to meet the established quality reporting standards. This reduced conversion factor applies to CY 2009 payment for blood and blood products.

Also, CMS created new status indicator "U" to designate brachytherapy source APCs for which separate payment is made in CY 2009. This definition does not specify the payment methodology. CY 2009 payment for brachytherapy sources, to which the reduced market basket conversion factor does not apply, is discussed in detail in section 20 below.

2. Reporting Unlisted Services or Procedures

An unlisted HCPCS code represents an item, service, or procedure for which there is no specific Current Procedural Terminology (CPT) or Level II alphanumeric HCPCS code. The CPT code book lists a number of unlisted service or procedure codes, which can be found at the end of a section or subsection. The long descriptors for these codes start with the term "Unlisted" and the last two digits of the codes often end in "99."

Under the OPPS, CMS generally assigns the unlisted service or procedure codes to the lowest level APC within the most appropriate clinically related series of APCs. Payment for items reported with unlisted codes is often packaged.

For non-OPPS payment purposes, when an unlisted service or procedure code is reported, a report describing the service or procedure should be submitted with the claim. Pertinent information includes a definition or description of the nature, extent, and need for the procedure or service, as well as the provider's time, effort, and equipment necessary to provide the service.

When a Medicare contractor receives a claim with an unlisted HCPCS code for non-OPPS payment, the contractor shall verify that no existing HCPCS code adequately describes the procedure or service. Unlisted codes should be reported only if no other specific HCPCS codes adequately describe the procedure or service. If an unlisted code is submitted on a claim and the contractor has verified that the code submitted is correct, the contractor pays the claim using the unlisted code, based on the applicable non-OPPS payment methodology. However, if it is determined that an unlisted code was submitted in error because the procedure or service is described by a specific HCPCS code, the contractor shall advise the hospital (or critical access hospital (CAH)) of the appropriate code and process the claim with the correct code. If a procedure or service reported with an unlisted code is reported frequently, the contractor shall advise the provider that a request for a specific CPT code or alphanumeric HCPCS code should be made.

The latest list of "Unlisted" CPT codes for procedures and services can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html under the category titled "Annual Policy Files."

3. National Correct Coding Initiative (NCCI) Edits Update

The NCCI edits are updated quarterly and the institutional version is one calendar quarter behind the physician version. In the past, the Outpatient Code Editor (OCE) had not applied the NCCI edits for the following categories of services: anesthesiology, evaluation and management, and mental health services. Effective January 1, 2009, these categorical exclusions will no longer apply. As a result, a large number of new institutional NCCI edits will be applied to claims effective January 1, 2009 to take into account the edits that were previously excluded. The NCCI files are available at http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html on the CMS website. One may use anesthesiology, evaluation and management, or mental health services CPT or Level II HCPCS codes to search these files.

4. Payment Adjustment for Failure to Meet the Hospital Outpatient Quality Reporting Requirements

Effective for services furnished on or after January 1, 2009, Section 1833(t)(17)(A) of the Act requires that "Subsection (d) hospitals" that have failed to meet the specified hospital outpatient quality reporting requirements for the relevant calendar year will receive payment under the OPPS that reflects a 2 percentage point reduction of the annual OPPS update factor. See

http://www.qualitynet.org/ for information on complying with the reporting requirements and standards that must be met to receive the full update. See MLN Matters article MM6072 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6072.pdf for information on this issue.

NOTE: When Transmittal 368 (CR 6072) was issued, CMS inadvertently omitted status indicator "R" in the specifications for the services to which the reduction is applicable and didn't list status indicator "R" in the Business Requirements. CMS is making a correction to include blood APCs with status indicator "R" under the application of the quality reporting ratio where appropriate.

For the CY 2009 OPPS, the reduced conversion factor that will apply to payments for applicable services to Subsection (d) hospitals that have failed to meet the specified hospital outpatient quality reporting requirements for CY 2009 is $64.784. The full CY 2009 OPPS conversion factor that will apply to payments for applicable services to Subsection (d) hospitals that have satisfied the specified hospital outpatient quality reporting requirements for CY 2008 is $66.059. The reporting ratio by which the payment and copayment for the applicable services will be adjusted for Subpart (d) hospitals that failed to meet the specified hospital outpatient quality reporting requirements for the CY 2009 update is 0.981.

The quality reporting support contractor to whom FIs/MACs should refer new hospitals is FMQAI which can be contacted at hopqdrp@fmqai.com, by phone at 866-800-8756, or in writing at FQMAI, 5201 West Kennedy Blvd., Suite 900, Tampa, FL 33609.

5. CY 2009 Transitional Outpatient Payments (TOPs)

Section 5105 of the Deficit Reduction Act of 2005 (DRA) extended hold harmless transitional outpatient payments (TOPs) through December 31, 2008 for rural hospitals having 100 or fewer beds that are not sole community hospitals (SCHs). Hospitals received 95 percent of the hold harmless amount for services furnished in CY 2006, 90 percent in CY 2007, and 85 percent in CY 2008. Section 147 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) extended the hold harmless provision for small rural hospitals with 100 or fewer beds through December 31, 2009, at 85 percent of the hold harmless amount. Section 147 also provided 85 percent of the hold harmless amount from January 1, 2009 through December 31, 2009 to sole community hospitals with 100 or fewer beds.

Eighty-five percent of hold harmless TOPs shall continue for services rendered through December 31, 2009, for rural hospitals with 100 or fewer beds. Eighty-five percent of hold harmless TOPs shall be paid for services rendered through December 31, 2009, for sole community hospitals with 100 or fewer beds. Essential Access Community Hospitals (EACHs) are considered to be sole community hospitals under Section 1886(d)(5)(D)(iii)(III) of the Act. Therefore, EACHs are also eligible for TOPs payments for CY 2009. Cancer and children's hospitals continue to receive hold harmless TOPs permanently.

For purposes of TOPs, a hospital is considered rural if it is either geographically rural or classified to rural for wage index purposes. For example, a hospital that is geographically rural is always considered rural for TOPs, even if it is reclassified to urban for wage index purposes. A hospital that is geographically urban, but reclassified to rural for the wage index, is considered rural for purposes of TOPs.

