CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1803	**Date: August 28, 2009**
	Change Request 6626

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

I. SUMMARY OF CHANGES: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the October 2009 OPPS update. The October 2009 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this Change Request (CR).

October 2009 revisions to the I/OCE data files, instructions, and specifications are provided in CR 6618, October 2009 Integrated Outpatient Code Editor (I/OCE) Specifications Version 10.3.

New / Revised Material
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	1/50.3.1/Background
R	1/50.3.2/Policy and Billing Instructions for Condition Code 44

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1803	Date: August 28, 2009	Change Request: 6626

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

Effective Date: October 1, 2009

Implementation Date: October 5, 2009

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the October 2009 OPPS update. The October 2009 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this Change Request (CR).

October 2009 revisions to the I/OCE data files, instructions, and specifications are provided in CR 6618, "October 2009 Integrated Outpatient Code Editor (I/OCE) Specifications Version 10.3."

B. Policy:

1. Changes to Procedure and Device Edits for October 2009

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

2. Billing for Drugs, Biologicals, and Radiopharmaceuticals

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

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

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

For CY 2009, payment for nonpass-through drugs and biologicals is made at a single rate of ASP+4 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug or biological. In CY 2009, a single payment of ASP+6 percent for pass-through drugs and biologicals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. We note that for the third quarter of CY 2009, payment for drugs and biologicals with pass-through status is not made at the Part B Drug Competitive Acquisition Program (CAP) rate, as the CAP program is suspended beginning January 1, 2009. Should the Part B Drug CAP program be reinstituted sometime during CY 2009, we would again use the Part B drug CAP rate for pass-through drugs and biologicals if they are a part of the Part B drug CAP program, as required by the statute.

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

b. New HCPCS Code Effective for Certain Drugs and Biologicals

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

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

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

c. Adjustment to Status Indicator for HCPCS code Q4115 Effective October 1, 2009

CMS assigned HCPCS code Q4115, Skin substitute, alloskin, per square centimeter, a status indicator of "M" for services billed on or after July 1, 2009 through September 30, 2009, indicating that the service is not billable to the FI/MAC. For services furnished on or after October1, 2009, CMS is changing the status indicator for Q4115 to "K" to indicate that separate payment may be made for this product. HCPCS code Q4115 is assigned to APC 1287 (Alloskin skin sub).

d. Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2008 through June 30, 2008

The payment rates for several HCPCS codes were incorrect in the April 2008 OPPS Pricer. The corrected payment rates are listed in Table 2 below and have been installed in the October 2009 OPPS Pricer, effective for services furnished on April 1, 2008, through implementation of the July 2008 update.

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

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

e. Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2008 through September 30, 2008

The payment rates for several HCPCS codes were incorrect in the July 2008 OPPS Pricer. The corrected payment rates are listed in Table 3 below and have been installed in the October 2009 OPPS Pricer, effective for services furnished on July 1, 2008, through implementation of the October 2008 update.

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

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

f. Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2008 through December 31, 2008

The payment rates for several HCPCS codes were incorrect in the October 2008 OPPS Pricer. The corrected payment rates are listed in Table 4 below and have been installed in the October 2009 OPPS Pricer, effective for services furnished on October 1, 2008, through implementation of the January 2009 update.

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

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J1441	K	7049	Filgrastim 480 mcg injection	$304.32	$60.86
J2505	K	9119	Injection, pegfilgrastim 6mg	$2,175.85	$435.17
J9209	K	0732	Mesna injection	$6.99	$1.40
J9226	G	1142	Supprelin LA implant	$14,413.33	$2,855.47
J9303	G	9235	Panitumumab injection	$81.86	$16.22

g. Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2009 through September 30, 2009

The payment rates for several HCPCS codes were incorrect in the July 2009 OPPS Pricer. The corrected payment rates are listed in Table 5 below and have been installed in the October 2009 OPPS Pricer, effective for services furnished on July 1, 2009, through implementation of the October 2009 update.

