



News Flash – The Affordable Care Act (ACA) imposes a 0.25 percentage point reduction to the Inpatient Prospective Payment System (IPPS) hospital's market basket for fiscal year (FY) 2010, effective for discharges on or after April 1, 2010. The reduction to the market basket will affect IPPS rates for discharges occurring on or after April 1, 2010, through September 30, 2010. Likewise, Section 3401(c) of ACA imposes a 0.25 percentage point reduction to the Long Term Care Hospital's (LTCH) market basket for FY 2010, effective for discharges on or after April 1, 2010. The reduction to the market basket will affect LTCH rates for discharges occurring on or after April 1, 2010, through September 30, 2010. Section 3401(d) of ACA imposes a 0.25 percentage point reduction to the Inpatient Rehabilitation Facility market basket for FY 2010, effective for discharges on or after April 1, 2010. This reduction is also resulting in changes to the standard payment conversion factor, payment rates, and the outlier threshold amount.

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Implementation Date: July 6, 2010

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

Note: This article was updated on December 6, 2012, to reflect current Web addresses. This article was previously revised on June 7, 2010, to reflect a revised CR 6996 that was issued on June 4. The CR was revised to show a correct payment rate of \$25.61 for HCPCS code G9141 ((Influenza a (h1n1) immunization administration (includes the physician counseling the patient/family)). The article was revised accordingly. In addition, the CR release date, transmittal number, and the Web address for accessing the CR were revised. All other information remains the same.

Provider Types Affected

Providers and suppliers 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 are affected.

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What You Need to Know

This article is based on Change Request (CR) 6996 which describes changes to and billing instructions for various payment policies implemented in the July 2010 OPSS update. The July 2010 Integrated Outpatient Code Editor (I/OCE) and OPSS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR 6996.

July 2010 revisions to I/OCE data files, instructions, and specifications are provided in CR 6967, July 2010 Integrated Outpatient Code Editor (I/OCE) Specifications **Version 11.2.** The MLN Matters® article related to CR 6967 is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6967.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

Background

Change Request (CR) 6996 updates Sections 20.4 and 20.5 of Chapter 6 of the Medicare Benefits Policy Manual to further clarify CMS policies requiring physician supervision of diagnostic and therapeutic services provided to hospital outpatients.

CMS updated Sections 20.4 and 20.5 to reflect changes in these policies that were implemented in the Calendar Year (CY) 2010 Outpatient Prospective Payment System/Ambulatory Surgical Center Payment System (OPSS/ASC) final rule with comment period [(74 FR 60588 through 60591; Hospital Outpatient Diagnostic Services); (74 FR 60578 through 60588); Hospital Outpatient Therapeutic Services)]. CR 6996 further clarifies CY 2010 CMS policies in response to additional questions and comments received since publication of that rule. Specifically, CR 6996 discusses:

- Discusses supervision of diagnostic tests by non-physician practitioners;
- Defines the term “immediately available”;
- Clarifies the credentials, knowledge, skills, ability, and privileges that the supervisory practitioner must possess in order to be qualified to perform a given service or procedure; and
- Clarifies what constitutes a therapeutic service in the hospital outpatient department, including observation.

These updates to Sections 20.4 and 20.5 of the Medicare Benefits Policy Manual are included as an attachment to CR 6996. The updates are summarized as follows:

- Physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives who operate within the scope of practice under State law may order and perform diagnostic tests, as discussed in 42 CFR 410.32(a)(2) and corresponding guidance in chapter 15, section 80 of this manual. However, this manual guidance and the long established regulation at 42 CFR 410.32(b)(1) also state that diagnostic x-ray and other diagnostic tests

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must be furnished under the appropriate level of supervision by a physician as defined in section 1861(r) of the Act. Some of these non-physician practitioners may perform diagnostic tests without supervision, see the regulation at 410.32(b)(2) and 42 CFR 410.32(b)(3). Thus, while physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives only require physician supervision included in any collaboration or supervision requirements particular to that type of practitioner when they personally perform a diagnostic test, these practitioners are not permitted to function as supervisory “physicians” for the purposes of other hospital staff performing diagnostic tests.