6. Outlier Reconciliation

Section 1833(t)(5) of the Act provides for Medicare payments to Medicare-participating hospitals in addition to the basic prospective payments for outpatient services furnished when they incur extraordinarily high costs. This additional payment, known as an "outlier," is designed to mitigate the financial risk associated with extremely costly and complex services. In order to qualify for outlier payments, services must have estimated cost above a fixed-dollar threshold and a multiple threshold, which are published in the annual OPPS final rule. The regulations governing payments for outlier cases are located at 42 CFR 419.43.

As provided in Section 1833(t) (5) (D) of the Social Security Act, CMS uses each hospital overall cost to charge ratio (CCR), rather than a CCR for each department within the hospital, to estimate costs from charges for outlier payments. To ensure that an accurate CCR is used to estimate cost, CMS already requires substitution of a Statewide average CCR when the Medicare contractor is unable to identify an accurate CCR for a hospital, including hospitals that are new, hospitals experiencing a change of ownership that have not accepted assignment, and hospitals with CCRs greater than the upper limit. Under 42 CFR 419.43(d)(5)(i), CMS also may specify an alternative to the overall ancillary CCR from the hospital or community mental health center's (CMHC) most recently settled or tentatively settled cost report. Further, a hospital or CMHC may request that its Medicare contractor use a different (higher or lower) CCR based on substantial evidence presented by the hospital. Such a request must be approved by CMS.

Under 42 CFR 419.43(d)(6)(i), for hospital outpatient services furnished during cost reporting periods beginning on or after January 1, 2009, outlier payments may be reconciled upon cost report settlement to account for differences between the CCR used to pay the claim at its original submission by the provider, and the CCR determined at final settlement of the cost reporting period during which the service was furnished. Since OPPS outlier payments are no longer final payments, CMS will consider reprocessing claims for errors in CCRs or outlier payments on a case by case basis.

In addition, under 42 CFR 419.43(d)(6)(ii), for hospital outpatient services furnished during cost reporting periods beginning on or after January 1, 2009, at the time of reconciliation under 42 CFR 419.43(d)(6)(i), outlier payments may be adjusted to account for the time value of any underpayments or overpayments. Any adjustment will be based on a widely available index to be established in advance by the Secretary, and will be applied from the midpoint of the cost reporting period to the date of reconciliation.

CMS is clarifying OPPS CCR and outlier reconciliation policies for Medicare contractors, specifically, when to specify an alternative CCR other than a Statewide average or one calculated from the hospital or CMHC's most recent cost report; how to use the outlier reconciliation thresholds to determine eligibility for reconciliation; how to execute OPPS outlier reconciliation; and how the time value of money will be applied to the amount of outlier under or overpayment. CMS has not finished the program that will recalculate outlier payments using the CCR determined at final settlement. Further instructions on performing outlier reconciliation will be forthcoming when this utility becomes available.

7. Partial Hospitalization APCs (APC 0172 and APC 0173)

For CY 2009, CMS is creating two new APCs, 0172 (Level I Partial Hospitalization (3 services)) and 0173 (Level II Partial Hospitalization (4 or more services)), to replace APC 0033 (Partial Hospitalization), which CMS is deleting for CY 2009. When a community mental health center (CMHC) or hospital 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 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 Medicare Claims Processing Manual, Chapter 4, sections 260.1 and 260.1.1 are revised to reflect these new APCs.

8. Mental Health Services Composite APC (APC 0034)

Since the beginning of the OPPS, CMS set the annual payment rate for the mental health composite APC at the same rate as APC 0033, the partial hospitalization APC. For CY 2009, we are creating two new APCs, 0172 (Level I Partial Hospitalization (3 services)) and 0173 (Level II Partial Hospitalization (4 or more services)), to replace APC 0033 (Partial Hospitalization), which we are deleting for CY 2009. When a community mental health center (CMHC) or hospital 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 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.

CMS set the CY 2009 payment rate for mental health composite APC 0034 at the same rate as APC 0173 ($200.17), which is the maximum partial hospitalization per diem payment. The I/OCE will continue to determine whether to pay specified mental health services individually or to make a single payment at the same rate as the APC 0173 per diem rate for partial hospitalization for all of the specified mental health services furnished on that date of service. Through the I/OCE, when the payment for specified mental health services provided by one hospital to a single beneficiary on one date of service based on the payment rates associated with the APCs for the individual services would exceed the maximum per diem partial hospitalization payment [listed as APC 0173], those specified mental health services would be assigned to APC 0034 (Mental Health Services Composite), which has the same payment rate as APC 0173, and the hospital would be paid one unit of APC 0034.

9. 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 will be paid by applying a composite APC payment methodology. The services will be 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 will determine the assignment of the composite APCs for payment. Prior to January 1, 2009, hospitals receive a full APC payment for each imaging service on a claim, regardless of how many procedures are 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 results in the creation of five new 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) will be assigned.

The specified HCPCS codes within the three imaging families and five composite APCs are provided as follows:

Family 1 - Ultrasound	
APC 8004 (Ultrasound Composite)	
76604	Us exam, chest
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp
76775	Us exam abdo back wall, lim
76776	Us exam k transpl w/doppler
76831	Echo exam, uterus
76856	Us exam, pelvic, complete
76870	Us exam, scrotum
76857	Us exam, pelvic, limited

Family 2 - CT and CTA with and without Contrast	
APC 8005 (CT and CTA without Contrast Composite)*	
0067T	Ct colonography;dx
70450	Ct head/brain w/o dye
70480	Ct orbit/ear/fossa w/o dye
70486	Ct maxillofacial w/o dye
70490	Ct soft tissue neck w/o dye
71250	Ct thorax w/o dye
72125	Ct neck spine w/o dye
72128	Ct chest spine w/o dye
72131	Ct lumbar spine w/o dye
72192	Ct pelvis w/o dye
73200	Ct upper extremity w/o dye
73700	Ct lower extremity w/o dye
74150	Ct abdomen w/o dye
APC 8006 (CT and CTA with Contrast Composite)	
70487	Ct maxillofacial w/dye
70460	Ct head/brain w/dye
70470	Ct head/brain w/o & w/dye
70481	Ct orbit/ear/fossa w/dye
70482	Ct orbit/ear/fossa w/o&w/dye
70488	Ct maxillofacial w/o & w/dye
70491	Ct soft tissue neck w/dye
70492	Ct sft tsue nck w/o & w/dye
70496	Ct angiography, head
70498	Ct angiography, neck
71260	Ct thorax w/dye

