DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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MLN Matters® Number: MM7672 Revised

Related Change Request (CR) #: CR 7672

Related CR Release Date: January 13, 2012

Effective Date: January 1, 2012

Related CR Transmittal #: R2386CP and R152BP

Implementation Date: January 3, 2012

January 2012 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Note: This article was updated on July 31, 2012, to reflect current Web addresses. Previously, it was revised on February 23, 2012, to reflect a revised CR7672, issued on January 13, 2012. CR7672 was revised to correct the fixed dollar threshold amount in Section 17.d of the CR and this article was revised accordingly. Also, the CR was revised to change HCPCS code Q1079 in Table 5 to show the correct code of Q0179. The CR release date, transmittal number, and the Web address for accessing the CR have also been changed. All other information is the same.

Provider Types Affected

This MLN Matters® article is intended for 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 subject to the Outpatient Prospective Payment System (OPPS) that are provided to Medicare beneficiaries.

Provider Action Needed

 STOP – Impact to You

This article is based on change request (CR) 7672 which describes changes to the OPPS to be implemented in the January 2012 OPPS update.

 CAUTION – What You Need to Know

CR7672, from which this article is taken:

1. Describes changes to, and billing instructions for, various payment policies implemented in the January 2012 OPPS update; and
2. Implements several changes and clarifications in the manual requirements for the provision of hospital outpatient therapeutic services, finalized in the Calendar Year (CY) 2012 OPPS/Ambulatory Surgical Center (ASC) Final Rule.

 GO – What You Need to Do

You should make sure your billing staffs are aware of these changes

Background

CR7672 describes changes to and billing instructions for various payment policies implemented in the January 2012 OPPS update. The January 2012 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this CR.

The January 2012 revisions to I/OCE data files, instructions, and specifications are provided in CR7668, “January 2012 Integrated Outpatient Code Editor (I/OCE) Specifications Version 13.0.” (You can find the associated MLN Matters® article at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7668.pdf on the Centers for Medicare & Medicaid Services (CMS) website.)

Key changes to and billing instructions for various payment policies implemented in the October 2010 OPPS update are as follows:

Physician Supervision

In the "Medicare Benefit Policy Manual," Chapter 6 (Hospital Services Covered Under Part B), Section 20.4.4 (Coverage of Outpatient Diagnostic Services Furnished on or After January 1, 2010), CMS is making several revisions to the standards governing the supervision of hospital or Critical Access Hospital (CAH) outpatient therapeutic services.

Currently, CMS requires the direct supervision of outpatient therapeutic services except for nonsurgical extended duration therapeutic services, for which CMS allows general supervision during a portion of the service at the discretion of the supervising practitioner.

CR7672 provides that (effective January 1, 2012) CMS may assign general or personal supervision for the duration of the service to certain hospital outpatient therapeutic services. To enable such assignment, CMS is defining those levels of supervision using the definitions that are used in the Medicare Physician Fee Schedule.

CR7672 also provides (as specified in CMS regulations), that in addition to providing direct supervision certain non-physician practitioners may also furnish the required general or personal supervision.

New Device Pass-Through Categories

The Social Security Act (the Act) (Section 1833(t)(6)(B); see http://www.ssa.gov/OP_Home/ssact/title18/1833.htm on the Internet) requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that additional categories be created for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

CMS is establishing one new device pass-through category as of January 1, 2012. Table 1, below, provides a listing of new coding, Status Indicator (SI), Ambulatory Payment Classification (APC), and payment information concerning the new device category for transitional pass-through payment.

Table 1
New Device Pass-Through Code

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	APC for Device Offset from Payment
C1886	01-01-12	H	1886	Catheter, ablation	Catheter, extravascular tissue ablation, any modality (insertable)	0415

Device Offset from Payment for C1886

Section 1833(t)(6)(D)(ii) of the Act requires that CMS deduct, from pass-through payments for devices, an amount that reflects the portion of the APC payment amount determined to be associated with the cost of the device. (Please see 2005 Federal Register, Vol. 70, page 68627-8 at http://www.gpo.gov/fdsys/search/submitcitation.action?publication=FR on the Internet).

CMS has determined that it is able to identify a portion of the APC payment amount associated with the cost of C1886 (Catheter, extravascular tissue ablation, any modality (insertable)), in APC 0415, Level II, Endoscopy, lower airway. The device offset from payment represents this deduction from pass-through payments for category C1886, when it is billed with a service included in APC 0415. The device offset amount for APC 0415, along with the device offsets for other APCs, is available

under "Annual Policy Files" at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html on the CMS website.

