Medicare Learning Network

MLN Matters®

Information for Medicare Fee-For-Service Health Care Professionals

News Flash – Are you ready for the new Medicare provider authentication process at Fiscal Intermediaries (FIs), Carriers, or Medicare Administrative Contractors (MACs)? Effective April 6, 2009, for all Medicare provider telephone and written inquiries to your Medicare claims processing contractors, inquirers will need to give the last five digits of the provider's tax identification number (TIN) in addition to the provider's national provider identifier (NPI) and provider transaction access number (PTAN). In addition, inquirers will only be allowed three attempts to provide the correct NPI, PTAN, and last five digits of the TIN. You can find more information about the new provider authentication requirements for Medicare inquiries to your Medicare claims processing contractors by going to the MLN Matters article related to CR 6139, located at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM6139.pdf on the CMS website.

MLN Matters Number: MM6416 | Related Change Request (CR) #: 6416

Related CR Release Date: March 13, 2009 | Effective Date: April 1, 2009

Related CR Transmittal #: R1702 | Implementation Date: April 6, 2009

Note: This article was updated on December 20, 2012, to reflect current Web addresses. All other information remains unchanged.

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

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6416 which describes changes to the OPPS to be implemented in the April 2009 OPPS update. Be sure your billing staff are aware of these changes.

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2008 American Medical Association.

Background

Change Request (CR) 6416 describes changes to and billing instructions for payment policies implemented in the April 2009 OPPS update. The April 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 Change Request.

April 2009 revisions to I/OCE data files, instructions, and specifications are provided in CR 6413, April 2009 Integrated Outpatient Code Editor (I/OCE) Specifications Version 10.1." Upon release of CR 6413, a related MLN Matters article will be available at *http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM6413.pdf* on the Centers for Medicare & Medicaid Services (CMS) website.

Key OPPS Updates for April 2009

1. Pass-Through Devices and Non Pass-Through Devices Included in Kits

Manufacturers frequently package a number of individual items used with a device in a particular procedure in a kit. Generally, to avoid complicating the device pass-through category list unnecessarily and to avoid the possibility of double coding, CMS has not established HCPCS codes for such kits. However, hospitals may purchase and use such kits. If the kits contain individual items that separately qualify for transitional pass-through payments, these items should be separately billed using applicable HCPCS codes. Hospitals may not bill for transitional pass-through payments for supplies that may be contained in kits. This information can also be found in the revised Medicare Claims Processing Manual, Chapter 4, Section 60.4 (General Coding and Billing Instructions and Explanations) which is included as an attachment to CR 6416.

In cases of devices that are described by 1) device category HCPCS codes whose pass-through status has expired or 2) device category HCPCS codes that describe devices without pass-through status and that are packaged in kits with other items used in a particular procedure, hospitals may consider all kit costs in their line-item charge for the associated device/device category HCPCS code that is assigned status indicator "N" for packaged payment. That is, hospitals may report the total charge for the whole kit with the associated device/device category HCPCS code. Payment for device/device category HCPCS codes without pass-through status is packaged into payment for the procedures in which they are used, and these

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2008 American Medical Association.

codes are assigned status indicator "N." In the case of a device kit, should a hospital choose to report the device charge alone under a device/ device category HCPCS code with status indicator "N," the hospital should report charges for other items that may be included in the kit on a separate line on the claim. Hospitals may use the same revenue code to report all components of the kit. This information can also be found in the Medicare Claims Processing Manual, Chapter 4, Section 61.1 (Requirement that Hospitals Report Device Codes on Claims on Which They Report Specified Procedures) which is included as an attachment to CR 6416.

Hospitals are advised to continue to report all HCPCS codes that describe packaged items and services that were provided, unless CPT instructions or CMS provide other guidance. Further, hospitals should include charges for packaged items or services described and reported by those HCPCS codes with status indicator "N" on their claims when those codes can be appropriately reported, so that the costs associated with the packaged items or services can then be added to the costs of separately payable procedures on the same claims when establishing the annual payment rates for the separately payable services under the OPPS.

2. 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 Benefit Policy Manual, Chapter 15, Sections 120 and 130 and take-home surgical dressings; see http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf on the CMS Web site) 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 rate setting, 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) (see http://www.gpo.gov/fdsys/search/submitcitation.action?publication=CFR on the internet).

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,

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2008 American Medical Association.

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.

3. Billing for Inherently Bilateral Procedures

Inherently bilateral procedures represent services that are performed bilaterally. Often, the word "bilateral" appears in the HCPCS code long descriptor. Since the implementation of the OPPS on August 1, 2000, inherently bilateral procedure codes have been included in the I/OCE as a table that is used in applying edit 17 (inappropriate specification of bilateral procedure). I/OCE edit 17 occurs when a bilateral procedure code appears on the claim form more than once per day on the same date for the same patient. Recently, CMS received reports of a clinical scenario where a bilateral procedure may be performed more than once per day on the same date for the same patient. For only those instances that involve more than one bilateral procedure and are medically necessary and appropriate, hospitals are advised to report the procedure code with a modifier -76 (repeat procedure or service by same physician) in order for the claim to process correctly. Appending modifier -76 to one of the reported bilateral HCPCS code indicates that the bilateral procedure or service was repeated on the same day for the same

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2008 American Medical Association.

patient. CMS expects these types of claims to be uncommon and will be monitoring claims to ensure that this is the case.