71270	Ct thorax w/o & w/dye
71275	Ct angiography, chest
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
72191	Ct angiograph pelv w/o&w/dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o&w/dye
73206	Ct angio upr extrm w/o&w/dye
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o&w/dye
73706	Ct angio lwr extr w/o&w/dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o & w/dye
74175	Ct angio abdom w/o & w/dye
75635	Ct angio abdominal arteries
* If a “without contrast” CT or CTA procedure is performed during the same session as a “with contrast” CT or CTA procedure, assign APC 8006 rather than 8005.	
Family 3 - MRI and MRA with and without Contrast	
APC 8007 (MRI and MRA without Contrast Composite)*	
70336	Magnetic image, jaw joint
70540	Mri orbit/face/neck w/o dye
70544	Mr angiography head w/o dye

70547	Mr angiography neck w/o dye
70551	Mri brain w/o dye
70554	Fmri brain by tech
71550	Mri chest w/o dye
72141	Mri neck spine w/o dye
72146	Mri chest spine w/o dye
72148	Mri lumbar spine w/o dye
72195	Mri pelvis w/o dye
73218	Mri upper extremity w/o dye
73221	Mri joint upr extrem w/o dye
73718	Mri lower extremity w/o dye
73721	Mri jnt of lwr extre w/o dye
74181	Mri abdomen w/o dye
75557	Cardiac mri for morph
75559	Cardiac mri w/stress img
C8901	MRA w/o cont, abd
C8904	MRI w/o cont, breast, uni
C8907	MRI w/o cont, breast, bi
C8910	MRA w/o cont, chest
C8913	MRA w/o cont, lwr ext
C8919	MRA w/o cont, pelvis
APC 8008 (MRI and MRA with Contrast Composite)	
70549	Mr angiograph neck w/o&w/dye
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w/dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o&w/dye
70548	Mr angiography neck w/dye

70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
72142	Mri neck spine w/dye
72147	Mri chest spine w/dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o&w/dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o&w/dye
73719	Mri lower extremity w/dye
73720	Mri lwr extremity w/o&w/dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o&w/dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
75561	Cardiac mri for morph w/dye
75563	Card mri w/stress img & dye
C8900	MRA w/cont, abd
C8902	MRA w/o fol w/cont, abd
C8903	MRI w/cont, breast, uni
C8905	MRI w/o fol w/cont, brst, un
C8906	MRI w/cont, breast, bi

C8908	MRI w/o fol w/cont, breast,
C8909	MRA w/cont, chest
C8911	MRA w/o fol w/cont, chest
C8912	MRA w/cont, lwr ext
C8914	MRA w/o fol w/cont, lwr ext
C8918	MRA w/cont, pelvis
C8920	MRA w/o fol w/cont, pelvis
* If a "without contrast" MRI or MRA procedure is performed during the same session as a "with contrast" MRI or MRA procedure, assign APC 8008 rather than 8007.	

10. Payment for Extended Assessment and Management Composite APCs

Beginning January 1, 2009, HCPCS code G0384 (Level 5 Hospital Type B ED Visit) will be included in the criteria that determines eligibility for payment of composite APC 8003 (Level II Extended Assessment and Management). APC 8003 (Level II Extended Assessment and Management Composite) describes an encounter for care provided to a patient that includes a high level (Level 4 or 5) Type A emergency department visit, a high level (Level 5) Type B emergency department visit, or critical care services in conjunction with observation services of substantial duration. There is no limitation on diagnosis for payment of these composite APCs; however, composite payment will not be made when observation services are reported in association with a surgical procedure (status indicator T) or the hours of observation care reported are less than 8. The I/OCE will evaluate every claim received to determine if payment through a composite APC is appropriate. If payment through a composite APC is inappropriate, the I/OCE, in conjunction with the OPPS Pricer, will determine the appropriate status indicator, APC, and payment for every code on a claim.

11. Billing for Wound Care Services

As provided under Section 1834(k)(5) of the Social Security Act, CMS has created a therapy code list to identify and track therapy services paid under the Medicare Physician Fee Schedule (MPFS). CMS provides this list of therapy codes along with their respective designations in the Medicare Claims Processing Manual, Chapter 5, Section 20. Two of the designations that CMS uses in that manual denote whether the listed therapy code is an "always therapy" service or a "sometimes therapy" service.

For CY 2009, CPT code 0183T, Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day, is newly designated as a "sometimes therapy" wound care service. In CY 2009, hospitals will receive separate payment under the OPPS when they bill for wound care services described by

CPT code 0183T that are furnished to hospital outpatients by individuals independent of a therapy plan of care. In contrast, when such services are performed by a qualified therapist under a certified therapy plan of care, providers should attach an appropriate therapy modifier (that is, "GP" for physical therapy, "GO" for occupational therapy, and "GN" for speech language pathology) or report their charges under a therapy revenue code (that is, revenue codes in the 042x, 043x, or 044x series), or both, to receive payment under the MPFS.

12. Further Clarification Related to Billing for Medical and Surgical Supplies

When medical and surgical supplies (other than prosthetic and orthotic devices as described in the Medicare Claims Processing Manual, Chapter 20, Section 10.1) described by HCPCS codes with status indicators other than “H” or “N,” are provided incident to a physician's service by a hospital outpatient department, the HCPCS codes for these items should not be reported because these items represent supplies. Claims containing charges for medical and surgical supplies used in providing hospital outpatient services are submitted to the Medicare contractor providing OPPS payment for the services in which they are used. The hospital should include charges associated with these medical and surgical supplies on claims so their costs are incorporated in ratesetting, and payment for the supplies is packaged into payment for the associated procedures under the OPPS in accordance with 42 CFR 419.2(b)(4).

For example, if the hospital staff in the emergency department initiate the intravenous administration of a drug through an infusion pump described by HCPCS code E0781 (Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient), complete the drug infusion, and discontinue use of the infusion pump before the patient leaves the hospital outpatient department, HCPCS code E0781 should not be reported because the infusion pump was used as a supply and would be paid through OPPS payment for the drug administration service. The hospital should include the charge associated with the infusion pump on the claim.