Revised Device Offset from Payment for Category C1840

Effective January 1, 2012, device pass-through category C1840 must be billed with procedure code C9732 (Insertion of ocular telescope prosthesis including removal of crystalline lens), (see New Procedure Code section below) to receive pass-through payment. C9732 is assigned to APC 0234, Level IV Anterior Segment Eye Procedures. Therefore, as of January 1, 2012, device C1840 will be used with an APC 0234 service. The new device offset for CY 2012 for APC 0234, is available under "Annual Policy Files" at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html on the CMS website.

New Procedure Code

CMS is establishing one new procedure code, effective January 1, 2012. Table 2 provides a listing of the descriptor and payment information for this new code.

Table 2
New Procedure Code

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor
C9732	01-01-12	T	0234	Insert ocular telescope pros	Insertion of ocular telescope prosthesis including removal of crystalline lens

Billing Instructions for C9732 and C1840

Pass-through category C1840 (Lens, intraocular (telescopic)), is to be billed and paid for as a pass-through device only when provided with C9732 (Insertion of ocular telescope prosthesis including removal of crystalline lens) beginning on and after the effective date for C9732 of January 1, 2012.

Note: These billing instructions supersede prior billing instructions for C1830 provided in the October 2011 update of the OPPS, Transmittal 2296, CR7545.

Billing for Thermal Anal Lesions by Radiofrequency Energy

For CY 2012, the CPT Editorial Panel created new CPT code 0288T (Anoscopy, with delivery of thermal energy to the muscle of the anal canal (e.g., for fecal incontinence)) to describe the procedure associated with radiofrequency energy creation of thermal anal lesions. Prior to CY 2012, this procedure was described by HCPCS code C9716 (Creations of thermal anal lesions by radiofrequency energy). In Addendum B of the CY 2012 OPPS/ASC final rule, both HCPCS code C9716 and 0288T were assigned to specific APCs. Specifically, HCPCS code C9716 was assigned to APC 0150 (Level IV Anal/Rectal Procedures) and CPT code 0288T was assigned to APC 0148 (Level I Anal/Rectal Procedures). Because HCPCS code C9716 is described by CPT code 0288T, CMS is deleting HCPCS code C9716 on December 31, 2011, since it will be replaced with CPT code 0288T effective January 1, 2012. In addition, CPT code 0288T is being reassigned from APC 0148 to APC 0150 effective January 1, 2012. This change will be reflected in the January 2012 OPPS I/OCE and OPPS Pricer. Table 3 below lists the final OPPS status indicator and APC assignment for HCPCS codes C9716 and 0288T.

Table 3 – CY 2012 OPPS Status Indicator and APC Assignment for HCPCS Codes C9716 and 0288T

HCPCS Code	Short Descriptor	CY 2012 SI	CY 2012 APC
C9716	Radiofrequency energy to anu	D	N/A
0288T	Anoscopy w/rf delivery	T	0150

Cardiac Resynchronization Therapy Payment for CY 2012

Effective for services furnished on or after January 1, 2012, cardiac resynchronization therapy involving an implantable cardioverter defibrillator (CRT-D) will be recognized as a single, composite service combining implantable cardioverter defibrillator procedures and pacing electrode insertion procedures when performed on the same date of service.

CMS also is implementing claims processing edits that will return to providers incorrectly coded claims on which a pacing electrode insertion procedure described by CPT code 33225 (Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (including upgrade to dual chamber system)) is billed without one of the primary CPT codes for insertion of an implantable cardioverter defibrillator or pacemaker as specified in the 2012 CPT code book. CMS is adding new Section 10.2.2 to the "Medicare Claims Processing Manual", Chapter 4, to reflect the implementation of this new composite service policy and claims processing edits for CPT code 33225.

Billing for Drugs, Biologicals, and Radiopharmaceuticals

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 OPPS 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 OPPS 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 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 OPPS payments are based.

CMS reminds hospitals that under the OPPS, if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used in the care of the patient. The mixing together of two or more products does not constitute a "new" drug as regulated by the Food and Drug Administration (FDA) under the New Drug Application (NDA) process. In these situations, hospitals are reminded that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399 (Unclassified drug or biological) is for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned.