- Immediate availability requires the immediate physical presence of the physician. CMS has not specifically defined the word “immediate” in terms of time or distance; however, an example of a lack of immediate availability would be situations where the supervisory physician is performing another procedure or service that he or she could not interrupt. Also, for services furnished on-campus, the supervisory physician may not be so physically far away on-campus from the location where hospital outpatient services are being furnished that he or she could not intervene right away.
- The supervisory physician must have, within his or her State scope of practice and hospital-granted privileges, the knowledge, skills, ability, and privileges to perform the service or procedure. Specially trained ancillary staff and technicians are the primary operators of some specialized diagnostic testing equipment, and while in such cases CMS does not expect the supervisory physician to operate this equipment instead of a technician, the physician that supervises the provision of the diagnostic service must be knowledgeable about the test and clinically appropriate to furnish the test.
- The supervisory responsibility is more than the capacity to respond to an emergency, and includes the ability to take over performance of a procedure and, as appropriate to the supervisory physician and the patient, to change a procedure or the course of care for a particular patient. CMS would not expect that the supervisory physician would make all decisions unilaterally without informing or consulting the patient’s treating physician or nonphysician practitioner. In summary, the supervisory physician must be clinically appropriate to supervise the service or procedure.
- Direct supervision is the minimum standard for supervision of all Medicare hospital outpatient therapeutic services. Considering that hospitals furnish a wide array of very complex outpatient services and procedures, including surgical procedures, CMS would expect that hospitals already have the credentialing procedures, bylaws, and other policies in place to ensure that hospital outpatient services furnished to Medicare beneficiaries are being provided only by qualified practitioners in accordance with all applicable laws and regulations. For services not furnished directly by a physician or nonphysician practitioner, CMS would expect that these hospital bylaws and policies would ensure that the therapeutic services are being supervised in a manner commensurate with their complexity, including personal supervision where appropriate.

Note: CMS decided not to enforce the requirements for direct supervision of therapeutic services that are furnished to outpatients in critical access hospitals (CAHs) during calendar year 2010. For

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more information on this issue, see <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/downloads/WebNotice.pdf> on the CMS website.

In addition, CR 6996 makes the following OPPS changes:

1. Procedure to Device Edits for July 2010

Procedure to device edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code. Failure to pass these edits will result in the claim being returned to the provider. Procedures for which both a Device A and a Device B are specified require that at least one each of Device A and Device B be present on the claim (i.e., there must be some combination of a Device A with a Device B in order to pass the edit). Device B can be reported with any Device A for the same procedural HCPCS code.

Device to procedure edits require that a claim that contains one of a specified set of device codes be returned to the provider if it fails to contain an appropriate procedure code. The updated lists of both types of edits can be found under "Device, Radiolabeled Product, and Procedure Edits" at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html> on the CMS website.

2. Category III CPT Codes

The American Medical Association (AMA) releases Category III CPT codes in January, for implementation beginning the following July, and in July, for implementation beginning the following January. Prior to CY 2006, CMS implemented new Category III CPT codes once a year in January of the following year.

As discussed in the CY 2006 OPPS final rule with comment period (70 FR 68567; see http://www.access.gpo.gov/su_docs/fedreg/a051110c.html on the Internet), CMS modified the process for implementing the Category III codes that the AMA releases each January for implementation in July to ensure timely collection of data pertinent to the services described by the codes; to ensure patient access to the services the codes describe; and to eliminate potential redundancy between Category III CPT codes and some of the C-codes that are payable under the OPPS and were created in response to applications for new technology services. Therefore, on July 1, 2010, CMS is implementing the OPPS 11 Category III CPT codes that the AMA released in January 2010 for implementation in July 2010. Of the 11 Category III CPT codes, 10 are separately payable under the hospital OPPS. The Category III CPT codes, status indicators (SI), and Ambulatory Payment Classifications (APC) are shown in Table 1 below. Payment rates for these services can be found in Addendum B of the July 2010 OPPS Update that is posted at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html> on the CMS website. CPT code 0233T (skin advanced glycation end products (AGE) measurement by multi-wavelength fluorescent spectroscopy) will be paid under the Medicare Physician Fee Schedule, beginning July 1, 2010, when billed by OPPS providers.