In another example, if hospital outpatient staff perform a surgical procedure on a patient in which temporary bladder catheterization is necessary and use a catheter described by HCPCS code A4338 (Indwelling catheter; Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each), the hospital should not report A4338 because the catheter was used as a supply and would be paid through OPPS payment for the surgical procedure. The hospital should include the charge associated with the urinary catheter on the claim.

When hospital outpatient staff provide a prosthetic or orthotic device, and the HCPCS code that describes that device includes the fitting, adjustment, or other services necessary for the patient’s use of the item, the hospital should not bill a visit or procedure HCPCS code to report the charges associated with the fitting, adjustment, or other related services. Instead, the HCPCS code for the device already includes the fitting, adjustment or other similar services. For example, if the hospital outpatient staff provides the orthotic device described by HCPCS code L1830 (KO, immobilizer, canvas longitudinal, prefabricated, includes fitting and adjustment), the hospital should only bill HCPCS code L1830 and should not bill a visit or procedure HCPCS code to describe the fitting and adjustment.

13. Reporting Hospital Critical Care Services under the OPPS

Hospitals should separately report all HCPCS codes in accordance with correct coding principles, CPT code descriptions, and any additional CMS guidance, when available. Specifically with respect to CPT code 99291, Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes, hospitals must follow the CPT instructions related to reporting that CPT code. Any services that CPT indicates are included in the reporting of CPT code 99291 (including those services that would otherwise be reported by and paid to hospitals using any of the CPT codes specified by CPT) should not be billed separately by the hospital. Instead, hospitals should report charges for any services provided as part of the critical care services. In establishing payment rates for critical care services, and other services, CMS packages the costs of certain items and services separately reported by HCPCS codes into payment for critical care services, and other services, according to the standard OPPS methodology for packaging costs.

The July 2008 OPPS quarterly update, Transmittal 1536, CR 6094, issued on June 19, 2008, contains further clarification about the reporting of CPT codes for hospital outpatient services paid under the OPPS. Readers may want to review the related MLN Matters article at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6094.pdf for further information.

14. Changes to the Initial Preventive Physical Examination (IPPE)

The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, extends the eligibility period for receiving an IPPE from 6 months to 12 months following the beneficiary's initial enrollment in Medicare Part B, effective January 1, 2009. Any beneficiary who has not yet had an IPPE and whose initial enrollment in Medicare began in CY 2008 will be able to have an IPPE in CY 2009, as long as it is done within 12 months of the beneficiary's initial enrollment. Medicare will pay for one IPPE for each beneficiary in a lifetime. The Medicare deductible does not apply to the IPPE if it is performed on or after January 1, 2009. OPPS providers will report IPPE visits occurring on or after January 1, 2009 using new HCPCS code G0402 (Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment). HCPCS code G0344 (Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 6 months of Medicare enrollment) will be active until December 31, 2008, for beneficiaries who have an IPPE prior to January 1, 2009.

The policy for reporting a medically necessary hospital visit during the same visit as the IPPE continues to apply for CY 2009. The CPT codes 99201 through 99215 for hospital clinic visits of new and established patients at all five levels of resource intensity may also be appropriately reported, depending on the circumstances, but they must be appended with the CPT -25 modifier, identifying the hospital visit as a separately identifiable service from the IPPE described by HCPCS code G0402.

The MIPPA also removes the screening electrocardiogram (EKG) as a mandatory requirement to be performed as part of the IPPE. The MIPPA requires that there be education, counseling, and referral for an EKG, as appropriate, for a once-in-a lifetime screening EKG performed as a result of

a referral from an IPPE. The facility service for the screening EKG (tracing only) is payable under the OPPS when it is the result of a referral from an IPPE. Providers paid under the OPPS should report new HCPCS code G0404 (Electrocardiogram, routine ECG with 12 leads, tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination) for services furnished on or after January 1, 2009. HCPCS code G0367 (Tracing only, without interpretation and report, performed as a component of the initial preventive physical exam) will be active until December 31, 2008, for reporting the facility service for a screening EKG performed prior to January 1, 2009.

15. Changes to Device Edits for January 2009

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. CMS has determined that the devices contained in this list cannot be correctly reported without one of the specified procedure codes also being reported on the same claim. Where these devices were billed without an appropriate procedure code prior to January 1, 2007, the cost of the device was being packaged into the median cost for an incorrect procedure code and therefore inflated the payment for the incorrect procedure code. In addition, hospitals billing devices without the appropriate procedure code were being incorrectly paid. The device-to-procedure edits are designed to ensure that the costs of these devices are assigned to the appropriate APC in OPPS rate setting.

Both types of device edits can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html on the CMS website. Failure to pass these edits will result in the claim being returned to the provider.

16. Manual Updates for the No Cost/Full Credit and Partial Credit Device Payment Adjustment Policy

CMS is revising the Medicare Claims Processing Manual, Chapter 4, Sections 20.6.9, 20.6.10, and 61.3 to clarify correct coding and charging practices for devices furnished without cost or with a full or partial credit from the manufacturer. Effective January 1, 2009, payment is reduced only for procedure codes that map to the APCs on the list of APCs subject to the adjustment that are reported with modifier –FB or –FC, and that are present on claims with specified device HCPCS codes.

17. Manual Updates for Billing No Cost Items, Investigational Device Exemption (IDE), and Qualifying Clinical Trials

CMS is revising the Medicare Claims Processing Manual, Chapter 4, Sections 67-69 to clarify correct billing practices for no cost items, IDE devices, and routine costs, and qualifying clinical trials. Typically, institutional providers should not report the usage of a no cost item. However, for some claims, providers may be required to bill a no cost item, including certain IDE devices and other items provided free of charge in a clinical trial, due to claims processing edits such as the OPPS procedure-to-device edits. Because these edits require a device to be billed along with an associated service, even if the item was received at no cost, OPPS providers must report a token charge of less than $1.01 for the item in the covered charge field, along with HCPCS modifier –FB appended to the procedure code that reports the service that requires the device.

