



News Flash – The Centers for Medicare & Medicaid Services (CMS) has posted the 2011 versions of the ICD-10-CM and ICD-10-PCS crosswalks, formally referred to as the General Equivalence Mappings (GEMs) at <http://www.cms.gov/ICD10> on the ICD-10 website. See the links on that page for 2011 ICD-10-CM and GEMs, and 2011 ICD-10-PCS and GEMs. In addition, CMS has also posted a document, "ICD-10 GEMs 2011 Version Update, Update Summary". This document describes the number of comments CMS received, the type of changes recommended, the types of changes made based on the comments, the types of comments not accepted, and the reasons why some comments were not accepted.

MLN Matters® Number: MM7271

Related Change Request (CR) #: 7271

Related CR Release Date: January 24, 2011

Effective Date: January 1, 2011

Related CR Transmittal #: R2141CP

Implementation Date: January 3, 2011

January 2011 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 Outpatient Prospective Payment System (OPPS).

Provider Action Needed

This article is based on Change Request (CR) 7271 which provides the January 2011 update for the OPPS, describes changes to and billing instructions for various payment policies implemented in the 2011 OPPS updates, and includes instructions addressing hold harmless payment. The January 2011 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 CR7271. Be sure your billing staff is aware of these changes.

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Background

The Medicare and Medicaid Extenders Act of 2010 (MMEA) extends the Outpatient Hold Harmless Provision for small rural hospitals with 100 or fewer beds and all Sole Community and Essential Access Hospitals and reclassification wage indices originally authorized under Section 508 of MMA. CR7271 also includes instructions addressing hold harmless payment. CMS will issue a separate notification to address the extension of Section 508 reclassification wage indices.

The January 2011 revisions to I/OCE data files, instructions, and specifications are provided in CR 7252, Transmittal 2114, "January 2011 Integrated Outpatient Code Editor (I/OCE) Specifications Version 12.0." The related article is at <http://www.cms.gov/MLN MattersArticles/downloads/MM7252.pdf> on the CMS website.

Key changes to and billing instructions for various payment policies implemented in the January 2011 OPSS update are detailed below.

Key OPSS Updates for April 2010

Changes to Device Edits for January 2011

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

Since January 1, 2007, CMS also has required that a claim that contains one of a specified set of device codes be returned to the provider if it fails to contain an appropriate procedure code. The device-to-procedure edits are designed to ensure that the costs of these devices are assigned to the appropriate APC in OPSS rate-setting.

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

Payment for Multiple Imaging Composite Ambulatory Payment Classifications (APCs)

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

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APCs for payment. Prior to January 1, 2009, hospitals received a full APC payment for each imaging service on a claim, regardless of how many procedures were performed during a single session.

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

CMS has updated the list of specified HCPCS codes within the three imaging families and five composite APCs to reflect HCPCS coding changes. Specifically, CMS added CPT code 74176 (Computed tomography, abdomen and pelvis; without contrast material), CPT code 74177 (Computed tomography, abdomen and pelvis; with contrast material(s)), and CPT code 74178 (Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions) to the CT and CTA family. These codes are new for CY 2011. CMS also added HCPCS codes C8931 (Magnetic resonance angiography with contrast, spinal canal and contents), C8932 (Magnetic resonance angiography without contrast, spinal canal and contents), C8933 (Magnetic resonance angiography without contrast followed by with contrast, spinal canal and contents), C8934 (Magnetic resonance angiography with contrast, upper extremity), C8935 (Magnetic resonance angiography without contrast, upper extremity), and C8936 (Magnetic resonance angiography without contrast followed by with contrast, upper extremity), to the MRI and MRA family. These codes were recognized for OPPS payment in the October 2010 OPPS Update (Transmittal 2061, CR7117, dated September 17, 2010). See <http://www.cms.gov/Transmittals/downloads/R2061CP.pdf> on the CMS website.

The specified HCPCS codes within the three imaging families and five composite APCs for CY 2011 are provided in Table 1 of CR7271.

Partial Hospitalization APCs

For CY 2011, CMS is creating four separate PHP per diem payment rates: two for CMHCs (for Level I and Level II PH services based on only CMHC data), and two for hospital-based PHPs (for Level I and Level II services based on only hospital-based data). CMS will be implementing a two-year transition for the two CMHC PHP per diem rates to mitigate their payment reduction. The APCs for the CMHCs are: APC 0172 (Level I Partial Hospitalization (3 services)) and APC 0173 (Level II Partial Hospitalization (4 or more services)). The APCs for the hospital-based PHPs are: APC 0175 (Level I Partial Hospitalization (3 services)) and APC 0176 (Level Level II Partial Hospitalization (4 or more services)).

