



News Flash – The *Medicare Dependent Hospital Fact Sheet* (April 2009), which provides the criteria that rural hospitals must meet in order to be classified as a Medicare Dependent Hospital, is now available in downloadable format from the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedDependHospfctsht508.pdf> on the CMS website.

MLN Matters® Number: MM6626

Related Change Request (CR) #: 6626

Related CR Release Date: August 28, 2008

Effective Date: October 1, 2009

Related CR Transmittal #: R1803CP

Implementation Date: October 5, 2009

Note: This article was updated on January 3, 2013, to reflect current Web addresses. All other information remains unchanged.

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

Provider Types Affected

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

Provider Action Needed

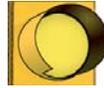


STOP – Impact to You

This article is based on Change Request (CR) 6626 which describes changes to and billing instructions for various payment policies implemented in the October 2009 OPPS update.

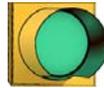
Disclaimer

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.

**CAUTION – What You Need to Know**

The October 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 for October. Those revisions to the I/OCE data files, instructions, and specifications are provided in CR 6618, "October 2009 Integrated Outpatient Code Editor (I/OCE) Specifications Version 10.3." Once CR 6618 is published, a related MLN Matters® article will be available at

<http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM6618.pdf> on the Centers for Medicare & Medicaid services (CMS) website.

**GO – What You Need to Do**

See the Background and Additional Information Sections of this article for further details regarding these changes.

Key Points of CR 6626

Changes to Procedure and Device Edits for October 2009

Procedure to device edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code. Failure to pass these edits will result in the claim being returned to the provider. Device to procedure edits require that a claim that contains one of a specified set of device codes be returned to the provider if it fails to contain an appropriate procedure code. The updated lists of both types of edits can be found under "Device, Radiolabeled Product, and Procedure Edits" at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html> on the website.

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.

For 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

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.

code C9399, Unclassified drug or biological, is for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned.

Unless otherwise specified in the long description, HCPCS code descriptors refer to the non-compounded, FDA-approved final product. If a product is compounded and a specific HCPCS code does not exist for the compounded product, the hospital should report an appropriate unlisted code such as J9999 or J3490.

- **Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective October 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 pharmacy overhead costs of these pass-through items. CMS notes that for the third quarter of CY 2009, payment for drugs and biologicals with pass-through status is not made at the Part B Drug Competitive Acquisition Program (CAP) rate, as the CAP program is suspended beginning January 1, 2009. Should the Part B Drug CAP program be reinstated sometime during CY 2009, CMS would again use the Part B drug CAP rate for pass-through drugs and biologicals if they are a part of the Part B drug CAP program, as required by the statute.

In the CY 2009 OPPS/ASC final rule with comment period, it was stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the October 2009 release of the OPPS Pricer. The updated payment rates, effective October 1, 2009 will be included in the October 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.

- **New HCPCS Code Effective for Certain Drugs and Biologicals**

A new HCPCS code has been created for reporting drugs and biologicals in the hospital outpatient setting for October 2009. HCPCS code Q2024 is listed in Table 1 below and is effective for services furnished on or after October 1, 2009. This HCPCS code is assigned status indicator "K," to indicate separate payment may be made for the product.

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.

Table 1 - New HCPCS Code Effective for Certain Drugs and Biologicals Effective October 1, 2009

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 10/1/09
Q2024	Injection, Bevacizumab, 0.25 mg	1281	K

- Adjustment to Status Indicator for HCPCS code Q4115 Effective October 1, 2009**
 CMS assigned HCPCS code Q4115, Skin substitute, alloskin, per square centimeter, a status indicator of "M" for services billed on or after July 1, 2009 through September 30, 2009, indicating that the service is not billable to the FI/MAC. For services furnished on or after October 1, 2009, CMS is changing the status indicator for Q4115 to "K" to indicate that separate payment may be made for this product. HCPCS code Q4115 is assigned to Ambulatory Payment Classification (APC) 1287 (Alloskin skin sub).

- 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 in Table 2 below and have been installed in the October 2009 OPPS Pricer, effective for services furnished on April 1, 2008, through implementation of the July 2008 update. If you have claims for these HCPCS codes for dates of service of April 1, 2008, through June 30, 2008 (inclusive) that were processed incorrectly and you bring such claims to your FI/MAC's attention, they will adjust such claims after the October 2009 OPPS Pricer is installed.