18. Payment for Implanted Prosthetic Devices Furnished to Hospital Inpatients who Have Coverage Under Part B of Medicare but do not Have Coverage of Inpatient Hospital Services under Medicare Part A at the Time that the Device is Furnished

Effective for services furnished on and after January 1, 2009 Medicare will make separate payment for implanted prosthetic devices furnished to hospital inpatients who have coverage under Part B of Medicare, but who do not have coverage of inpatient hospital services under Medicare Part A at the time the device is furnished. To receive payment for these services, hospitals must determine if the device furnished meets the definition of an implanted prosthetic device as defined in the Medicare Benefit Policy Manual, Chapter 6, Section 10, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf on the CMS website. If so, hospitals should report the implanted prosthetic device using HCPCS code C9899, long descriptor: Implanted prosthetic device, payable only for inpatients who do not have inpatient coverage, and short descriptor: Inpt implant pros dev, no cov. The Medicare contractor will determine whether payment can be made and if so, will establish the payment to be made and the amount of copayment for which the beneficiary will be liable. See MLN Matters article MM6050 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6050.pdf for more details.

19. Stereotactic Radiosurgery (SRS) CPT Code 61793

For CY 2009, CPT code 61793, Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator), one or more sessions, will be deleted on December 31, 2008, and replaced with several new CPT codes, specifically CPT codes 61796, 61797, 61798, 61799, 61800, 63620, and 63621, effective January 1, 2009. Similar to its predecessor code, all of the replacement codes have been assigned status indicator “B” under the OPPS because CMS continues to recognize the HCPCS G-codes for SRS treatment delivery services under the OPPS. Refer to Section 200.3 (Billing Codes for Intensity Modulated Radiation Therapy (IMRT) and Stereotactic Radiosurgery (SRS)) of Chapter 4 of the Medicare Claims Processing Manual for information on the G-codes. The replacement codes for CPT code 61793 are displayed in Table 1 below.

Table 1-Replacement Codes for CPT Code 61793 Effective January 1, 2009

CPT Code	Long Descriptor	CY 2009 SI
61796	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion	B
61797	Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); each additional cranial lesion, simple	B
61798	Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); 1 complex cranial lesion	B
61799	Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); each additional cranial lesion, complex	B
61800	Application of stereotactic headframe for stereotactic radiosurgery	B
63620	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion	B
63621	Stereotactic radiosurgery (particle beam, gamma ray or linear accelerator); each additional spinal lesion	B

20. Payment for Brachytherapy Sources

The 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. We, therefore, have continued paying brachytherapy sources based on charges adjusted to cost for CY 2008. The status indicators of brachytherapy source HCPCS codes (except C2637) which were previously paid at charges adjusted to cost have remained "H" effective July 1, 2008 through December 31, 2008 for payment of brachytherapy sources at hospitals' charges adjusted to their costs.

Table 2- Comprehensive List of Brachytherapy Sources

Payable as of January 1, 2009

HCPCS Code	Long Descriptor	SI	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

HCPCS Code	Long Descriptor	SI	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	
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

21. Billing for Drugs, Biologicals, and Radiopharmaceuticals

a. Newly Recognized HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals for CY 2009

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

CMS reminds hospitals that under the 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.

For CY 2009, 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 codes are listed in Table 3 below.

Table 3- New HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals in CY 2009

CY2009 HCPCS Code	CY 2009 Short Descriptor	CY 2009 SI	CY 2009 APC
A9580	Sodium fluoride F-18	N	
C9245	Injection, romiplostim	G	9245
C9246	Inj, gadoxetate disodium	G	9246
C9247	Inj, iobenguane, I-123, dx	N	
C9248	Inj, clevidipine butyrate	G	9248
J0641	Levoleucovorin injection	K	1236
J3300	Triamcinolone A inj PRS-free	N	
Q4100	Skin substitute, NOS	N	
Q4111	Gammagraft skin sub	K	1252
J8705	Topotecan oral	K	1238

In addition, similar to CMS policy for CY 2008 where CMS began recognizing multiple HCPCS codes for the same drugs with different dosage descriptors, for CY 2009 CMS is newly recognizing

the six HCPCS codes shown in Table 4 below. Payment for these newly recognized HCPCS drug codes for different doses of the same drugs is made on the same basis as payment for the previously recognized HCPCS codes for those drugs. Hospitals that may be burdened by reporting multiple HCPCS codes for the same drugs need not change their current billing practices for purposes of the OPPS, but hospitals that would like additional flexibility when billing for drugs with multiple HCPCS code dosages may report these codes.

Table 4 – HCPCS Codes Unrecognized in CY 2007 and CY 2008, Associated Recognized HCPCS Codes, and Status Indicators for CY 2009

CY 2009 HCPCS Codes Previously Unrecognized	CY 2007 SI	CY 2009 Short Descriptor	Associated HCPCS Recognized in CY 2007	Final CY 2009 SI for Newly Recognized HCPCS Code
Q0165	B	Prochlorperazine maleate 10 mg	Q0164	N
Q0168	B	Dronabinol 5 mg oral	Q0167	N
Q0170	B	Promethazine HCl 25 mg oral	Q0169	N
Q0172	B	Chlorpromazine HCl 25 mg oral	Q0171	N
Q0176	B	Perphenazine 8 mg oral	Q0175	N
Q0178	B	Hydroxyzine pamoate 50 mg	Q0177	N

Many HCPCS codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS code descriptors that will be effective in CY 2009. In addition, several temporary C-codes have been deleted effective December 31, 2008 and replaced with permanent HCPCS codes in CY 2009. 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 2009 HCPCS codes.

Table 5-HCPCS Code Changes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals in CY 2008

CY 2008 HCPCS Code	CY 2008 Long Descriptor	CY 2009 HCPCS Code	CY 2009 Long Descriptor
C9003	Palivizumab-RSV-IgM, per 50 mg	90378	Respiratory syncytial virus immune globulin (rsv-igim), for intramuscular use, 50 mg, each
J0348	Injection, anadulafungin, 1 mg	J0348	Injection, anidulafungin, 1 mg
C9241	Injection, doripenem, 10 mg	J1267	Injection, doripenem, 10 mg
C9242	Injection, fosaprepitant, 1 mg	J1453	Injection, fosaprepitant, 1 mg