When a Community Mental Health Center (CMHC) provides three services of partial hospitalization services and meets all other partial hospitalization payment criteria, the CMHCs would be paid through APC 0172. Similarly, when a hospital-based PHP provides three services of partial hospitalization services and meets all other partial hospitalization payment criteria, the hospital-based PHP would be paid through APC 0175. When the CMHCs provide four or more services of partial

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hospitalization services and meet all other partial hospitalization payment criteria, the CMHC would be paid through APC 0173 and the hospital-based PHP providing four or more services would be paid through APC 0176.

The tables below provide the updated per diem payment rates:

CY 2011 Median Per Diem Costs for CMHC PHP Services Plus Transition

APC	Group Title	Median Per Diem Costs Plus Transition
0172	Level I Partial Hospitalization (3 services) for CMHCs	\$128.25
0173	Level II Partial Hospitalization (4 or more services) for CMHCs	\$162.67

CY 2011 Median Per Diem Costs for Hospital-Based PHP Services

APC	Group Title	Median Per Diem Costs
0175	Level I Partial Hospitalization (3 services) for hospital-based PHPs	\$202.71
0176	Level II Partial Hospitalization (4 or more services) for hospital-based PHPs	\$235.79

Changes to Regulations to Incorporate Provisions of the Health Care and Education Reconciliation Act (HCERA) 2010

Section 1301 (a) and (b) of HCERA 2010 established new requirements for CMHCs and amended the definition of a PHP. Section 1301 (a) of HCERA revised the definition of a CMHC by adding a requirement that the CMHC must provide at least 40 percent of its services to non-Medicare beneficiaries, effective April 1, 2010. Section 1301 (b) of HCERA amends the description of a PHP to specify that the program must be a distinct and organized intensive ambulatory treatment program offering less than 24-hour daily care "other than in an individual's home or in an inpatient or residential setting".

Mental Health Services Composite APC 0034

Since CY 2009, CMS has set the annual payment rate for the mental health composite APC at the same rate as the maximum partial hospitalization per diem payment. For CY 2011, CMS is adapting a provider-specific two tiered payment approach for partial hospitalization services that distinguishes payment made for services furnished in a Community Mental Health Center (CMHC) from payment made for services furnished in a hospital. CMS has modified the titles of APCs 0172 (Level I Partial Hospitalization (3 services) for CMHCs) and 0173 (Level II Partial Hospitalization (4 or more services) for CMHCs) to solely reflect CMHC-based partial hospitalization services. Additionally, CMS has created APCs 0175 (Level I Partial Hospitalization (3 services) for Hospital-Based Partial

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Hospitalization Programs (PHPs) and 0176 (Level II Partial Hospitalization (4 or more services) for Hospital-Based PHPs) to pay for Hospital-Based partial hospitalization services. In accordance with CMS policy to pay for the mental health composite APC at the same rate as the maximum partial hospitalization per diem payment, for CY 2011, CMS will use the hospital-based partial hospitalization APC 0176 as the daily payment cap for less intensive mental health services provided in hospital outpatient departments and will set the CY 2011 payment rate for APC 0034 at the same rate as APC 0176. CMS is updating the Medicare Claims Processing Manual, Chapter 4, Section 10.2.1 to reflect this change. This Manual update is included as an attachment to CR7271.

The I/OCE will continue to determine whether to pay specified mental health services individually or to make a single payment at the same rate as the APC 0176 per diem rate for partial hospitalization for all of the specified mental health services furnished on that date of service. Through the I/OCE, when the payment for the specified mental health services provided by one hospital to a single beneficiary on one date of service based on the payment rates associated with the APCs for the individual services would exceed the maximum per diem partial hospitalization payment, those specified mental health services would be assigned to APC 0034 (Mental Health Services Composite), which has the same payment rate as APC 0176, and the hospital would be paid one unit of APC 0034.

Reporting Hospital Critical Care Services Under the OPPS

For CY 2010 and in prior years, the American Medical Association (AMA) Common Procedural Terminology (CPT) Editorial Panel has defined critical care CPT codes 99291 (critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes) and 99292 (critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (list separately in addition to code for primary service)) to include a wide range of ancillary services such as electrocardiograms, chest X-rays and pulse oximetry. As CMS has stated in its manual instructions, hospitals should report in accordance with CPT guidance unless CMS instructs otherwise. For critical care in particular, CMS instructs hospitals that any services that the CPT Editorial Panel indicates are included in the reporting of CPT code 99291 (including those services that would otherwise be reported by and paid to hospitals using any of the CPT codes specified by the CPT Editorial Panel) should not be billed separately. Instead, hospitals should report charges for any services provided as part of the critical care services.

Beginning January 1, 2011, under revised AMA CPT Editorial Panel guidance, hospitals that report in accordance with the CPT guidelines will begin reporting all of the ancillary services and their associated charges separately when they are provided in conjunction with critical care. CMS will continue to recognize the existing CPT codes for critical care services and is establishing a payment rate based on its historical data, into which the cost of the ancillary services is intrinsically packaged. The I/OCE logic will conditionally package payment for the ancillary services that are reported on the same date of service as critical care services in order to avoid overpayment. The payment status of the ancillary services will not change when they are not provided in conjunction with critical care services. Hospitals may use HCPCS modifier -59 to indicate when an ancillary procedure or service is distinct or independent from critical care when performed on the same day but in a different encounter.