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

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

h. Recognition of Multiple HCPCS Codes For Drugs

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

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

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

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

j. Correct Reporting of Units for Drugs

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

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

It has come to our attention that there are certain rare instances when a diagnostic radiopharmaceutical may be administered to a beneficiary in a given calendar year prior to a hospital furnishing an associated nuclear medicine procedure in the subsequent calendar year. As Medicare billing does not allow multiple calendar year services to be reported on a single claim, some hospitals have had difficulty reporting the radiolabeled product on the same claim as the nuclear medicine procedure when these associated services are not provided to the beneficiary in the same calendar year. Because of the nuclear medicine procedure-to-radiolabeled product claims processing edits included in the I/OCE, payment for a nuclear medicine procedure requires reporting of an appropriate radiolabeled product on the same claim. In this limited circumstance, hospitals are instructed to report the date the radiolabeled product is furnished to the beneficiary as the same date that the nuclear medicine procedure is performed. We believe that this situation is extremely rare and we expect that the majority of hospitals will not encounter this situation.

l. H1N1 Vaccine and Administration Level II HCPCS Codes

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

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

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

Additional information will be made available to contractors through a separate CR.

3. Updating the OPSF for New CBSA and Wage Indices for Hospitals Receiving Section 508 Reclassification

This serves as a reminder that per our instructions published in Transmittal 1657, Change Request (CR) 6320, issued December 31, 2008, contractors shall update the OPSF specifically for providers for which reclassifications under section 508 have been extended through September 30, 2009, that will no longer be reclassified under section 508 for the last quarter of CY 2009 (10/1-12/31). Contractors shall do the following to update the OPSF:

1) Create a new provider record, effective October 1, 2009; and
    a) If the provider is not eligible for the out commuting adjustment,
        i. Enter a blank in the Special Payment Indicator field; and
        ii. Enter zeroes in the special wage index field.

    b) If the provider is eligible for the out commuting adjustment,
        i. Enter a value of "1" in the Special Payment Indicator field; and
        ii. Enter the final wage index value (given for the provider in column 4 of Table 6) in the Special Wage Index field in the OPSF.

Table 6 – October 1, 2009 to December 31, 2009 Wage Index for Section 508 Hospitals that Receive Payment Under the OPPS

Provider	CBSA	Final Wage Index for last quarter of CY 2009 (10/1-12/31) includes out-commuting adjustment, if applicable	Section 505 Out-Commuting Adjustment	Section 508 Provider
010150	01	0.7745	YES	YES
020008	02	1.1852		YES
050549	37100	1.1972		YES
060075	06	0.9311		YES
070001	35300	1.2214		YES
070005	35300	1.2214		YES
070016	35300	1.2214		YES
070017	35300	1.2214		YES
070019	35300	1.2214		YES
070022	35300	1.2214		YES
070031	35300	1.2214		YES
070039	35300	1.2214		YES
150034	23844	0.9267		YES
160040	47940	0.8954		YES
160064	16	0.8954		YES
160067	47940	0.8954		YES
160110	47940	0.8954		YES
190218	19	0.7656		YES
220046	38340	1.0406		YES
230003	26100	0.9287	YES	YES
230004	34740	1.019		YES
230013	47644	0.9964	YES	YES
230019	47644	0.9964	YES	YES
230020	19804	1.002		YES
230024	19804	1.002		YES
230029	47644	0.9964	YES	YES
230036	23	0.8863		YES
230038	24340	0.9245		YES
230053	19804	1.002		YES
230059	24340	0.9245		YES
230066	34740	1.019		YES
230071	47644	0.9964	YES	YES
230072	26100	0.9287	YES	YES
230089	19804	1.002		YES
230097	23	0.8863		YES
230104	19804	1.002		YES
230106	24340	0.9245		YES
230119	19804	1.002		YES
230130	47644	0.9964	YES	YES
230135	19804	1.002		YES
230146	19804	1.002		YES
230151	47644	0.9964	YES	YES