CY 2008 HCPCS Code	CY 2008 Long Descriptor	CY 2009 HCPCS Code	CY 2009 Long Descriptor
Q4097	Injection, immune globulin (Privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg	J1459	Injection, immune globulin (Privigen), intravenous, non-lyophilized (e.g. liquid), 500 mg
J1751	Injection, iron dextran, 165, 50 mg	J1750	Injection, iron dextran, 50 mg
J1752	Injection, iron dextran 267, 50 mg		
Q4098	Injection, iron dextran, 50 mg		
C9237	Injection, lanreotide acetate, 1mg	J1930	Injection, lanreotide, 1 mg
C9238	Injection, levetiracetam, 10 mg	J1953	Injection, levetiracetam, 10 mg
C9244	Injection, regadenoson, 0.4 mg	J2785	Injection, regadenoson, 0.1 mg
J3100	Injection, tenecteplase, 50 mg	J3101	Injection, tenecteplase, 1 mg
Q4096	Injection, von willebrand factor complex, human, ristocetin cofactor (not otherwise specified), per i.u. vwf:rco	J7186	Injection, antihemophilic factor viii/von willebrand factor complex (human), per factor viii i.u.
C9243	Injection, bendamustine hcl, 1 mg	J9033	Injection, bendamustine hcl, 1 mg
J9182	Etoposide, 100 mg	J9181	Etoposide 100 MG inj
C9240	Injection, ixabepilone, 1 mg	J9207	Injection, ixabepilone, 1 mg
C9239	Injection, temsirolimus, 1 mg	J9330	Injection, temsirolimus, 1 mg
J7340	Dermal and epidermal, (substitute) tissue of human origin, with or without bioengineered or processed elements, with metabolically active elements, per square centimeter	Q4101	Skin substitute, Apligraf, per square centimeter
J7341	Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, with metabolically active elements, per square centimeter	Q4102	Skin substitute, Oasis Wound Matrix, per square centimeter
		Q4103	Skin substitute, Oasis Burn Matrix, per square centimeter
J7343	Dermal and epidermal, (substitute) tissue of nonhuman origin, with or without other bioengineered or	Q4104	Skin substitute, Integra Bilayer Matrix Wound Dressing (BMWD), per square centimeter

CY 2008 HCPCS Code	CY 2008 Long Descriptor	CY 2009 HCPCS Code	CY 2009 Long Descriptor
	processed elements, without metabolically active elements, per square centimeter	Q4105	Skin substitute, Integra Dermal Regeneration Template (DRT), per square centimeter
J7342	Dermal (substitute) tissue of human origin, with or without other bioengineered or processed elements, with metabolically active elements, per square centimeter	Q4106	Skin substitute, Dermagraft, per square centimeter
J7344	Dermal (substitute) tissue of human origin, with or without other bioengineered or processed elements, without metabolically active elements, per square centimeter	Q4107	Skin substitute, Graft Jacket, per square centimeter
J7347	Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, without metabolically active elements (Integra Matrix), per sq. cm.	Q4108	Skin substitute, Integra Matrix, per square centimeter
J7348	Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, without metabolically active elements (TissueMend), per sq. cm.	Q4109	Skin substitute, Tissuemend, per square centimeter
J7349	Dermal (substitute) tissue of nonhuman origin, with or without other bioengineered or processed elements, without metabolically active elements (PriMatrix), per sq. cm.	Q4110	Skin substitute, Primatrix, per square centimeter
J7346	Dermal (substitute) tissue of human origin, injectable, with or without other bioengineered or processed elements, but without metabolically active elements, 1 cc	Q4112	Allograft, Cymetra, Injectable, 1cc
		Q4113	Allograft, Graft Jacket Express, injectable, 1cc

CY 2008 HCPCS Code	CY 2008 Long Descriptor	CY 2009 HCPCS Code	CY 2009 Long Descriptor
C9357	Dermal substitute, granulated cross-linked collagen and glycosaminoglycan matrix (Flowable Wound Matrix), 1 cc	Q4114	Dermal substitute, granulated cross-linked collagen and glycosaminoglycan matrix (Flowable Wound Matrix), 1 cc

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

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

In the CY 2009 OPPS/ASC final rule with comment period, it was stated that payments for drugs and biologicals based on average sale prices (ASPs) will be updated on a quarterly basis as later quarter ASP submissions become available. Effective January 1, 2009, payment rates for many drugs and biologicals have changed from the values published in the CY 2009 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2008. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2009 release of the OPPS Pricer. CMS is not publishing the updated payment rates in this Change Request implementing the January 2009 update of the OPPS. However, the updated payment rates effective January 1, 2009 can be found in the January 2009 update of the OPPS Addendum A and Addendum B at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html on the CMS website.

c. Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2008 Through June 30, 2008

The payment rates for several HCPCS codes were incorrect in the April 2008 OPPS Pricer. The corrected payment rates are listed below and have been installed in the January 2009 OPPS Pricer, effective for services furnished on April 1, 2008 through implementation of the July 2008 update. Where claims were processed incorrectly, your Medicare contractor will make adjustments if you bring such claims to their attention.

Table 6-Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2008 through June 30, 2008

HCPCS Code	CY 2008 SI	CY 2008 APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J0150	K	0379	Injection adenosine 6 MG	$12.71	$2.54
J1626	K	0764	Granisetron HCl injection	$5.99	$1.20
J2405	K	0768	Ondansetron hcl injection	$0.23	$0.05
J2730	K	1023	Pralidoxime chloride inj	$83.17	$16.63
J9208	K	0831	Ifosfomide injection	$36.77	$7.35
J9209	K	0732	Mesna injection	$7.81	$1.56

d. Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2008 through September 30, 2008

The payment rates for several HCPCS codes were incorrect in the July 2008 OPPS Pricer. The corrected payment rates are listed below and have been installed in the January 2009 OPPS Pricer, effective for services furnished on July 1, 2008 through implementation of the October 2008 update. Where claims were processed incorrectly, your Medicare contractor will make adjustments if you bring such claims to their attention.

Table 7-Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2008 through September 30, 2008

CY 2008 HCPCS Code	CY 2008 SI	CY 2008 APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J0150	K	0379	Injection adenosine 6 MG	$11.57	$2.31
J1566	K	2731	Immune globulin, powder	$28.37	$5.67
J1569	K	0944	Gammagard liquid injection	$34.66	$6.93
J2730	K	1023	Pralidoxime chloride inj	$84.90	$16.98
J7190	K	0925	Factor viii	$0.85	$0.17
J7192	K	0927	Factor viii recombinant	$1.12	$0.22
J7198	K	0929	Anti-inhibitor	$1.47	$0.29
J8510	K	7015	Oral busulfan	$2.55	$0.51
J9208	K	0831	Ifosfomide injection	$34.04	$6.81

e. Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2008 through December 31, 2008

The payment rates for certain HCPCS codes were incorrect in the October 2008 OPPS Pricer. The corrected payment rates are listed below and have been installed in the January 2009 OPPS Pricer, effective for services furnished on October 1, 2008 through implementation of the January 2009 update. Where claims were processed incorrectly, your Medicare contractor will make adjustments if you bring such claims to their attention.