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CMS is updating the Medicare Claims Processing Manual, Chapter 4, Section 160.1, to reflect the revised critical care reporting guidelines and OPSS payment policy and that revised manual chapter is included as an attachment to CR7271.

Waiver of Cost- Sharing for Preventive Services

The Affordable Care Act waives any copayment and deductible that would otherwise apply for the defined set of preventive services to which the U.S. Preventive Services Task Force (USPSTF; see <http://www.uspreventiveservicestaskforce.org/recommendations.htm> on the Internet) has given a grade of A or B, as well as, the Initial Preventive Physical Examination (IPPE), and the Annual Wellness Visit (AWV) providing Personalized Preventive Plan Services (PPPS). These provisions are effective for services furnished on and after January 1, 2011. CMS is revising the Medicare Claims Processing Manual, Chapter 4, Section 30, which references the 25% copayment for screening colonoscopies and screening flexible sigmoidoscopies, effective prior to January 1, 2011, to reflect this change. This Manual revision is included as an attachment to CR7271. Further information on the implementation of waiver of cost- sharing for preventive services as prescribed by the Affordable Care Act can be found in CR7012, Transmittal 739, issued on July 30, 2010.

Billing for Tobacco Cessation Counseling

Effective for claims with dates of service on and after August 25, 2010, CMS will cover tobacco cessation counseling for outpatient and hospitalized Medicare beneficiaries, 1) who use tobacco, regardless of whether they have signs or symptoms of tobacco-related disease; 2) who are competent and alert at the time that counseling is provided; and 3) whose counseling is furnished by a qualified physician or other Medicare-recognized practitioner. To implement this recent coverage determination, CMS created new C-codes and G-codes to report tobacco cessation counseling service. The long descriptors for both the C-codes and G-codes appear in the following table:

Tobacco Cessation Counseling Services

CY 2011 HCPCS Code	CY 2010 HCPCS Code	CY 2011 Long Descriptor	CY 2011 Status Indicator	CY 2011 APC
G0436	C9801	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes	X	0031
G0437	C9802	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes	X	0031

For dates of service between August 25, 2010, through December 31, 2010, hospital outpatient facilities must have reported either HCPCS code C9801 or C9802 for tobacco cessation counseling services. HCPCS codes C9801 and C9802 will be deleted December 31, 2010, and replaced with HCPCS codes G0436 and G0437, respectively, effective January 1, 2011. Both HCPCS codes G0436 and G0437 have been assigned to the same status indicators and APC assignments as their predecessor C-codes. Further reporting guidelines on tobacco cessation counseling services can be

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found in the Medicare Claims Processing Manual, Chapter 18, Section 150 and in CR 7133 (see the related MLN Matters® article at <http://www.cms.gov/MLN MattersArticles/downloads/MM7133.pdf> on the CMS website).

Inpatient Only Services

With CR7271, CMS is adding Section 180.7 Inpatient Only Services to the Medicare Claims Processing Manual, Chapter 4, to clarify that OPSS does not pay hospitals for an inpatient only procedure and related ancillary services provided on the same day. The Section 180.7 added to Chapter 4 of the Medicare Claims Processing Manual is included as an attachment to CR7271.

Billing for Drugs, Biologicals, and Radiopharmaceuticals

a. Reporting HCPCS Codes for All Drugs, Biologicals, and Radiopharmaceuticals

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

More complete data from hospitals on the drugs and biologicals provided during an encounter would help improve payment accuracy for separately payable drugs and biologicals in the future. CMS strongly encourages hospitals to report HCPCS codes for all drugs and biologicals furnished, if specific codes are available. CMS realizes that this may require hospitals to change longstanding reporting practices. Precise billing of drug and biological HCPCS codes and units, especially in the case of packaged drugs and biologicals for which the hospital receives no separate payment, is critical to the accuracy of the OPSS payment rates for drugs and biologicals each year.

CMS notes that it makes packaging determinations for drugs and biologicals annually based on charge information reported with specific HCPCS codes on claims, so the accuracy of OPSS payment rates for drugs and biologicals improves when hospitals report charges for all items and services that have HCPCS codes under those HCPCS codes, whether or not payment for the items and services is packaged or not. It is the CMS standard rate-setting methodology to rely on hospital cost and charge information as it is reported to CMS by hospitals through the claims data and cost reports. Precise billing and accurate cost reporting by hospitals allow CMS to most accurately estimate the hospital costs for items and services upon which OPSS payments are based.

CMS reminds hospitals that under the OPSS, 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.

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

b. New Calendar Year 2011 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

For CY 2011, several new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available.