Provider	CBSA	Final Wage Index for last quarter of CY 2009 (10/1-12/31) includes out-commuting adjustment, if applicable	Section 505 Out-Commuting Adjustment	Section 508 Provider
230165	19804	1.002		YES
230174	26100	0.9287	YES	YES
230176	19804	1.002		YES
230207	47644	0.9964	YES	YES
230223	47644	0.9964	YES	YES
230236	24340	0.9245		YES
230254	47644	0.9939		YES
230269	47644	0.9964	YES	YES
230270	19804	1.002		YES
230273	19804	1.002		YES
230277	47644	0.9964	YES	YES
250002	25	0.7625		YES
250122	25	0.7625		YES
270023	33540	0.8876		YES
270032	27	0.8607		YES
270057	27	0.8607		YES
310021	45940	1.1294		YES
310028	35084	1.1518		YES
310050	35084	1.1717	YES	YES
310051	35084	1.1518		YES
310060	10900	1.1294		YES
310115	10900	1.1294		YES
310120	35084	1.1518		YES
330049	39100	1.0922		YES
330106	35004	1.2809	YES	YES
330126	39100	1.1564	YES	YES
330135	39100	1.1564	YES	YES
330205	39100	1.1564	YES	YES
330264	39100	1.1564	YES	YES
340002	11700	0.9159		YES
350002	13900	0.7336		YES
350003	35	0.7336		YES
350006	35	0.7336		YES
350015	13900	0.7336		YES
350017	35	0.7336		YES
350030	35	0.7336		YES
380090	38	1.0862		YES
390001	42540	0.8333		YES
390003	39	0.8333		YES
390072	39	0.8333		YES
390095	42540	0.8333		YES
390119	42540	0.8333		YES
390137	42540	0.8333		YES
390169	42540	0.8333		YES

Provider	CBSA	Final Wage Index for last quarter of CY 2009 (10/1-12/31) includes out-commuting adjustment, if applicable	Section 505 Out-Commuting Adjustment	Section 508 Provider
390185	42540	0.8333		YES
390192	42540	0.8333		YES
390237	42540	0.8333		YES
390270	42540	0.8333		YES
430005	43	0.8396		YES
430015	43	0.8396		YES
430048	43	0.8525	YES	YES
430060	43	0.8396		YES
430064	43	0.8396		YES
450072	26420	0.989		YES
450591	26420	0.989		YES
470003	15540	1.0255		YES
490001	49	0.8032		YES
530015	53	0.9189		YES

[1]Table 6 shows the final wage indexes, including the out-commuting adjustment if applicable, that would be in effect under the OPPS for providers that would no longer be reclassified under section 508 for the last quarter of CY 2009 (10/1/09-12/31/09).

4. Clarification Related to Condition Code 44

The changes to Pub.100-04, Medicare Claims Processing Manual, Chapter 1, section 50.3, incorporate minor revisions clarifying the use of Condition Code 44.

5. 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.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6626.1	Medicare contractors shall install the October 2009 OPPS Pricer.	X		X		X	X				COBC
6626.2	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service that fall on or after April 1, 2008, but prior to July 1, 2008; 2) Contain HCPCS code listed in Table 2; and 3) Were originally processed prior to the installation of the October 2009 OPPS Pricer.	X		X		X					COBC
6626.3	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service that fall on or after July 1, 2008, but prior to October 1, 2008; 2) Contain HCPCS code listed in Table 3; and 3) Were originally processed prior to the installation of the October 2009 OPPS Pricer.	X		X		X					COBC
6626.4	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service that fall on or after October 1, 2008, but prior to January 1, 2009; 2) Contain HCPCS code listed in Table 4; and 3) Were originally processed prior to the installation of the October 2009 OPPS Pricer.	X		X		X					COBC
6626.5	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service that fall on or after July 1, 2009, but prior to October 1, 2009; 2) Contain HCPCS code listed in Table 5; and 3) Were originally processed prior to the installation of the October 2009 OPPS Pricer.	X		X		X					COBC
6626.6	Medicare contractors shall not apply deductible and beneficiary copayment to HCPCS code G9141 (for both OPPS and non OPPS providers).	X		X		X	X				COBC
6626.7	Medicare contractors shall update the OPSF as necessary with special consideration of section 508 hospitals as explained in Policy section 3 above.	X		X		X					COBC