Table 8-Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2008 through December 31, 2008

CY 2008 HCPCS Code	CY 2008 SI	CY 2008 APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J1568	K	0943	Octagam injection	$35.58	$7.12
J2323	G	9126	Natalizumab injection	$7.51	$1.49

f. 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, a separate payment for the biological 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.

g. 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, 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.

h. Vaccines approved by FDA

In July 2007, the CPT Editorial Panel released two vaccine codes on the American Medical Association Web site, specifically CPT codes 90681 and 90696 that were implemented in January 2008. Although the vaccines associated with these codes were not approved by the Food and Drug Administration (FDA) until April 2008 (for CPT code 90681) and June 2008 (for CPT code 90696), and we did not assign the codes to separate APCs under the OPPS until the January 2009 update, their payments are retroactive to the FDA approval dates. Below in Table 9 are the long descriptors for CPT codes 90681 and 90696 and their APC assignments. Also, note that the "Effective Date of Payment Rate" listed in Table 9 reflects the specific date the vaccine received its FDA approval. Items that are reported using these HCPCS codes with dates of service prior to the date of the FDA approval, will be rejected.

Table 9 – New Vaccine Codes

HCPCS Code	CY 2008 SI	CY 2008 APC	Long Descriptor	Payment Rate	Effective Date of Payment Rate
90681	K	1239	Rotavirus vaccine, human, attenuated, 2 dose schedule, live, for oral use	$106.60	4/3/2008
90696	K	1219	Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children 4 through 6 years of age, for intramuscular use	$49.92	6/24/2008

i. Payment for Therapeutic Radiopharmaceuticals

The MIPPA of 2008 requires CMS to pay for therapeutic radiopharmaceuticals for the period of July 1, 2008 through December 31, 2009 at hospitals' charges adjusted to the costs. Therefore, the status indicators of therapeutic radiopharmaceutical HCPCS codes will remain "H" effective July 1, 2008 through December 31, 2009, to indicate payment will be made for therapeutic radiopharmaceuticals at hospitals' charges adjusted to their costs.

Table 10 – Therapeutic Radiopharmaceuticals Paid At Charges Adjusted to Cost From July 1, 2008 through December 31, 2009

CY 2009 HCPCS Code	CY 2009 Long Descriptor	CY 2009 SI
A9517	Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie	H
A9530	Iodine I-131 sodium iodide solution, therapeutic, per millicurie	H
A9543	Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries	H
A9545	Iodine I-131 tositumomab, therapeutic, per treatment dose	H
A9563	Sodium phosphate P-32, therapeutic, per millicurie	H
A9564	Chromic phosphate P-32 suspension, therapeutic, per millicurie	H
A9600	Strontium Sr-89 chloride, therapeutic, per millicurie	H
A9605	Samarium Sm-153 lexidronamm, therapeutic, per 50 millicuries	H

j. Reporting of Outpatient Diagnostic Nuclear Medicine Procedures

Effective January 1, 2008 under the OPPS, payment for all nonpass-through diagnostic radiopharmaceuticals is packaged into payment for their associated nuclear medicine procedures and this payment methodology is continuing for CY 2009. In order to ensure that CMS captures appropriate diagnostic radiopharmaceutical costs for future ratesetting purposes, CMS implemented nuclear medicine procedure-to-radiolabeled product edits in the I/OCE effective January 2008 that required a radiolabeled product to be present on the same claim as a nuclear medicine procedure for payment under the OPPS 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.

Most recently, for the October 2008 update CMS created 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. This HCPCS code is assigned status indicator "N" because no separate payment is made for the code under the OPPS. The effective date of the code is January 1, 2008, the date the nuclear medicine procedure-to-radiolabeled product edits were initially implemented. Because the Medicare claims processing system requires that there be a charge for each HCPCS code reported on the claim, hospitals should always report a token charge of less than $1.01 for HCPCS code C9898. The date of service reported on the claim for HCPCS code C9898 should be the same as the date of service for the nuclear medicine procedure HCPCS code, which should always accompany the reporting of HCPCS code C9898. HCPCS code C9898 should never be reported on a claim without a diagnostic nuclear medicine procedure that is subject to the nuclear medicine procedure-to-radiolabeled product edits.

With the specific exception described above for HCPCS code C9898, 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.

CMS expects that the majority of hospital outpatient claims for diagnostic nuclear medicine procedures will include reporting of a diagnostic radiopharmaceutical because both the radiopharmaceutical and the nuclear medicine procedure are provided in the hospital outpatient department, and that it will be only in uncommon circumstances that hospitals will provide a radiolabeled product during a hospital inpatient stay, followed by a diagnostic nuclear medicine procedure after the patient has been discharged. CMS will be monitoring claims to ensure that this is the case.

The complete list of updated nuclear medicine procedure-to-radiolabeled product edits can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html on the CMS website.

22. Drug Administration Services

Several of the CY 2008 CPT codes for drug administration services have been renumbered or edited for CY 2009. Both the CY 2008 CPT codes and the CY 2009 CPT codes, along with the CY 2009 long code descriptors, are shown in Table 11 below.

Table 11–Drug Administration CPT and HCPCS Codes Effective CY 2009

2008 HCPCS Code	2009 HCPCS Code	2009 Long Descriptor
90760	96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour
90761	96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)
90765	96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour
90766	96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
90767	96367	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour (List separately in addition to code for primary procedure)
90769	96369	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to one hour, including pump set-up and establishment of subcutaneous infusion site(s)
90770	96370	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
90771	96371	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure)
90772	96372	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
90773	96373	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intra-arterial
90774	96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug
90775	96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)
90779	96379	Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion

23. Billing for Cardiac Echocardiography Services

a. Cardiac Echocardiography Without Contrast

Hospitals are instructed to bill for echocardiograms without contrast in accordance with the CPT code descriptors and guidelines associated with the applicable Level I CPT code(s) (93303-93350). We note that for CY 2009, the AMA revised several CPT codes in the 93000 series to more specifically describe particular services provided during echocardiography procedures. These new and revised codes are listed in Table 12 below.