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Table 1--Category III CPT Codes Implemented as of July 1, 2010

HCPCS	Long Descriptor	SI	APC
0223T	Acoustic cardiography, including automated analysis of combined acoustic and electrical intervals; single, with interpretation and report	S	0099
0224T	Multiple, including serial trended analysis and limited reprogramming of device parameter - AV or VV delays only, with interpretation and report	S	0690
0225T	Multiple, including serial trended analysis and limited reprogramming of device parameter - AV and VV delays, with interpretation and report	S	0690
0226T	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed	X	0340
0227T	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)	T	0146
0228T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; single level	T	0207
0229T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; each additional level (List separately in addition to code for primary procedure)	T	0206
0230T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; single level	T	0207
0231T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; each additional level (List separately in addition to code for primary procedure)	T	0206
0232T	Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed	X	0340
0233T	Skin advanced glycation endproducts (AGE) measurement by multi-wavelength fluorescent spectroscopy	A	NA

3. Dermal Injections for Treatment of Facial Lipodystrophy Syndrome (LDS)

Effective for claims with dates of service on and after March 23, 2010, coverage for dermal injections for the treatment of facial lipodystrophy syndrome (LDS) is considered reasonable and necessary only in HIV-infected beneficiaries who manifest depression secondary to the physical stigma of HIV treatment. CMS will cover and pay separately for the dermal filler injection procedure and the dermal filler products that are approved by the Food and Drug Administration (FDA).

CMS has created four Level II HCPCS codes to describe the dermal filler injection procedure and the dermal filler products. Those codes are shown in Table 2 below. Under the hospital OPPS, CMS has assigned HCPCS code C9800 to APC 0135 with an SI of "T." Since HCPCS code C9800 describes both the injection procedure and the dermal filler items and supplies, CMS has assigned HCPCS codes G0429, Q2026, and Q2027 to SI "B" to indicate that these codes are not recognized by OPPS when submitted on an outpatient hospital Part B bill type 12x or 13x.

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Table 2—HCPCS Codes for Dermal Filler Injection Implemented as of July 1, 2010

HCPCS	Long Descriptor	SI	APC
C9800	Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies	T	0135
G0429	Dermal Filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy)	B	NA
Q2026	Injection, Radiesse, 0.1 ml	B	NA
Q2027	Injection, Sculptra, 0.1 ml	B	NA

4. Billing for Allogeneic Stem Cell Transplant Procedures

CR 6996 revises Section 231.11 of the Medicare Claims Processing Manual (Chapter 4) to clarify that charges for allogeneic stem cell acquisition services billed with revenue code 0819 (Other Organ Acquisition) should be reported on the same date of service as the allogeneic transplant procedure in order to be appropriately packaged for payment purposes. The revision to Section 231.11 of the Medicare Claims Processing Manual is included as an attachment to CR 6996.

5. 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 OPDS, 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 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.

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a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective July 1, 2010

For CY 2010, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 4 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2010, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. CMS notes that for the third quarter of CY 2010, payment for drugs and biologicals with pass-through status is not made at the Part B Drug Competitive Acquisition Program (CAP) rate, as the CAP program was suspended beginning January 1, 2009. Should the Part B Drug CAP program be reinstated sometime during CY 2010, 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 2010 OPPS/ASC final rule with comment period, CMS stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the July 2010 release of the OPPS Pricer. The updated payment rates, effective July 1, 2010 will be included in the July 2010 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 July 1, 2010

Six drugs and biologicals have been granted OPPS pass-through status effective July 1, 2010. These items, along with their descriptors and APC assignments, are identified in Table 3 below.

Table 3—Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2010

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 7/1/10
C9264*	Injection, tocilizumab, 1mg	9264	G
C9265*	Injection, romidepsin, 1 mg	9265	G
C9266*	Injection, collagenase clostridium histolyticum, 0.1 mg	9266	G
C9267*	Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO	9267	G
C9268*	Capsaicin, patch, 10cm2	9268	G
C9367*	Skin substitute, Endoform Dermal Template, per square centimeter	9367	G

NOTE: The HCPCS codes identified with an "*" indicate that these are new codes effective July 1, 2010.

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c. New HCPCS Codes Effective for Certain Drugs and Biologicals

One new HCPCS code has been created for reporting drugs and biologicals in the hospital outpatient setting for July 2010. This code is listed in Table 4 below and replaces C9262. This code is effective for services furnished on or after July 1, 2010.