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6626.8	Medicare contactors shall manually add HCPCS codes: Q2024, G9141, and G9142 to their systems. These HCPCS codes will be included with the October 2009 IOCE update. They are currently not on the 2009 HCPCS file; however, they will be listed on the CMS Web site at http://www.cms.hhs.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp#TopOfPage. Status and payment indicators for these HCPCS codes will be listed in the October 2009 update of the OPPS Addendum A and Addendum B on the CMS Web site.	X		X		X	X				COBC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6626.9	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X		X					COBC

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
CR 6618	"October 2009 Integrated Outpatient Code Editor (I/OCE) Specifications Version 10.3"

Section B: For all other recommendations and supporting information:

V. CONTACTS

Pre-Implementation Contact: Marina Kushnirova at marina.kushnirova@cms.hhs.gov

Post-Implementation Contact: Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual
Chapter 1 - General Billing Requirements

50.3.1 - Background
(Rev.1803, Issued: 08-28-09, Effective: 10-01-09, Implementation: 10-05-09)

Payment is made under the hospital Outpatient Prospective Payment System (OPPS) for Medicare Part B services furnished by hospitals subject to the OPPS, and under the applicable other payment methodologies for hospitals not subject to the OPPS. "Outpatient" means a person who has not been admitted as an inpatient but who is registered on the hospital or critical access hospital (CAH) records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH.

Patients are admitted to the hospital as inpatients only on the recommendation of a physician or licensed practitioner permitted by the State to admit patients to a hospital. For more detail, see the hospital Conditions of Participation (CoP) at 42 C.F.R. §482.12(c). In some instances, a physician may order a beneficiary to be admitted as an inpatient, but upon reviewing the case, the hospital's utilization review (UR) committee determines that an inpatient level of care does not meet the hospital's admission criteria.

The hospital CoP*s* require all hospitals to have a UR plan. The hospital *must* ensure that all the UR activities, including the review of medical necessity of hospital admissions and continued stays are fulfilled as described in 42 CFR §482.30. The CoP standards in 42 C.F.R. §482.30 of the regulations are comprehensive and broadly applicable with regard to the medical necessity of admissions to the hospital and continued inpatient stays. *The conditions for the use of Condition Code 44, as stated in section 50.3.2 below, require physician concurrence with the UR committee decision. For Condition Code 44 decisions, in accordance with 42 CFR §482.30(d)(1), one physician member of the UR committee may make the determination for the committee that the inpatient admission is not medically necessary. This physician member of the UR committee must be a different person from the concurring physician, who is the physician responsible for the care of the patient.*

Review of admissions may be performed before, at, or after hospital admission. More information about the hospital CoP may be found in Pub.100-07, State Operations Manual, Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals.

Taking into consideration these requirements, CMS obtained a condition code from the National Uniform Billing Committee (NUBC), effective April 1, 2004, that specifies:

Condition Code 44--Inpatient admission changed to outpatient – For use on outpatient claims only, when the physician ordered inpatient services, but upon internal utilization review performed before the claim was originally submitted, the hospital determined that the services did not meet its inpatient criteria.