4. Billing for Processing and Storage of Blood and Blood Products

CMS updated (and included as an attachment to CR 6416) the Medicare Claims Processing Manual, Chapter 4, Section 231.1 and Section 231.2) to include Revenue Code 0392 (Blood Processing/Storage; Processing and Storage) as an acceptable revenue code for billing blood processing and storage charges. Most OPPS providers obtain blood or blood products from community blood banks that charge only for processing and storage, and not for the blood itself. These hospitals should follow the instructions outlined in Section 231.1, which require using Revenue Code 0390 (Blood Processing/Storage), 0392 (Blood Processing/Storage; Processing and Storage), or 0399 (Blood Processing /Storage; Other Processing and Storage), along with the appropriate blood HCPCS code, the number of units transfused, and the line item date of service (LIDOS).

OPPS providers that incur a charge for the blood or blood product itself in addition to the charge for processing and storage should follow the coding requirements outlined in Section 231.2, which instructs hospitals to report charges for the blood or blood product itself using Revenue Code series 038X (excluding 0380) with the LIDOS, the number of units transfused, and the appropriate blood product HCPCS code and HCPCS modifier BL. The OPPS provider also should report charges for processing and storage services on a separate line using Revenue Code 0390, 0392, or 0399 with the LIDOS, the number of units transfused, and the appropriate blood product HCPCS code and HCPCS modifier BL. The same LIDOS, the same number of units, the same HCPCS code, and HCPCS modifier BL must be reported on both lines.

5. Billing for Autologous Stem Cell Transplant Procedures

CMS updated (and included as an attachment to CR 6416) the Medicare Claims Processing Manual, Chapter 3, Section 90.3.3) to clarify billing for allogeneic stem cell transplant acquisition services, which are billed and payable under Part A, and to clarify billing for autologous stem cell transplant procedures, which may be billed and payable under either Part A or Part B. CMS also revised (and included as an attachment to CR 6416) Chapter 4, Section 231.10 on billing for autologous stem cell transplant procedures.

The hospital bills and shows all charges for autologous stem cell harvesting, processing, and transplant procedures based on the status of the patient (i.e., inpatient or outpatient) when the services are furnished. It shows charges for the

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2008 American Medical Association.

actual transplant, described by the appropriate ICD-9-CM procedure or CPT codes, in revenue center code 0362 or another appropriate cost center.

CPT codes describing autologous stem cell harvesting procedures may be billed and are separately payable under the OPPS when provided in the hospital outpatient setting of care. CPT codes describing autologous stem cell processing procedures also may be billed and are separately payable under the OPPS when provided to hospital outpatients.

Payment for stem cell harvesting procedures performed in the hospital inpatient setting of care, with transplant also occurring in the inpatient setting of care, is included in the MS-DRG payment for the autologous stem cell transplant.

6. Billing for Drugs, Biologicals, and Radiopharmaceuticals

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

CMS reminds hospitals that under the 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.

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

For Calendar Year (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

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2008 American Medical Association.

pharmacy overhead costs of these pass-through items. CMS notes that for the second quarter of CY 2009, payment for drugs and biologicals with pass-through status is not made at the Part B Drug Competitive Acquisition Program (CAP) rate, as the CAP program was suspended beginning January 1, 2009. Should the Part B Drug CAP program be 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 ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the April 2009 release of the OPPS PRICER.

Note: The updated payment rates, effective April 1 2009, will be included in the April 2009 update of the OPPS Addendum A and Addendum B, which will be posted at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html on the CMS website.

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

Three drugs and one diagnostic radiopharmaceutical have been granted OPPS pass-through status effective April 1, 2009. These items, along with their descriptors and APC assignments, are identified in Table 1 below.

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

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 4/1/09
C9247	Iobenguane, I-123, diagnostic, per study dose, up to 10 millicuries	9247	G
C9249*	Injection, certolizumab pegol, 1 mg	9249	G
J0641	Injection, levoleucovorin calcium, 0.5 mg	1236	G
J8705	Topotecan, oral, 0.25 mg	1238	G

NOTE: The HCPCS code identified with a "*" indicates that this is a new code effective April 1, 2009.

c. Adjustment to Status Indicator for HCPCS Code J3300 For CY 2009

As stated in the CY 2009 OPPS/ASC correction notice, CMS erroneously assigned a packaged status indicator (SI = "N") to HCPCS code J3300, Injection,triamcinolone acetonide, preservative free, 1 mg, for CY 2009. To correct this error, CMS is updating the payment rate in the OPPS PRICER retroactively to

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2008 American Medical Association.