These new codes are listed in the following table:

New CY 2011 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2011 HCPCS Code	CY 2011 Long Descriptor	CY 2011 SI	CY 2011 APC
C9274	Crotalidae Polyvalent Immune Fab (Ovine), 1 vial	G	9274
C9275	Injection, hexaminolevulinate hydrochloride, 100 mg, per study dose	G	9275
C9276	Injection, cabazitaxel, 1 mg	G	9276
C9277	Injection, alglucosidase alfa (Lumizyme), 1 mg	G	9277
C9278	Injection, incobotulinumtoxin A, 1 unit	G	9278
C9279	Injection, ibuprofen, 100 mg	G	9279
J0638	Injection, canakinumab, 1 mg	K	1311
J1559	Injection, immune globulin (Hizentra), 100 mg	K	1312
J1599	Injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), not otherwise specified, 500 mg	N	N/A
J2358	Injection, olanzapine, long-acting, 1 mg	K	1331
J7196	Injection, antithrombin recombinant, 50 IU	K	1332
J7309	Methyl aminolevulinate (mal) for topical administration, 16.8%, 10 mg	K	1338
Q4118	Matristem micromatrix, 1 mg	K	1342
Q4121	Theraskin, per square centimeter	K	1345

c. Other Changes to CY 2011 HCPCS and CPT Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals

Many HCPCS and CPT codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS and CPT code descriptors that will be effective in CY 2011. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2010, and replaced with permanent HCPCS codes in CY 2011. Hospitals should pay close attention to accurate billing

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for units of service consistent with the dosages contained in the long descriptors of the active CY 2011 HCPCS and CPT codes. The changes are detailed in Table 6 of CR7271.

d. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective January 1, 2011

For CY 2011, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 5 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2011, 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 first quarter of CY 2011, 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 postponed beginning January 1, 2009. Should the Part B Drug CAP program be reinstated sometime during CY 2011, 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 2011 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. Effective January 1, 2011, payment rates for many drugs and biologicals have changed from the values published in the CY 2011 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2010. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2011 release of the OPPS Pricer. CMS is not publishing the updated payment rates in CR7271. However, the updated payment rates effective January 1, 2011 can be found in the January 2011 update of the OPPS Addendum A and Addendum B at <http://www.cms.gov/HospitalOutpatientPPS/AU/list.asp> on the CMS website.

e. Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2010, through September 30, 2010

The payment rates for several HCPCS codes were incorrect in the July 2010 OPPS Pricer. The corrected payment rates are listed in the following table below and have been installed in the January 2011 OPPS Pricer, effective for services furnished on July 1, 2010, through implementation of the October 2010 update. Your Medicare contractor will adjust any claims that you bring to their attention which were processed for these service dates prior to implementation of the corrected Pricer.

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**Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2010 through
September 30, 2010**

CY 2010 HCPCS Code	CY 2010 SI	CY 2010 APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
A9543	K	1643	Y90 ibritumomab, rx	\$30,581.01	\$6,116.20
J0150	K	0379	Injection adenosine 6 MG	\$13.74	\$2.75
J0641	G	1236	Levoleucovorin injection	\$0.73	\$0.14
J2430	K	0730	Pamidronate disodium /30 MG	\$15.61	\$3.12
J2850	K	1700	Inj secretin synthetic human	\$26.97	\$5.39
J9065	K	0858	Inj cladribine per 1 MG	\$24.12	\$4.82
J9178	K	1167	Inj, epirubicin hcl, 2 mg	\$2.06	\$0.41
J9185	K	0842	Fludarabine phosphate inj	\$112.61	\$22.52
J9200	K	0827	Floxuridine injection	\$42.31	\$8.46
J9206	K	0830	Irinotecan injection	\$4.23	\$0.85
J9208	K	0831	Ifosfomide injection	\$30.95	\$6.19
J9209	K	0732	Mesna injection	\$4.96	\$0.99
J9211	K	0832	Idarubicin hcl injection	\$40.09	\$8.02
J9263	K	1738	Oxaliplatin	\$4.37	\$0.87
J9293	K	0864	Mitoxantrone hydrochl / 5 MG	\$44.07	\$8.81

f. New Vaccine CPT Codes

One new vaccine code is effective for services provided beginning January 1, 2011. That code is 90654 (influenza virus vaccine, split virus, preservative free, for intradermal use) with a CY2011 SI of E.

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

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implanted biological has pass-through status, either as a biological or a device, a separate payment for the biological or device is made. In circumstances where the implanted biological does not have pass-through status, the OPPS payment for the biological is packaged into the payment for the associated procedure.