Table 2 - Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2008 through June 30, 2008

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J1440	K	0728	Filgrastim 300 mcg injection	\$197.37	\$39.47
J1441	K	7049	Filgrastim 480 mcg injection	\$303.75	\$60.75
J2505	K	9119	Injection, pegfilgrastim 6mg	\$2,179.44	\$435.89
J2788	K	9023	Rho d immune globulin 50 mcg	\$26.06	\$5.21
J2790	K	0884	Rho d immune globulin inj	\$83.63	\$16.73
J9050	K	0812	Carmus bischl nitro inj	\$155.30	\$31.06

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

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.

The payment rates for several HCPCS codes were incorrect in the July 2008 OPSS Pricer. The corrected payment rates are listed in Table 3 below and have been installed in the October 2009 OPSS Pricer, effective for services furnished on July 1, 2008, through implementation of the October 2008 update. If you have claims for these HCPCS codes for dates of service of July 1, 2008, through September 30, 2008 (inclusive) that were processed incorrectly and you bring such claims to your FI/MAC's attention, they will adjust such claims after the October 2009 OPSS Pricer is installed.

Table 3 - Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2008 through September 30, 2008

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J1438	K	1608	Etanercept injection	\$172.44	\$34.49
J1440	K	0728	Filgrastim 300 mcg injection	\$197.44	\$39.49
J1626	K	0764	Granisetron HCl injection	\$5.28	\$1.06
J2505	K	9119	Injection, pegfilgrastim 6mg	\$2,154.48	\$430.90
J2788	K	9023	Rho d immune globulin 50 mcg	\$26.70	\$5.34
J2790	K	0884	Rho d immune globulin inj	\$84.15	\$16.83
J9208	K	0831	Ifosfomide injection	\$34.10	\$6.82
J9209	K	0732	Mesna injection	\$7.86	\$1.57
J9226	G	1142	Supprelin LA implant	\$14,463.26	\$2,865.36

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

The payment rates for several HCPCS codes were incorrect in the October 2008 OPSS Pricer. The corrected payment rates are listed in Table 4 below and have been installed in the October 2009 OPSS Pricer, effective for services furnished on October 1, 2008, through implementation of the January 2009 update. If you have claims for these HCPCS codes for dates of service of October 1, 2008, through December 31, 2008 (inclusive) that were processed incorrectly and you bring such claims to your FI/MAC's attention, they will adjust such claims after the October 2009 OPSS Pricer is installed.

Table 4 - Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2008 through December 31, 2008

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J1441	K	7049	Filgrastim 480 mcg injection	\$304.32	\$60.86
J2505	K	9119	Injection, pegfilgrastim 6mg	\$2,175.85	\$435.17

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.

HCPSC Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J9209	K	0732	Mesna injection	\$6.99	\$1.40
J9226	G	1142	Supprelin LA implant	\$14,413.33	\$2,855.47
J9303	G	9235	Panitumumab injection	\$81.86	\$16.22

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

The payment rates for several HCPCS codes were incorrect in the July 2009 OPSS Pricer. The corrected payment rates are listed in Table 5 below and have been installed in the October 2009 OPSS Pricer, effective for services furnished on July 1, 2009, through implementation of the October 2009 update. If you have claims for these HCPCS codes for dates of service of July 1, 2009, through September 30, 2009 (inclusive) that were processed incorrectly and you bring such claims to your FI/MAC's attention, they will adjust such claims after the October 2009 OPSS Pricer is installed.

Table 5 - Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2009 through September 30, 2009

HCPSC Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
90585	K	9137	Bcg vaccine, percut	\$115.47	\$23.09
C9359	G	9359	Implnt,bon void filler-putty	\$65.21	\$12.80
J9031	K	0809	Bcg live intravesical vac	\$114.73	\$22.95
J9211	K	0832	Idarubicin hcl injection	\$126.12	\$25.22
J9265	K	0863	Paclitaxel injection	\$7.62	\$1.52
J9293	K	0864	Mitoxantrone hydrochl / 5 MG	\$66.26	\$13.25
Q0179	K	0769	Ondansetron hcl 8 mg oral	\$7.91	\$1.58

- **Recognition of Multiple HCPCS Codes For Drugs**

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

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.