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

New CY 2012 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

For CY 2012, 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 Table 4.

Table 4
New CY 2012 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2012 HCPCS Code	CY 2012 Long Descriptor	CY 2012 SI	CY 2012 APC
A9585	Injection gadobutrol, 0.1 ml	N	N/A
C9287	Injection, brentuximab vedotin, 1 mg	G	9287
C9366	EpiFix, per square centimeter	G	9366
J0257	Injection, alpha 1 proteinase inhibitor (human), (glassia), 10 mg	K	1415
J7180	Injection, factor xiii (antihemophilic factor, human), 1 i.u.	G	1416
J7326	Hyaluronan or derivative, gel-one, for intra-articular injection, per dose	K	1417
J8561	Everolimus, oral, 0.25 mg	K	1418
Q4122	Dermacell, per square centimeter	K	1419

Other Changes to CY 2012 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 2012. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2011, and replaced with permanent HCPCS codes in CY 2012. Hospitals should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the active CY 2012 HCPCS and CPT codes.

Table 5 displays those drugs, biologicals, and radiopharmaceuticals that have undergone changes in either their HCPCS/CPT codes, their long descriptors, or both. Each product's CY 2011 HCPCS/CPT code and CY 2011 long descriptor are noted in the two left hand columns, with the CY 2012 HCPCS/CPT code and long descriptor are noted in the adjacent right hand columns.

Table 5

Other CY 2012 HCPCS and CPT Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2011 HCPCS/ CPT code	CY 2011 Long Descriptor	CY 2012 HCPCS/CPT Code	CY 2012 Long Descriptor
C9270	Injection, immune globulin (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg	J1557	Injection, immune globulin, (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg
C9272	Injection, denosumab, 1 mg	J0897	Injection, denosumab, 1 mg
C9273***	Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion	Q2043	Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion
C9274	Crotalidae Polyvalent Immune Fab (Ovine), 1 vial	J0840	Injection, crotalidae polyvalent immune fab (ovine), up to 1 gram
C9276	Injection, cabazitaxel, 1 mg	J9043	Injection, cabazitaxel, 1 mg
C9277	Injection, alglucosidase alfa (Lumizyme), 1 mg	J0221	Injection, alglucosidase alfa, (lumizyme), 10 mg
C9278*	Injection, incobotulinumtoxin A, 1 unit	J0588	Injection, incobotulinumtoxin A, 1 unit
Q2040*	Injection, incobotulinumtoxin A, 1 unit	J0588	Injection, incobotulinumtoxin A, 1 unit
C9280	Injection,eribulin mesylate, 1 mg	J9179	Injection, eribulin mesylate, 0.1 mg

CY 2011 HCPCS/ CPT code	CY 2011 Long Descriptor	CY 2012 HCPCS/CPT Code	CY 2012 Long Descriptor
C9281	Injection, pegloticase, 1 mg	J2507	Injection, pegloticase, 1 mg
C9282	Injection, ceftaroline fosamil, 10 mg	J0712	Injection, ceftaroline fosamil, 10 mg
C9283	Injection, acetaminophen, 10 mg	J0131	Injection, acetaminophen, 10 mg
C9284	Injection, ipilimumab, 1 mg	J9228	Injection, ipilimumab, 1 mg
C9365	Oasis Ultra Tri-Layer matrix, per square centimeter	Q4124	Oasis ultra tri-layer wound matrix, per square centimeter
C9406	Iodine I-123 ioflupane, diagnostic, per study dose, up to 5 millicuries	A9584	Iodine i-123 ioflupane, diagnostic, per study dose, up to 5 millicuries
J0220	Injection, alglucosidase alfa, 10 mg	J0220	Injection, alglucosidase alfa, 10 mg, not otherwise classified
J0256	Injection, alpha 1 - proteinase inhibitor - human, 10 mg	J0256	Injection, alpha 1 proteinase inhibitor (human), not otherwise specified, 10mg
J1561**	'Injection, immune globulin, (Gamunex), intravenous, non-lyophilized (e.g. liquid), 500 mg	J1561	Injection, immune globulin, (Gamunex/Gamunex-c/Gammaked), non-lyophilized (e.g., liquid), 500 mg
Q2044	Injection, belimumab, 10 mg	J0490	Injection, belimumab, 10 mg
Q2042	Injection, hydroxyprogesterone caproate, 1 mg	J1725	Injection, hydroxyprogesterone caproate, 1 mg
J7130	Hypertonic saline solution, 50 or 100 meq, 20 cc vial	J7131	Hypertonic saline solution, 1 ml
Q2041	Injection, von willebrand factor complex (human), wilate, 1 i.u. vwf:rco	J7183	Injection, von willlebrand factor complex (human), wilate, 1 i.u. vwf:rco
Q0179	Ondansetron hydrochloride 8 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	Q0162	Ondansetron 1 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen

*HCPCS code C9278 was replaced with HCPCS code Q2040 effective April 1, 2011. HCPCS code Q2040 was subsequently replaced with HCPCS code J0588, effective January 1, 2012.

** The short descriptor for HCPCS code J1561 has been revised from "Gamunex/Gamunex C" to "Gamunex, Gamunex-C, Gammaked" effective January 1, 2012.

*** HCPCS code C9273 was replaced with HCPCS code Q2043 effective July 1, 2011.

Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective January 1, 2012

For CY 2012, payment for non-pass-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 2012, 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. Payment for drugs and biologicals with pass-through status for the first quarter of CY 2012 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 reinstituted sometime during CY 2012, 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 2012 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, 2012, payment rates for many drugs and biologicals have changed from the values published in the CY 2012 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 2011.

In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2012 release of the OPPS Pricer. CMS is not publishing the updated payment rates in this instruction implementing the January 2012 update of the OPPS. However, the updated payment rates effective January 1, 2012 can be found in the January 2012 update of the OPPS Addendum A and Addendum B at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html on the CMS website.

Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2011, through December 31, 2011

The payment rates for several HCPCS codes were incorrect in the October 2011 OPPS Pricer. The corrected payment rates are listed in Table 6 and have been installed in the January 2012 OPPS Pricer, effective for services furnished on October 1, 2011, through implementation of the January 2012 update. Your Medicare contractor will adjust any claims related to the changes shown in Table 6, provided you make the contractor aware of such claims.

Table 6
Updated payment Rates for Certain HCPCS Codes Effective
October 1, 2011, through December 31, 2011

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J9600	K	0856	Porfimer sodium injection	$19,143.46	$3,828.69

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
Q4121	K	1345	Theraskin	$20.77	$4.15

Correct Reporting of Biologicals When Used As Implantable Devices

When billing for biologicals where the HCPCS code describes a product that is only 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 as a device, separate payment for the device is made. In circumstances where the implanted biological does not have pass-through status, the OPPS payment for the implanted 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.

Hospitals are reminded that HCPCS codes describing skin substitutes (Q4100 – Q4130) should only be reported when used with one of the CPT codes describing application of a skin substitute (15271-15278). These Q codes for skin substitutes should not be billed when used with any other procedure besides the skin substitute application procedures.

Payment for Therapeutic Radiopharmaceuticals

Beginning in CY 2010, non-pass-through separately payable therapeutic radiopharmaceuticals are paid under the OPPS based upon the ASP. If ASP data are unavailable, payment for therapeutic radiopharmaceuticals will be provided based on the most recent hospital mean unit cost data. Therefore, for January 1, 2012, 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 non-pass-through separately payable therapeutic radiopharmaceuticals will be updated on a quarterly basis.

Table 7 - Non-Pass-Through Separately Payable Therapeutic Radiopharmaceuticals for January 1, 2012

CY 2012 HCPCS Code	CY 2012 Long Descriptor	Final CY 2012 APC	Final CY 2012 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

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, 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. (You can find the associated MLN Matters® article at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6416.pdf on the CMS website).

Effective July 1, 2011, the diagnostic radiopharmaceutical reported with HCPCS code A9584 (Iodine i-123 ioflupane, diagnostic, per study dose, up to 5 millicuries) was granted pass-through status under the OPPS and assigned status indicator "G." HCPCS code A9584 will continue on pass-through status for CY 2012 and therefore, when HCPCS code A9584 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 A9584 by the corresponding 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 2012 APC payments for nuclear medicine procedures may be found on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html in the download file labeled 2012 OPPS Offset Amounts by APC.

CY 2012 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:

Table 8
APCs to Which Nuclear Medicine Procedures are Assigned for CY 2012

CY 2012 APC	CY 2012 APC Title
0308	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.