When billing for biologicals where the HCPCS code describes a product that may either be surgically implanted or inserted or otherwise applied in the care of a patient, hospitals should not separately report the biological HCPCS codes, with the exception of biologicals with pass-through status, when using these items as implantable devices (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures. Under the OPPS, hospitals are provided a packaged APC payment for surgical procedures that includes the cost of supportive items, including implantable devices without pass-through status. When using biologicals during surgical procedures as implantable devices, hospitals may include the charges for these items in their charge for the procedure, report the charge on an uncoded revenue center line, or report the charge under a device HCPCS code (if one exists) so these costs would appropriately contribute to the future median setting for the associated surgical procedure.

h. Correct Reporting of Units for Drugs

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

As discussed in the Medicare Claims Processing Manual, Chapter 17, Section 40, 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. Payment for Therapeutic Radiopharmaceuticals

Beginning in CY 2010, nonpass-through separately payable therapeutic radiopharmaceuticals are paid under the OPPS based upon the ASP. If ASP data is unavailable, payment for therapeutic radiopharmaceuticals will be provided based on the most recent hospital mean unit cost data.

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Therefore, for January 1, 2011, the status indicator for separately payable therapeutic radiopharmaceuticals is "K" to reflect their separately payable status under the OPPS. Similar to payment for other separately payable drugs and biologicals, the payment rates for nonpass-through separately payable therapeutic radiopharmaceuticals will be updated on a quarterly basis.

**Nonpass-Through Separately Payable Therapeutic Radiopharmaceuticals
for January 1, 2011**

CY 2011 HCPCS Code	CY 2011 Long Descriptor	Final CY 2011 APC	Final CY 2011 SI
A9517	Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie	1064	K
A9530	Iodine I-131 sodium iodide solution, therapeutic, per millicurie	1150	K
A9543	Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries	1643	K
A9545	Iodine I-131 tositumomab, therapeutic, per treatment dose	1645	K
A9563	Sodium phosphate P-32, therapeutic, per millicurie	1675	K
A9564	Chromic phosphate P-32 suspension, therapeutic, per millicurie	1676	K
A9600	Strontium Sr-89 chloride, therapeutic, per millicurie	0701	K
A9604	Samarium SM-153 lexidronam, therapeutic, per treatment dose, up to 150 millicuries	1295	K

j. 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 the same date that the nuclear medicine procedure is performed. CMS believes that this situation is extremely rare and expects that the majority of hospitals will not encounter this situation.

When a hospital or a nonhospital location, administers a diagnostic radiopharmaceutical product for a different hospital providing the nuclear medicine scan, hospitals should comply with the OPPS policy that requires that radiolabeled products be reported and billed with the nuclear medicine

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scan. In these cases, the first hospital or nonhospital location may enter into an arrangement under the Social Security Act (Section 1861(w)(1); see http://www.ssa.gov/OP_Home/ssact/title18/1861.htm on the Internet), and as discussed in 42 CFR 410.28(a)(1) (See http://edocket.access.gpo.gov/cfr_2009/octqtr/pdf/42cfr410.28.pdf on the Internet) and defined in 42 CFR 409.3 (See http://edocket.access.gpo.gov/cfr_2009/octqtr/pdf/42cfr409.3.pdf on the Internet), where the second hospital that administers the nuclear medicine scan both bills Medicare for the administration of the nuclear medicine scan with diagnostic radiopharmaceutical and pays the first hospital or nonhospital location that administers the diagnostic radiopharmaceutical some amount for administration of the diagnostic radiopharmaceutical. CMS notes that it considers the radiolabeled product and the nuclear medicine scan to be part of one procedure and CMS would expect both services to be performed together.

k. Implementation of the FB modifier for Diagnostic Radiopharmaceuticals

As discussed in the CY 2011 OPPS/ASC final rule with comment period, beginning on January 1, 2011, CMS is extending the use of the "FB" modifier ("Item Provided Without Cost to Provider, Supplier or Practitioner, or Credit Received for Replacement Device (Examples, but not limited to: Covered Under Warranty, Replaced Due to Defect, Free Samples") to diagnostic radiopharmaceuticals received free of charge or with full credit. Hospitals should report diagnostic radiopharmaceuticals received free of charge (including free samples or trial diagnostic radiopharmaceuticals received free of charge) by reporting the "FB" modifier on the line with the procedure code for the nuclear medicine scan in the APCs listed in Table 10 below. In addition, hospitals should report a token charge of less than \$1.01 for diagnostic radiopharmaceuticals received free of charge or with full credit. The payment amount for the procedures in the APCs listed in Table 10 below will be reduced by the full "policy-packaged" offset amount appropriate for diagnostic radiopharmaceuticals.

l. Payment Offset for Pass-Through Diagnostic Radiopharmaceuticals

Effective for nuclear medicine services furnished on and after April 1, 2009, CMS implemented a payment offset for pass-through diagnostic radiopharmaceuticals under the OPPS. As discussed in the April 2009 OPPS CR6416 (Transmittal 1702; see <https://www.cms.gov/transmittals/downloads/R1702CP.pdf> on the CMS website), pass-through payment for a diagnostic radiopharmaceutical is the difference between the payment for the pass-through product and the payment for the predecessor product that, in the case of diagnostic radiopharmaceuticals, is packaged into the payment for the nuclear medicine procedure in which the diagnostic radiopharmaceutical is used.