Table 12 – New and Revised CY 2009 Electrocardiography CPT Codes

CY 2009 HCPCS	Long Descriptor	New or Revised for CY 2009
93306	Echocardiography, transthoracic real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography	New
93307	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography	Revised
93308	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study	Revised
93350	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report	Revised
93351	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision	New
93352	Use of echocardiographic contrast agent during stress echocardiography (List separately in addition to codes for stress echocardiography) (Use 93352 in conjunction with 93350 or 93351)	New

b. Cardiac Echocardiography With Contrast

Hospitals are instructed to bill for echocardiograms with contrast using the applicable HCPCS code(s) included in Table 13 below. Hospitals should also report the appropriate units of the HCPCS codes for the contrast agents used in the performance of the echocardiograms. CPT codes should be used for without contrast studies only. In the without contrast followed by with contrast case, hospitals should not bill the CPT code for a without contrast study in addition to the C-code when they provide a without contrast followed by with contrast study.

Table 13 – HCPCS Codes For Echocardiograms With Contrast

HCPCS	Long Descriptor	New or Revised for CY 2009
C8921	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; complete	No change
C8922	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; follow-up or limited study	No change
C8923	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography	Revised
C8924	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study	Revised
C8925	Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report	No change
C8926	Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report	No change
C8927	Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis	No change
C8928	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report	Revised
C8929	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography	New
C8930	Transthoracic echocardiography, with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision	New

24. 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 2009. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and services 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 coinsurance amounts will be effective January 1, 2009. All coinsurance rates will be limited to a maximum of 40 percent of the APC payment rate. Coinsurance rates cannot exceed the inpatient deductible of $1,068.

c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2009. This threshold of 1.75 is multiplied by the total line item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount. The payment formula is (cost-(APC payment x 1.75))/2.

d. However, there will be a change in the fixed-dollar threshold in CY 2009. The estimated cost of service must be greater than the APC payment amount plus $1,800 in order to qualify for outlier payments. The previous fixed-dollar threshold was $1,575.

e. The charges for services included in a composite payment will be aggregated to one line using Composite Adjustment Flags (CAF) 01-ZZ for each composite on a claim, including partial hospitalization composite APCs 0172 (Level I Partial Hospitalization (3 services)) and 0173 (Level II Partial Hospitalization (4 or more services)), and mental health services composite APC 0034 (Mental Health Services Composite), and will be considered the total charge for each composite service when determining eligibility for outlier payments. (Note: Effective January 1, 2009, the Payment Adjustment Flag values of 91-99 are no longer valid; thus, they are no longer used by Pricer to identify composites. See CR 6056 for more information.)

f. Payment will be made through APC 0034 if the total payment amount for mental health services provided on one day would otherwise exceed payment for APC 0173.

g. For outliers for Community Mental Health Centers (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2009. This threshold of 3.4 is multiplied by the total line item APC payment to determine eligibility for outlier payments. This multiple amount is also used to determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment formula is (cost-(APC payment x 3.4))/2.

h. The OPPS Pricer will continue to respond to claim lines that have an I/OCE Payment Adjustment Flag (PAF) #7 (Item provided without cost to provider) applied to the line. The OPPS I/OCE will apply the PAF #7 whenever a claim line has a HCPCS C code and procedure code on the lists of codes subject to this adjustment and an FB modifier. When OPPS Pricer finds a PAF #7 for a line item, it will apply the offset reduction to offset the device portion from the APC payment, which includes payment for packaged devices. The procedure payment amount remaining after the offset reduction is subject to normal procedure discounting rules. OPPS Pricer will apply the offset to line item payment before applying coinsurance logic so that coinsurance is based on the payment amount remaining after the offset reduction.

i. The OPPS Pricer will continue to respond to lines that have an I/OCE Payment Adjustment Flag (PAF) #8 (i.e., Item provided with partial credit to provider) applied to the line. The OPPS I/OCE will apply the PAF #8 whenever a claim line has a HCPCS C-code and procedure code on the lists of codes subject to this adjustment and an FC modifier. When OPPS Pricer finds a PAF #8 for a line item, it will apply 50 percent of the dollar offset reduction to offset the device portion from the APC payment, which includes payment for packaged devices. The procedure payment amount remaining after the offset reduction is subject to normal procedure discounting rules. OPPS Pricer will apply the offset to line item payment before applying coinsurance logic so that coinsurance is based on the payment amount remaining after the offset reduction.

j. Effective January 1, 2009, brachytherapy sources will be paid at charges adjusted to cost, as required by the MIPPA. Additionally, status indicator "U" will be used to denote brachytherapy sources for payment purposes.

k. Effective January 1, 2009, status indicator "R" will be used to denote blood and blood products for payment purposes.

l. Effective January 1, 2009, no items are eligible for pass through payment in the OPPS 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.

m. Effective January 1, 2009, the OPPS Pricer will apply a reduced update ratio of 0.981 to the payment and copayment for hospitals that fail to meet their reporting requirements or that fail to meet CMS validation edits. The reduced payment amount will be used to calculate outlier payments.

25. 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. FIs and 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

Revised portions of the Medicare Claims Processing and Medicare Benefit Policy Manuals are attached to CR 6320. There are two transmittals associated with CR6320. One is Transmittal 1657, which contains the changes to the Medicare Claims Processing Manual and is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1657CP.pdf on the CMS website. The other Transmittal is Transmittal 100, which has the changes to the Medicare Benefit Policy manual and is at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R101BP.pdf on the CMS site.

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.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html.on the CMS website.

News Flash - It's Not Too Late to Get the Flu Shot. We are in the midst of flu season and a flu vaccine is still the best way to prevent infection and the complications associated with the flu. Re-vaccination is necessary each year because flu viruses change each year. So please encourage your Medicare patients who haven't already done so to get their annual flu shot--and don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends. Get Your Flu Shot – Not the Flu! Remember - Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. Health care professionals and their staff can learn more about Medicare's coverage of the influenza vaccine and other Medicare Part B covered vaccines and related provider education resources created by the CMS Medicare Learning Network (MLN), by reviewing Special Edition *MLN Matters* article SE0838 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0838.pdf on the CMS website.