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.

- **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 OPPI payment for the biological is packaged into the payment for the associated procedure.

When billing for biologicals where the HCPCS code describes a product that may either be surgically implanted or inserted or otherwise applied in the care of a patient, hospitals should not separately report the biological HCPCS code, with the exception of biologicals with pass-through status, when using these items as implantable devices (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures. Under the OPPI, 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.

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

- **Correct Reporting of Diagnostic Radiopharmaceuticals and their Associated Nuclear Medicine Procedures Furnished In Separate Calendar Years**

There are certain rare instances when a diagnostic radiopharmaceutical may be administered to a beneficiary in a given calendar year prior to a hospital furnishing an associated nuclear medicine

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.

procedure in the subsequent calendar year. As Medicare billing does not allow multiple calendar year services to be reported on a single claim, some hospitals have had difficulty reporting the radiolabeled product on the same claim as the nuclear medicine procedure when these associated services are not provided to the beneficiary in the same calendar year. Because of the nuclear medicine procedure-to-radiolabeled product claims processing edits included in the I/OCE, payment for a nuclear medicine procedure requires reporting of an appropriate radiolabeled product on the same claim. In this limited circumstance, hospitals are instructed to report the date the radiolabeled product is furnished to the beneficiary as the same date that the nuclear medicine procedure is performed. CMS believes that this situation is extremely rare, and CMS expects that the majority of hospitals will not encounter this situation.

- **H1N1 Vaccine and Administration Level II HCPCS Codes**

In anticipation of the availability of a vaccine for the H1N1 virus in the fall of 2009, CMS is creating two new Level II HCPCS codes that are effective October 1, 2009. Similar to the influenza vaccine and its administration, one HCPCS code has been created to describe the H1N1 vaccine itself (G9142, Influenza A (H1N1) vaccine, any route of administration), while another HCPCS code has been created to describe the administration of the H1N1 vaccine (G9141, Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family)). More information on the H1N1 flu and the associated vaccine can be found at the Centers for Disease Control and Prevention website at <http://www.cdc.gov/h1n1flu/> on the Internet.

Under the OPPI, HCPCS code G9142 will be assigned status indicator "E," indicating that payment will not be made by Medicare when this code is submitted on an outpatient bill type because CMS anticipates that the H1N1 vaccine will be supplied at no cost to providers. Payment will be made to a provider for the administration of the H1N1 vaccine, even if the vaccine is supplied at no cost to the provider. Beneficiary copayment and deductible do not apply to HCPCS code G9141 (for both OPPI and non OPPI providers), and CMS is assigning HCPCS code G9141 to APC 0350 (Administration of Flu and PPV Vaccine) with a payment rate of \$24.89 for CY 2009. Providers should report one unit of HCPCS code G9141 for each administration of the H1N1 vaccine.

The effective date of G9141 and G9142 is September 1, 2009. This effective date is earlier than originally anticipated, and therefore, the effective date reflected in the October IOCE will be October 1, 2009. For the January IOCE release, CMS will change the effective date for these HCPCS to be retroactive to September 1, 2009. Claims containing G9141 and G9142 with dates of service on or after September 1, 2009 but prior to October 1, 2009 will be held until the successful installation of the January IOCE release.

Updating Wage Indices for Hospitals Receiving Medicare Modernization Act (MMA) Section 508 Reclassification

Table 6 of CR 6626 contains the October 1, 2009 to December 31, 2009 Wage Indexes for Section 508 hospitals that receive payment under the OPPI. This article will not repeat Table 6, but Section 508

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.

hospitals may view the table in CR 6626 by going to <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1803CP.pdf> on the CMS website.

Clarification Related to Condition Code 44

CR 6626 also makes changes to the Medicare Claims Processing Manual, Chapter 1, Section 50.3, incorporate minor revisions clarifying the use of Condition Code 44. The revised section of the manual is attached to CR 6626.

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, CR6626, issued to your FI, A/B MAC, and RHHI regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1803CP.pdf> on the CMS website.

If you have any questions, please contact your FI, A/B 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.