CY 2012 APC	CY 2012 APC Title
0408	Level III Tumor/Infection Imaging.
0414	Level II Tumor/Infection Imaging.

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 $20.00 (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 OPPS CR6751, 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. You can find the MLN Matters® article associated with this CR at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6416.pdf on the CMS website.

CY 2012 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 9. 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 2012, when a contrast agent with pass-through status is billed with a contrast-enhanced procedure assigned to any procedural APC listed in the table 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 2012, HCPCS code C9275 (Injection, hexaminolevulinate hydrochloride, 100 mg, per study dose) will continue on pass-through status and will be subject to the payment offset methodology for contrast agents. HCPCS code C9275 is assigned a status indicator of "G". Therefore, in CY 2012, CMS will reduce the 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 C9275 if the contrast-enhanced procedure is assigned to one of the APCs listed in the table

The "policy-packaged" portions of the CY 2012 APC payments that are the offset amounts may be found on the CMS website at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html in the download file labeled 2012 OPPS Offset Amounts by APC.

Table 9
APCs to Which a Pass-Through Contrast Agent Offset May Be Applicable for CY 2011

CY 2012 APC	CY 2012 APC Title
0080	Diagnostic Cardiac Catheterization
0082	Coronary or Non-Coronary Atherectomy
0083	Coronary Angioplasty, Valvuloplasty, and Level I Endovascular Revascularization
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	Level II Endovascular Revascularization of the Lower Extremity
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
0334	Combined Abdomen and Pelvis CT with Contrast
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
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

As noted in CR7271, in 2011 CMS revised the "Medicare Claims Processing Manual," Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS), Section 230.2 (Coding and Payment for Drug Administration)), to clarify the correct coding of drug administration services. Drug administration services are to be reported with a line-item date of services on the day they are provided. In addition, CMS noted that 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. CMS has subsequently become aware of new CPT guidance regarding the reporting of initial drug administration services in the event of a disruption in service; however, Medicare contractors are to continue to follow the guidance given in this manual. (You can find the associated MLN Matters® article at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7271.pdf on the CMS website and this manual reference at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf on the CMS website).

Provenge Administration

Effective July 1, 2010, the autologous cellular immunotherapy treatment reported with HCPCS code C9273 (Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion) was granted pass-through status under OPPS and assigned status indicator “G.” Effective July 1, 2011, this product was assigned to HCPCS code Q2043 (Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion) with status indicator “G.” HCPCS code Q2043 will continue on pass-through status for CY 2012.

Please note that the HCPCS long descriptor for CY 2012 for HCPCS code Q2043 includes payment for the drug itself, as well “all other preparatory procedures,” referring to the transportation process of collecting immune cells from a patient during a non-therapeutic leukapheresis procedure, subsequently sending the immune cells to the manufacturing facility, and then transporting the immune cells back to the site of service to be administered to the patient. Payment for Q2043 does not include OPPS payment for drug administration.

Billing for Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse – National Coverage Determination (NCD)

Effective for claims with dates of service on and after October 14, 2011, CMS will cover annual alcohol screening, and for those who screen positive, up to four, brief, face-to-face behavioral counseling interventions per year for Medicare beneficiaries, including pregnant women: 1) who misuse alcohol, but whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence (defined as at least three of the following: tolerance, withdrawal symptoms, impaired control, preoccupation with acquisition and/or use, persistent desire or unsuccessful efforts to quit, sustains social, occupational, or recreational disability, use continues despite adverse consequences); and 2) who are competent and alert at the time that counseling is provided; and 3) whose counseling is

furnished by qualified primary care physicians or other primary care practitioners in a primary care setting. In outpatient hospital settings, as in any other setting, services covered under this NCD must be provided by a primary care provider.

To implement this recent coverage determination, CMS created two new G-codes to report annual alcohol screening and brief, face-to-face behavioral counseling interventions. The long descriptors for both G-codes appear in Table 10.

Table 10 – Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse

CY 2012 HCPCS Code	CY 2012 Long Descriptor	CY 2012 Status Indicator	CY 2012 APC
G0442	Annual alcohol misuse screening, 15 minutes	S	0432
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	S	0432

Further reporting guidelines on Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse can be found in Pub. 100-03, "Medicare National Coverage Determinations Manual," Chapter 1, Section 210.8 and Pub. 100-04, "Medicare Claims Processing Manual," Chapter 18, Section 180, as well as in Transmittals 138, and 2358, CR7633 that was published on November 23, 2011. The related MLN Matters® on this NCD is at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7633.pdf on the CMS website.