Effective April 1, 2009, the diagnostic radiopharmaceutical reported with HCPCS code A9582 (Iobenguane, I-123, diagnostic, per study dose, up to 15 millicuries) was granted pass-through status under the OPPS and assigned status indicator "G". HCPCS code A9582 will continue on pass-through status for CY 2011 and therefore, when HCPCS code A9582 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 A9582 by the corresponding

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nuclear medicine procedure's portion of its APC payment associated with "policy-packaged" drugs (offset amount) so no duplicate radiopharmaceutical payment is made.

The "policy-packaged" portions of the CY 2011 APC payments for nuclear medicine procedures may be found on the CMS website at

http://www.cms.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage in the download file labeled 2011 OPPS Offset Amounts by APC.

CY 2011 APCs to which nuclear medicine procedures are assigned and for which CMS expects a diagnostic radiopharmaceutical payment offset could be applicable in the case of a pass-through diagnostic radiopharmaceutical are displayed in the following table:

APCs to Which Nuclear Medicine Procedures are Assigned for CY 2011

CY 2011 APC	CY 2011 APC Title
0307	Myocardial Positron Emission Tomography (PET) imaging
0308	Non-Myocardial Positron Emission Tomography (PET) imaging
0377	Level II Cardiac Imaging
0378	Level II Pulmonary Imaging
0389	Level I Non-imaging Nuclear Medicine
0390	Level I Endocrine Imaging
0391	Level II Endocrine Imaging
0392	Level II Non-imaging Nuclear Medicine
0393	Hematologic Processing & Studies
0394	Hepatobiliary Imaging
0395	GI Tract Imaging
0396	Bone Imaging
0397	Vascular Imaging
0398	Level I Cardiac Imaging
0400	Hematopoietic Imaging
0401	Level I Pulmonary Imaging
0402	Level II Nervous System Imaging
0403	Level I Nervous System Imaging
0404	Renal and Genitourinary Studies
0406	Level I Tumor/Infection Imaging

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CY 2011 APC	CY 2011 APC Title
0408	Level III Tumor/Infection Imaging
0414	Level II Tumor/Infection Imaging

m. Payment Offset for Pass-Through Contrast Agents

Effective for contrast-enhanced procedures furnished on or after January 1, 2010, CMS implemented a payment offset for pass-through contrast agents, for when a contrast-enhanced procedure that is assigned to a procedural APC with a “policy-packaged” drug amount greater than \$20 (that is not an APC containing nuclear medicine procedures) is billed on the same claim with a pass-through contrast agent on the same date of service. As discussed in the January 2010 OPSS CR6751 (Transmittal 1882; see <http://www.cms.gov/transmittals/downloads/R1882CP.pdf> on the CMS website), CMS will reduce the amount of payment for the contrast agent by the corresponding contrast-enhanced procedure’s portion of its APC payment associated with “policy-packaged” drugs (offset amount) so no duplicate contrast agent payment is made.

CY 2011 procedural APCs for which CMS expects a contrast agent payment offset could be applicable in the case of a pass-through contrast agent are identified in Table 11 of CR7271. Pass-through payment for a contrast agent is the difference between the payment for the pass-through product and the payment for the predecessor product that, in the case of a contrast agent, is packaged into the payment for the contrast-enhanced procedure in which the contrast agent is used. For CY 2011, when a contrast agent with pass-through status is billed with a contrast-enhanced procedure assigned to any procedural APC listed in Table 11 of CR7271 on the same date of service, a specific pass-through payment offset determined by the procedural APC to which the contrast-enhanced procedure is assigned will be applied to payment for the contrast agent to ensure that duplicate payment is not made for the contrast agent.

For CY 2011, HCPCS code A9583 (Injection, gadofosveset trisodium, 1 ml) will continue on pass-through status and will be subject to the payment offset methodology for contrast agents. In addition, HCPCS code C9275 (Injection, hexaminolevulinate hydrochloride, 100 mg, per study dose) describes a contrast agent that has been granted pass-through status beginning January 1, 2011, and will be subject to the payment offset methodology for contrast agents. Both HCPCS codes A9583 and C9275 will be assigned status indicator “G”. Therefore, in CY 2011, CMS will reduce the payment for HCPCS code A9583 and C9275 by the estimated amount of payment that is attributable to the predecessor contrast agent that is packaged into payment for the associated contrast-enhanced procedure reported on the same claim on the same date as HCPCS code A9583 or C9275 if the contrast-enhanced procedure is assigned to one of the APCs listed in Table 11 below. The “policy-packaged” portions of the CY 2011 APC payments that are the offset amounts may be found on the CMS website at http://www.cms.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage in the download file labeled 2011 OPSS Offset Amounts by APC.