January 1, 2009 to reflect the updated separately payable status of HCPCS code J3300 (SI = "K") for CY 2009. HCPCS code J3300 is assigned to APC 1253 (Triamcinolone A inj PRS-free) with a payment rate of $3.18 for the first quarter of CY 2009. If this payment rate changes for the second quarter of CY 2009, CMS will include the pricing update for HCPCS code J3300 in the corresponding update for other separately payable drugs and biologicals for the April 2009 OPPS PRICER.

d. Recognition of Multiple HCPCS Codes For Drugs

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

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

When billing for biologicals where the HCPCS code describes a product that is solely surgically implanted or inserted, whether the HCPCS code is identified as having pass-through status or not, hospitals are to report the appropriate HCPCS code for the product. In circumstances where the implanted biological has pass-through status, a separate payment for the biological is made. In circumstances where the implanted biological does not have pass-through status, the 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

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2008 American Medical Association.

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.

f. 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.

g. Introduction of Payment Offset for Pass-Through Diagnostic Radiopharmaceuticals

Effective April 1, 2009, diagnostic radiopharmaceutical HCPCS code C9247, Iobenguane, I-123, diagnostic, per study dose, up to 10 millicuries, has been granted pass-through status under the OPPS and will be assigned status indicator "G." As finalized in the CY 2009 OPPS/ASC final rule with comment period, payment for diagnostic radiopharmaceuticals with pass-through status during CY 2009 will be made according to the established ASP methodology. Therefore, beginning April 1, 2009, payment for HCPCS code C9247 will be made at 106 percent of ASP if ASP data are submitted by the manufacturer. Otherwise, payment will be made based on the product's wholesale acquisition cost (WAC). Further, if WAC data are not available, payment will be made at 95 percent of the average wholesale price (AWP).

Effective for nuclear medicine services furnished on and after April 1, 2009, when HCPCS code C9247 is billed on the same claim with a nuclear medicine procedure, CMS will reduce the amount of payment for the pass-through diagnostic radiopharmaceutical reported with HCPCS code C9247 by the corresponding nuclear medicine procedure's portion of its APC payment

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2008 American Medical Association.

associated with "policy packaged" drugs (offset amount) so no duplicate radiopharmaceutical payment is made. The "policy packaged" portions of the CY 2009 APC payments may be found on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html in the download file labeled "*2009 OPPS Offset Amounts by APC*." Pass-through payment for the diagnostic radiopharmaceutical is the difference between the payment for the pass-through product and the payment for the predecessor product that, in the case of diagnostic radiopharmaceuticals, is packaged into the payment for the nuclear medicine procedure in which the diagnostic radiopharmaceutical is used. Effective for services furnished on and after April 1, 2009 but before the date that HCPCS code C9247 expires from pass-through status, CMS will reduce the payment for HCPCS code C9247 by the estimated amount of payment that is attributable to the predecessor radiopharmaceutical that is packaged into payment for the associated nuclear medicine procedure reported on the same claim as HCPCS code C9247.

When HCPCS code C9247 is billed on a claim with one or more nuclear medicine procedures, the OPPS Pricer will identify the offset amount or amounts that apply to the nuclear medicine procedures that are reported on the claim. Where there is a single nuclear medicine procedure reported on the claim with a single occurrence of C9247, the OPPS Pricer will identify a single offset amount for the procedure billed and adjust the offset by the wage index that applies to the hospital submitting the bill. Where there are multiple nuclear medicine procedures on the claim with a single occurrence of the pass-through radiopharmaceutical, the OPPS Pricer will select the nuclear medicine procedure with the single highest offset amount and will adjust the selected offset amount by the wage index of the hospital submitting the claim. When a claim has more than one occurrence of C9247, the OPPS Pricer will rank potential offset amounts associated with the units of nuclear medicine procedures on the claim and identify a total offset amount that takes into account the number of occurrences of the pass-through radiopharmaceutical on the claim and adjust the total offset amount by the wage index of the hospital submitting the claim. The adjusted offset will be subtracted from the APC payment for the pass-through diagnostic radiopharmaceutical reported with HCPCS code C9247. The offset will cease to apply when the diagnostic radiopharmaceutical expires from pass-through status.

7. OPPS Pricer Changes

New Pass-Through Diagnostic Radiopharmaceutical Offset logic will be added (see section "6.g". above) along with the April Average Sales Pricer (ASP) APC updates.

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2008 American Medical Association.

8. Coverage Determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Fiscal Intermediaries (FIs)/Medicare Administrative Contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, FIs/MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Additional Information

The official instruction, CR6416, issued to your FI, A/B MAC, and RHHI regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1702CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website. If you have any questions, please contact your FI, MAC, or RHHI at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2008 American Medical Association.