Screening for Depression in Adults – NCD

Effective for claims with dates of service on and after October 14, 2011, Medicare covers annual screening for adults for depression in the primary care setting that have staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up. For the purposes of this NCD, a primary care setting is defined as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, Ambulatory Surgical Centers (ASCs), independent diagnostic testing facilities, Skilled Nursing Facilities (SNFs), inpatient rehabilitation facilities, and hospices are not considered primary care settings under this definition.

To implement this recent coverage determination, CMS created a new G-code to report the annual depression screening. The long descriptor for the G-code appears in Table 11.

Table 11 – Annual Depression Screening

CY 2012 HCPCS Code	CY 2012 Long Descriptor	CY 2012 Status Indicator	CY 2012 APC
G0444	Annual Depression Screening, 15 minutes	S	0432

Further reporting guidelines on depression screening can be found in Pub. 100-03, "Medicare National Coverage Determinations Manual," Chapter 1, Section 210.9 and Pub. 100-04, "Medicare Claims Processing Manual," Chapter 18, Section 190, as well as in Transmittals 139 and 2359, CR7637 that was published on November 23, 2011. The MLN Matters® article on this NCD is at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7637.pdf on the CMS site.

Billing for Sexually Transmitted Infections (STIs) Screening and High Intensity Behavioral Counseling (HIBC) to Prevent STIs – NCD

Effective for claims with dates of service on and after November 8, 2011, CMS will cover screening for chlamydia, gonorrhea, syphilis, and hepatitis B with the appropriate FDA approved/cleared laboratory tests, used consistent with FDA approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations, when ordered by the primary care provider, and performed by an eligible Medicare provider for these services. Also effective for claims with Dates of Service on and after November 8, 2011, CMS will cover up to two individual - 20 to 30 minute, face to face counseling sessions annually for Medicare beneficiaries for High Intensity Behavioral Counseling (HIBC) to prevent Sexually Transmitted Infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs, if referred for this service by a primary care provider and provided by a Medicare eligible primary care provider in a primary care setting. For the purposes of this NCD, a primary care setting is defined as the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, clinics providing a limited focus of health care services, and hospice are examples of settings not considered primary care settings under this definition.

To implement this recent coverage determination, CMS created a new G-code to report HIBC to Prevent STIs. The long descriptor for the G-code appears in Table 12.

Table 12 –STIs Screening and HIBC to Prevent STIs

CY 2012 HCPCS Code	CY 2012 Long Descriptor	CY 2012 Status Indicator	CY 2012 APC
G0445	High intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes	S	0432

HCPCS code G0445 has been assigned to APC 0432 and given a status indicator assignment of "S." Further reporting guidelines on HIBC to Prevent STIs will be provided in a future CR.

CMS is deleting screening code G0450 (Screening for sexually transmitted infections, includes laboratory tests for Chlamydia, Gonorrhea, Syphilis, and Hepatitis B) previously released on the 2012 HCPCS tape, from the OPPS addenda, effective November 8, 2011. This screening service will now be identified using ICD-9 screening and diagnosis codes. Coding and billing instructions will be issued in an upcoming CR.

Billing for Intensive Behavioral Therapy for Cardiovascular Disease – NCD

Effective for claims with dates of service on and after November 8, 2011, CMS will cover intensive behavioral therapy for cardiovascular disease (referred to below as a CVD risk reduction visit), which consists of the following three components: 1) encouraging aspirin use for the primary prevention of cardiovascular disease when the benefits outweigh the risks for men age 45-79 years and women 55-79 years; 2) screening for high blood pressure in adults age 18 years and older; and 3) intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age, and other known risk factors for cardiovascular and diet-related chronic disease. Effective for claims with dates of service on and after November 8, 2011, CMS covers one face-to-face CVD risk reduction per year for Medicare beneficiaries who are competent and alert at the time that counseling is provided, and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting. For the purposes of this NCD , a primary care setting is defined as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, and hospices are not considered primary care settings under this definition.

To implement this recent coverage determination, CMS created a new G-code to report the CVD risk reduction visit. The long descriptor for the G-code appears in Table 13.