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When HCPCS code A9583 or C9275 is billed on a claim on the same date of service as one or more procedures assigned to an APC listed in Table 11 of CR 7271, the OPPS Pricer will identify the offset amount or amounts that apply to the contrast-enhanced procedures that are reported on the claim. Where there is a single contrast-enhanced procedure reported on the claim with a single occurrence of either HCPCS code A9583 or C0275, the OPPS Pricer will identify a single offset amount for the procedure billed and adjust the offset by the wage index value that applies to the hospital submitting the claim. Where there are multiple contrast procedures on the claim with a single occurrence of the pass-through contrast agent, the OPPS Pricer will select the contrast-enhanced procedure with the single highest offset amount and adjust the selected offset amount by the wage index value of the hospital submitting the claim. When a claim has more than one occurrence of either HCPCS code A9583 or C9275, the OPPS Pricer will rank potential offset amounts associated with the units of contrast-enhanced procedures on the claim and identify a total offset amount that takes into account the number of occurrences of the pass-through contrast agent on the claim and adjust the total offset amount by the wage index value of the hospital submitting the claim. The adjusted offset amount will be subtracted from the APC payment for the pass-through contrast agent reported with either HCPCS code A9583 or C9275. The offset will cease to apply when each of these contrast agents expires from pass-through status. Table 11 of CR 7271 is as follows:

**APCs to Which a Pass-Through Contrast Agent Offset May Be Applicable for
CY 2011**

CY 2011 APC	CY 2011 APC Title
0080	Diagnostic Cardiac Catheterization
0082	Coronary or Non-Coronary Atherectomy
0083	Coronary or Non-Coronary Angioplasty and Percutaneous Valvuloplasty
0093	Vascular Reconstruction/Fistula Repair without Device
0104	Transcatheter Placement of Intracoronary Stents
0128	Echocardiogram with Contrast
0152	Level I Percutaneous Abdominal and Biliary Procedures
0229	Transcatheter Placement of Intravascular Shunts
0278	Diagnostic Urography
0279	Level II Angiography and Venography
0280	Level III Angiography and Venography
0283	Computed Tomography with Contrast
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast
0333	Computed Tomography without Contrast followed by Contrast

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CY 2011 APC	CY 2011 APC Title
0337	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast followed by Contrast
0375	Ancillary Outpatient Services When Patient Expires
0383	Cardiac Computed Tomographic Imaging
0388	Discography
0418	Insertion of Left Ventricular Pacing Elect.
0442	Dosimetric Drug Administration
0653	Vascular Reconstruction/Fistula Repair with Device
0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents
0662	CT Angiography
0668	Level I Angiography and Venography
8006	CT and CTA with Contrast Composite
8008	MRI and MRA with Contrast Composite

Clarification of Coding for Drug Administration Services

CMS revised the Medicare Claims Processing Manual, Chapter 4, Section 230.2, to clarify the correct coding of drug administration services. This Manual revision is included as an attachment to CR7271. Drug administration services are to be reported with a line-item date of services on the day they are provided. In addition, beginning in CY 2007, hospitals should report only one initial drug administration service, including infusion services, per encounter for each distinct vascular access site, with other services through the same vascular access site being reported via the sequential, concurrent or additional hour codes. Although new CPT guidance has been issued for reporting initial drug administration services, Medicare contractors are to continue to follow the guidance given in this manual.

Changes to OPPS Pricer Logic

- a. Rural Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in CY 2011. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with the Social Security Act (Section 1833(t)(13)(B); see http://www.ssa.gov/OP_Home/ssact/title18/1833.htm on the Internet), as added by Section 411 of Pub. L. 108-173.

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- b. New OPPS payment rates and copayment amounts will be effective January 1, 2011. All copayments amounts will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the CY 2011 inpatient deductible.
- c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2011. This threshold of 1.75 is multiplied by the total line-item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount. The payment formula is $(\text{cost} - (\text{APC payment} \times 1.75))/2$.
- d. However, there will be a change in the fixed-dollar threshold in CY 2011. The estimated cost of a service must be greater than the APC payment amount plus \$2,025 in order to qualify for outlier payments. The previous fixed-dollar threshold for CY 2010 was \$2,175.
- e. For outliers for CMHCs (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2011. This threshold of 3.4 is multiplied by the total line-item APC payment for APC 0173 to determine eligibility for outlier payments. This multiple amount is also used to determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment formula is $(\text{cost} - (\text{APC 0173 payment} \times 3.4))/2$.
- f. Effective January 1, 2011, one device is eligible for pass-through payment in the OPPS Pricer logic. Category C1749 for new Endoscope, retrograde imaging/illumination colonoscope device (implantable) has an offset amount of \$0 because CMS is not able to identify a portion of the APC payment amount associated with the cost of the device. For outlier purposes, when C1749 is billed with a service included in APC 0143 or APC 0158 it will be associated with specific HCPCS in those APCs for outlier eligibility and payment.
- g. Effective January 1, 2011, the OPPS Pricer will apply a reduced update ratio of 0.980 to the payment and copayment for hospitals that fail to meet their hospital outpatient quality data reporting requirements or that fail to meet CMS validation edits. The reduced payment amount will be used to calculate outlier payments.
- h. Effective January 1, 2011, there will be one diagnostic radiopharmaceutical receiving pass-through payment in the OPPS Pricer logic. For APCs containing nuclear medicine procedures, Pricer will reduce the amount of the pass-through diagnostic radiopharmaceutical payment by the wage-adjusted offset for the APC with the highest offset amount when the radiopharmaceutical with pass-through appears on a claim with a nuclear procedure. The offset will cease to apply when the diagnostic radiopharmaceutical expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals are the "policy-packaged" portions of the CY 2011 APC payments for nuclear medicine procedures and may be found on the CMS website.
- i. Effective January 1, 2011, there will be two contrast agents receiving pass-through payments in the OPPS Pricer logic. For a specific set of APCs identified elsewhere in this update, Pricer will reduce the amount of the pass-through contrast agent by the wage-adjusted offset for the APC with the highest offset amount when the contrast agent with pass-through status appears on a claim on the same date of service with a procedure from the identified list of APCs with procedures using