Table 4— New HCPCS Codes Effective for Certain Drugs and Biologicals Effective July 1, 2010

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 7/1/10
Q2025	Fludarabine phosphate, oral, 1 mg	9262	G

d. Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2010 through June 30, 2010

The payment rates for three HCPCS codes were incorrect in the April 2010 OPSS Pricer. The corrected payment rates are listed in Table 5 below and have been incorporated into the reissued Pricer, effective for services furnished on April 1, 2010, through implementation of the July 2010 update. Affected claims that were already processed/paid prior to the reissued Pricer, have been reprocessed (or are in the process of being reprocessed).

Table 5—Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2010 through June 30, 2010

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9258	G	9258	Telavancin injection	\$2.12	\$0.42
C9262	G	9262	Fludarabine phosphate, oral	\$8.18	\$1.61
J1540	K	0923	Gamma globulin 9 CC inj	\$141.64	\$28.33

e. Adjustment to Status Indicator for HCPCS Code 90670 Effective April 1, 2010

Effective April 1, 2010, the status indicator for HCPCS code 90670 (Pneumococcal conjugate vaccine, 13 valent, for intramuscular use) will change from SI=E (not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=K (paid under OPSS; separate APC payment). For the remainder of CY 2010, HCPCS code 90670 will be separately paid and the price will be updated on a quarterly basis.

f. Category I H1N1 Vaccine CPT Codes

As stated in the October 2009 Update of the hospital OPSS that was published in CR 6626 (Transmittal 1803, August 28, 2009; see <http://www.cms.gov/Outreach-and->

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[Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6626.pdf](#) on the CMS website), CMS created two Level II HCPCS codes to describe the H1N1 vaccine itself and the H1N1 vaccine administration. Specifically, G9141 (Influenza a (h1n1) immunization administration (includes the physician counseling the patient/family)) and G9142 (Influenza a (h1n1) vaccine, any route of administration) were made effective September 1, 2009. Under the OPPTS, HCPCS code G9142 is assigned to status indicator "E" indicating that payment is not made by Medicare when this code is submitted on an outpatient bill type because the H1N1 vaccine is supplied at no cost to providers. However, payment will be made to a provider for the administration of the H1N1 vaccine when reported under HCPCS code G9141, even if the vaccine is supplied at no cost to the provider. HCPCS code G9141 is assigned to APC 0350 (Administration of Flu and PPV Vaccine) with a status indicator of "S" and a payment rate of \$25.61 for CY 2010. Beneficiary copayment and deductible do not apply to HCPCS code G9141 (for both OPPTS and non OPPTS providers). Providers should report one unit of HCPCS code G9141 for each administration of the H1N1 vaccine.

In January 2010, the CPT Editorial Panel, through the AMA website, released four new H1N1 vaccine CPT codes for implementation on July 1, 2010. The four new H1N1 vaccine codes are: 90664, 90666, 90667, and 90668 (see Table 6 for the code descriptors). CMS notes that CPT code 90663 was made effective September 28, 2009, and was assigned to status indicator "E" under the OPPTS since its effective date. Because two existing H1N1 G-codes appropriately describe the vaccine itself and the administration, Medicare will only recognize the G-codes. Under the hospital OPPTS, providers must report the H1N1 vaccine itself by reporting G9142 and G9141 for the H1N1 vaccine administration. Table 6 provides a list of H1N1 vaccine and H1N1 vaccine administration HCPCS codes, status indicators, APCs, and payment rates as of July 1, 2010 under the hospital OPPTS.

Table 6—H1N1 Vaccine and H1N1 Vaccine Administration HCPCS Codes as of July 1, 2010

	HCPCS	Long Descriptor	SI	APC	Payment Rate
H1N1 Vaccine HCPCS Codes	G9142	Influenza a (h1n1) vaccine, any route of administration	E	NA	NA
	90663	Influenza virus vaccine, pandemic formulation, H1N1	E	NA	NA
	90664	Influenza Influenza virus vaccine, pandemic formulation, live, for intranasal use	E	NA	NA
	90666	Influenza virus vaccine, pandemic formulation, split virus, preservative free, for intramuscular use	E	NA	NA
	90667	Influenza virus vaccine, pandemic formulation, split virus, adjuvanted, for intramuscular use	E	NA	NA