CMS set the policy for the use of Condition Code 44 to address those relatively infrequent occasions, such as a late-night weekend admission when no case manager is on duty to offer guidance, when internal review subsequently determines that an inpatient admission does not meet hospital criteria and that the patient would have been registered as an outpatient under ordinary circumstances. The State Operations Manual states that in no case may a non-physician make a final determination that a patient's stay is not medically necessary or appropriate (see Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals). However, CMS encourages and expects hospitals to employ case management staff to facilitate the application of hospital admission protocols and criteria, to facilitate communication between practitioners and the UR committee or Quality Improvement Organization (QIO), and to assist the UR committee in the decision-making process. Use of Condition Code 44 is not intended to serve as a substitute for adequate staffing of utilization management personnel or for continued education of physicians and hospital staff about each hospital's existing policies and admission protocols. As education and staffing efforts continue to progress, the need for hospitals to correct inappropriate admissions and to report condition code 44 should become increasingly rare.

50.3.2. - Policy and Billing Instructions for Condition Code 44

(Rev.1803, Issued: 08-28-09, Effective: 10-01-09, Implementation: 10-05-09)

In cases where a hospital utilization review committee determines that an inpatient admission does not meet the hospital's inpatient criteria, the hospital may change the beneficiary's status from inpatient to outpatient and submit an outpatient claim (bill type 13x or 85x) for medically necessary Medicare Part B services that were furnished to the beneficiary, provided all of the following conditions are met:

1. The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital;

2. The hospital has not submitted a claim to Medicare for the inpatient admission;

3. A physician concurs with the utilization review committee's decision; and

4. The physician's concurrence with the utilization review committee's decision is documented in the patient's medical record.

When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be billed as an outpatient episode of care *on a 13x bill type and outpatient services that were ordered and furnished should be billed as appropriate*. Refer to Pub. 100-04, Medicare Claims Processing Manual; Chapter 30, Financial Liability Protections; Section 20, Limitation On Liability (LOL) Under §1879 Where Medicare Claims Are Disallowed, for information regarding financial liability protections.

When the hospital submits a 13x or 85x bill for services furnished to a beneficiary whose status was changed from inpatient to outpatient, the hospital is required to report Condition Code 44 on the outpatient claim in one of Form Locators 24-30, or in the ANSI X12N 837 I in Loop 2300, HI segment, with qualifier BG, on the outpatient claim. Additional information may be found in Chapter 25 of this manual, (Completing and Processing the Form CMS-1450 Data Set). Condition Code 44 is used by CMS and QIOs to track and monitor these occurrences. The reporting of Condition Code 44

on a claim does not affect the amount of hospital outpatient payment that would otherwise be made for a hospital outpatient claim that did not require the reporting Condition Code 44.

One of the requirements for the use of Condition Code 44 is physician concurrence with the determination that an inpatient admission does not meet the hospital's admission criteria and that the patient should have been registered as an outpatient. This prerequisite for use of Condition Code 44 is consistent with the requirements in the CoP in 42 C.F.R. §482.30 (d) of the regulations. This paragraph provides that the practitioner or practitioners responsible for the care of the patient must be consulted and allowed to present their views before the UR committee or QIO makes its determination that an admission is not medically necessary. It may also be appropriate to include the practitioner who admitted the patient if this is a different person than the practitioner responsible for the care of the patient.

If the conditions for use of Condition Code 44 are not met, the hospital may submit a 12x bill type for covered "Part B Only" services that were furnished to the inpatient. Medicare may still make payment for certain Part B services furnished to an inpatient of a hospital when payment cannot be made under Part A because an inpatient admission is determined not to be medically necessary. Information about "Part B Only" services is located in Pub. 100-02, Medicare Benefit Policy Manual, chapter 6, section 10. Examples of such services include, but are not limited to, diagnostic x-ray tests, diagnostic laboratory tests, surgical dressings and splints, prosthetic devices, and certain other services. The Medicare Benefit Policy Manual includes a complete list of the payable "Part B Only" services.

Entries in the medical record cannot be expunged or deleted and must be retained in their original form. Therefore, all orders and all entries related to the inpatient admission must be retained in the record in their original form. If a patient's status changes in accordance with the requirements for use of Condition Code 44, the change must be fully documented in the medical record, complete with orders and notes that indicate why the change was made, the care that was furnished to the beneficiary, and the participants in making the decision to change the patient's status.