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contrast agents. The offset will cease to apply when the contrast agent expires from pass-through status. The offset amounts for contrast agents are the “policy-packaged” portions of the CY 2011 APC payments for procedures using contrast agents and may be found on the CMS website.

- j. Pricer will update the payment rates for drugs, biologicals, therapeutic radiopharmaceuticals, and diagnostic radiopharmaceuticals with pass-through status when those payment rates are based on ASP on a quarterly basis.
- k. Effective January 1, 2011, CMS is adopting the Fiscal Year (FY 2011) Inpatient Prospective Payment System (IPPS) post-reclassification wage index values with application of out-commuting adjustment authorized by Section 505 of Pub. L. 108-173 to non-IPPS hospitals.

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. Fiscal Intermediaries (FIs) or 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.

Outpatient Provider Specific File (OPSF)

CR 7271 also provides instructions to Medicare contractor on updating the OPSF.

Updating the OPSF for Expiration of Transitional Outpatient Payments (TOPs)

Section 108 of the Medicare and Medicaid Extenders Act of 2010 (MEA) extends the Outpatient Hold Harmless provision from January 1, 2011, through December 31, 2011, for rural hospitals with 100 or fewer beds at 85 percent of the hold harmless amount and to all Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs), regardless of bed size, at 85 percent of the hold harmless amount from January 1, 2011, through December 31, 2011. Cancer and children's hospitals are permanently held harmless under Section 1833(t)(7)(D)(ii) of the Social Security Act and continue to receive transitional outpatient payments (TOPs)TOPs payments through CY 2011.

For CY 2011, small rural hospitals with 100 or fewer beds and all sole community hospitals (and essential access community hospitals) remain eligible for a TOPS adjustment. Cancer and children's hospitals continue to receive hold harmless TOPs permanently.

Updating the OPSF for the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) Requirements

Effective for OPSS services furnished on or after January 1, 2009, hospitals that have failed to submit timely hospital outpatient quality data as required in Section 1833(t)(17)(A) of the Act will receive payment under the OPSS that reflects a 2 percentage point deduction from the annual OPSS update for failure to meet the HOP QDRP requirements. This reduction will not apply to hospitals not required to submit quality data or hospitals that are not paid under the OPSS.

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For January 1, 2011, Medicare contractors will maintain the accuracy of the provider records in the OPSF by updating the Hospital Quality Indicator field.

Updating the OPSF for the Outpatient Cost to Charge Ratio (CCR)

As stated in Pub 100-04, Medicare Claims Processing Manual, Chapter 4, Section 50.1, Medicare contractors maintain the accuracy of the data and update the OPSF as changes occur in data element values, including changes to provider CCRs. The file of OPSS hospital upper limit CCRs and the file of statewide CCRs are located at www.cms.hhs.gov/HospitalOutpatientPPS under "Annual Policy Files." A spreadsheet listing the statewide CCRs also can be found in the file containing the preamble tables that appears in the most recent OPSS/ASC final rule.

Additional Information

The official instruction, CR7271, issued to your FIs, A/B MACs, and RHHs regarding this change may be viewed at <http://www.cms.gov/transmittals/downloads/R2141CP.pdf> on the CMS website.

The January 2011 revisions to I/OCE data files, instructions, and specifications are provided in CR 7252 titled "January 2011 Integrated Outpatient Code Editor (I/OCE) Specifications Version 12.0". A Medicare Learning Network (MLN) Matters® article MM7252, which is available at <http://www.cms.gov/MLNMattersArticles/downloads/MM7252.pdf> on the CMS website.

If you have any questions, please contact your FIs, A/B MACs, or RHHs at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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