Table 13 – Intensive Behavioral Therapy for Cardiovascular Disease

CY 2012 HCPCS Code	CY 2012 Long Descriptor	CY 2012 Status Indicator	CY 2012 APC
G0446	Intensive behavioral therapy to reduce cardiovascular disease risk, individual, face-to-face, annual, 15 minutes	S	0432

Further reporting guidelines on intensive behavioral therapy for cardiovascular disease can be found in 100-03, Medicare National Coverage Determinations Manual, Pub. chapter 1, section 210.11 and Pub. 100-04, Medicare Claims Processing Manual, chapter 18, section 160, as well as in Transmittals 137 and 2357, CR 7636 that was published on November 23, 2011. The MLN Matters® article on this NCD is at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7636.pdf on the CMS site.

Intensive Behavioral Therapy for Obesity – NCD

Effective for claims with dates of service on and after November 29, 2011, Medicare beneficiaries with obesity (BMI ≥ 30 kg/m^2), who are competent and alert at the time that counseling is provided and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting are eligible for: 1) One face to face visit every week for the first month; 2) One face to face visit every other week for months 2-6; and 3) One face to face visit every month for months 7-12.

To implement this recent coverage determination, CMS created a new G-code to report counseling for obesity. The long descriptor for the G-code appears in Table 14.

Table 14 – Intensive Behavioral Therapy for Obesity

CY 2012 HCPCS Code	CY 2012 Long Descriptor	CY 2012 Status Indicator	CY 2012 APC
G0447	Face-to-face behavioral counseling for obesity, 15 minutes	S	0432

Further reporting guidelines on intensive behavioral therapy for obesity will be provided in a future CR.

CMS is deleting screening code G0449 (Annual face to face obesity screening, 15 minutes) previously released on the 2012 HCPCS tape, from the OPPS addenda, effective November 29, 2011. This screening service will now be identified using ICD-9 screening and diagnosis codes. Coding and billing instructions will be issued in an upcoming CR.

Payment Window for Outpatient Services Treated as Inpatient Services

CMS is revising its billing instructions to clarify that in situations where there is no Part A coverage for the inpatient stay, there is no inpatient service into which outpatient services (i.e., services provided to a beneficiary on the date of an inpatient admission or during the 3 calendar days (or 1 calendar day for a non-IPPS hospital) prior to the date of an inpatient admission) must be bundled. Therefore services provided to the beneficiary prior to the point of admission (i.e., the admission order) may be separately billed to Part B as the outpatient services that they were. See the "Medicare Claims Processing Manual", Chapter 4, Section 10.12 and Chapter 1, Section 50.3.2 for the updated billing guidelines.

Partial Hospitalization APCs

For CY 2012, CMS is updating the four PHP per diem payment rates based on the median costs calculated using the most recent claims data for each provider type: 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). 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 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:

Table 15
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	$97.64
0173	Level II Partial Hospitalization (4 or more services) for CMHCs	$113.83

Table 16
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	$160.74

APC	Group Title	Median Per Diem Costs
0176	Level II Partial Hospitalization (4 or more services) for hospital-based PHPs	$191.16

Molecular Pathology Procedure Test Codes

The American Medical Association's (AMA) CPT Editorial Panel created 101 new molecular pathology procedure test codes for CY 2012. These new codes are in the following CPT code range: 81200-81299, 81300-81383, and 81400-81408. For payment purposes under the hospital OPPS these test codes will be assigned to status indicator "E" (Not recognized by Medicare for outpatient claims; alternate code for the same item or service may be available) effective January 1, 2012. These new codes will be listed in the January 2012 OPPS Addendum B, which can be downloaded from http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html on the CMS website.

Please note that each of the new molecular pathology procedure test code represents a test that is currently being utilized and which may be billed to Medicare. When these types of tests are billed to Medicare, CMS understand that existing CPT test codes are "stacked" to represent a given test. For example, Laboratory A has a genetic test that is generally billed to Medicare in the following manner – 83891 (one time) + 83898 (multiple times) + 83904 (multiple times) + 83909 (multiple times) + 83912 (one time) – in order to represent the performance of the entire test. If the new CPT test coding structure were active, Laboratory A would bill Medicare the new, single CPT test code that corresponds to the test represented by the "stacked" codes in the example above rather than billing each component of the test separately.