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	HCPCS	Long Descriptor	SI	APC	Payment Rate
	90668	Influenza virus vaccine, pandemic formulation, split virus, for intramuscular use	E	NA	NA
H1N1 Vaccine Administration HCPCS Codes	G9141	Influenza a (h1n1) immunization administration (includes the physician counseling the patient/family)	S	0350	\$25.61
	90470	H1N1 immunization administration (intramuscular, intranasal), including counseling when performed	E	NA	NA

g. Correct Reporting of Biologicals When Used As Implantable Devices

When billing for biologicals where the HCPCS code describes a product that is solely surgically implanted or inserted, whether the HCPCS code is identified as having pass-through status or not, hospitals are to report the appropriate HCPCS code for the product. Units should be reported in multiples of the units included in the HCPCS descriptor. Providers and hospitals should not bill the units based on the way the implantable biological is packaged, stored, or stocked. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the implantable biological. Therefore, before submitting Medicare claims for biologicals that are used as implantable devices, it is extremely important to review the complete long descriptors for the applicable HCPCS codes. In circumstances where the implanted biological has pass-through status, either as a biological or a device, a separate payment for the biological or device is made. In circumstances where the implanted biological does not have pass-through status, the 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.

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h. Correct Reporting of Units for Drugs

Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. 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; and
- 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, the hospital should bill 10 units, even though only 1 vial was administered. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

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

i. Reporting of Outpatient Diagnostic Nuclear Medicine Procedures

With the specific exception of HCPCS code C9898 (Radiolabeled product provided during a hospital inpatient stay) to be reported by hospitals on outpatient claims for nuclear medicine procedures to indicate that a radiolabeled product that provides the radioactivity necessary for the reported diagnostic nuclear medicine procedure was provided during a hospital inpatient stay, hospitals should only report HCPCS codes for products they provide in the hospital outpatient department and should not report a HCPCS code and charge for a radiolabeled product on the nuclear medicine procedure-to-radiolabeled product edit list solely for the purpose of bypassing those edits present in the I/OCE.

As CMS stated in the October 2009 OPPS update, in the rare instance when a diagnostic radiopharmaceutical may be administered to a beneficiary in a given calendar year prior to a hospital furnishing an associated nuclear medicine procedure in the subsequent calendar year, hospitals are instructed to report the date the radiolabeled product is furnished to the beneficiary as

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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.

6. Information regarding the Core-Based Statistical Area (CBSA) and Wage Indexes in effect for CY 2010

The Affordable Care Act (ACA); Sections 3137(a) and 10317 of Pub. L 111-148; (see http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf on the Internet) revised the wage indexes that are in effect for FY 2010. As a result of these changes, instructions were issued to contractors in a separate CR, regarding the revised wage indices in effect for FY 2010. The OPSS adopts the post reclassification fiscal year wage index in effect for the inpatient prospective payment system (IPPS) on a calendar year basis. Therefore, CMS adopted the reclassified wage indices that began for IPPS payment on April 1, 2010, for hospital outpatient payment under the OPSS beginning July 1, 2010, to align the mid-year change in post-reclassification wages for some CBSAs with the OPSS calendar year payment period. The OPSS also adopts section 508 geographic reclassifications on a fiscal year basis. The ACA extended section 508 reclassification wage indexes through September 30, 2010. Similar to CMS' treatment of section 508 reclassifications as previously extended under 124 of Pub. L. 110- 275 (MIPPA), hospitals with section 508 reclassifications will revert to their home area wage index, with out-migration adjustment if applicable, from October 1, 2010, to December 31, 2010. As CMS did for CY 2009, CMS is also beginning reclassification wage indexes for certain special exception hospitals on January 1, 2010, and extending them through December 31, 2010. Please note that the wage indices included in the July 1, 2010 OPSS Pricer reflect the revised post-reclassification wage index values implemented for the IPPS on April 1, 2010. Contractors shall maintain the current CBSA value assigned to all OPSS hospitals, including those with non section 508 wage index reclassifications that have been approved by the Medicare Geographic Classification Review Board (MGCRB).

7. Coverage Determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPSS 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/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, CR6996, was issued to your FI, RHHI, and A/B MAC in two transmittals. One transmittal modifies the Medicare Claims Processing Manual and it is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1980CP.pdf> on the CMS website. The other

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modifies the Medicare Benefit Policy Manual and it is at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R128BP.pdf> on the CMS website.

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

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