Effective January 1, 2012, under the hospital OPPS, hospitals are advised to report both the existing CPT "stacked" test codes that are required for payment and the new single CPT test code that would be used for payment purposes if the new CPT test codes were active. Referring to the example above, Laboratory A would report the existing stacked set of codes that are required to receive payment [i.e., 83891 (one time) + 83898 (multiple times) + 83904 (multiple times) + 83909 (multiple times) + 83912 (one time)]along with the new, single CPT test code that corresponds to the test represented by the "stacked" test codes.

Use of Modifiers for Discontinued Services (Modifiers 52, 53, 73, and 74)

CMS is revising the guidance related to use of modifiers for discontinued services in the "Medicare Claims Processing Manual", Chapter 4, Section 20.6.4.

Changes to OPPS Pricer Logic

a. Rural sole community hospitals and Essential Access Community Hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in CY 2012. 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 Section 1833(t)(13)(B) of the Social Security Act, as added by Section 411 of Pub. L. 108-173.

b. New OPPS payment rates and copayment amounts will be effective January 1, 2012. 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 2012 inpatient deductible.

c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2012. This threshold of 1.75 is multiplied by the total line-item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount. The payment formula is (cost-(APC payment x 1.75))/2.

d. There will be no change in the fixed-dollar threshold in CY 2012. The estimated cost of a service must be greater than the APC payment amount plus $2,025.in order to qualify for outlier payments.

e. For outliers for CMHCs (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2012. 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 (cost-(APC 0173 payment x 3.4))/2.

f. Effective January 1, 2012, 4 devices are eligible for pass-through payment in the OPPS Pricer logic. Categories C1749 (Endoscope, retrograde imaging/illumination colonoscope device (implantable)) and C1830 (Powered bone marrow biopsy needle) have an offset amount of $0 because CMS is not able to identify portions of the APC payment amounts associated with the cost of the devices. Category C1840 (Lens, intraocular (implantable)) and C1886 (Catheter, extravascular tissue ablation, any modality (insertable)) have offset amounts included in the Pricer for CY2012. Pass-through offset amounts are adjusted annually. 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, 2012, 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, 2012, there will be 1 diagnostic radiopharmaceutical receiving pass-through payment in the OPPS Pricer logic. For APCs containing nuclear medicine procedures, the 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 2012 APC payments for nuclear medicine procedures and may be found on the CMS website.

i. Effective January 1, 2012, there will be 1 contrast agent 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 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 2012 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, 2012, CMS is adopting the FY 2012 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 discussed below.

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

You can find the official instruction, CR7672, was issued to your FI, A/B MAC, or RHHI via two transmittals. The first transmittal revises the "Medicare Benefit Policy Manual" and it is at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R152BP.pdf on the CMS website. The second transmittal updates the "Medicare Claims Processing Manual" at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2386CP.pdf on the same site.

You will find the revised "Medicare Benefit Policy Manual," Chapter 6 (Hospital Services Covered Under Part B), Sections 20.4.4 (Coverage of Outpatient Diagnostic Services Furnished on or After January 1, 2010) and 20.5.2 (Coverage of Outpatient Therapeutic Services Incident to a Physicians Service Furnished on or After January 1, 2010); and the revised "Medicare Claims Processing Manual," Chapter 1 (General Billing Requirements), Section 50.3.2 (Policy and Billing Instructions for Condition Code 44), and Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS), Sections 10.2.2 (Cardiac Resynchronization Therapy), 10.12 (Payment Window for Outpatient Services Treated as Inpatient Services), 20.6.4 (Use of Modifiers for Discontinued Services), and 10.2.1 (Healthcare Common Procedure Coding System (HCPCS) and Diagnosis Codes) as an attachment to that CR.

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.

News Flash - **Flu Season is Here!** While seasonal flu outbreaks can happen as early as October, flu activity usually peaks in January. Remind your patients that annual vaccination is recommended for optimal protection. Medicare pays for the seasonal flu vaccine and its administration for seniors and others with Medicare with no co-pay or deductible. Healthcare workers, who may spread the flu to high risk patients, should get vaccinated too. **Protect your patients. Protect your family. Protect yourself. Get the Flu Vaccine—Not the Flu. Remember: The flu vaccine plus its administration are covered Part B benefits. The flu vaccine is NOT a Part D-covered drug.** For more information on coverage and billing of the flu vaccine and its administration, and related provider resources, visit 2011-2012 Provider Seasonal Flu Resources and Immunizations. For the 2011-2012 seasonal flu vaccine payment limits, visit http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html