DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

The ICD-10-related implementation date is now October 1, 2015. The switch to the new code set will affect every aspect of how your organization provides care, but with adequate planning and preparation, you can ensure a smooth transition for your practice. Keep Up to Date on ICD-10. Please visit the ICD-10 website for the latest news and resources to help you prepare.

MLN Matters® Number: MM8141

Related Change Request (CR) #: CR 8141

Related CR Release Date: December 14, 2012

Effective Date: January 1, 2013

Related CR Transmittal #: R2611CP

Implementation Date: January 7, 2013

January 2013 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Provider Types Affected

This MLN Matters® Article is intended for providers who submit claims to Medicare contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for services subject to the Outpatient Prospective Payment System (OPPS) provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8141 which describes changes to the OPPS to be implemented in the January 2013 OPPS update.CR8141 describes changes to and billing instructions for various payment policies implemented in the January 2013 OPPS update. The January 2013 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 CR8141. Make sure that your billing staffs are aware of these changes.

Background

Change Request (CR) 8141 describes changes to and billing instructions for various payment policies implemented in the January 2013 OPPS update. The January 2013 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 CR8141.

The January 2013 revisions to I/OCE data files, instructions, and specifications are provided in the upcoming January 2013 I/OCE CR, which is CR8137. Upon release of CR8137, a related MLN Matters® Article at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8137.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

Key changes to and billing instructions for various payment policies implemented in the January 2013 OPPS update are as follows:

Changes to Device Edits in January 2013

The most current list of device edits can be found under "Device, Radiolabeled Product, and Procedure Edits" at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/** on the CMS website. Failure to pass these edits will result in the claim being returned to the provider.

Current Procedural Terminology (CPT) Codes for Intracoronary Stent Placement Procedures

Effective January 1, 2013, the American Medical Association's (AMA's) Current Procedural Terminology (CPT) Editorial Panel is deleting CPT codes 92980 (Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel) and 92981 (Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel), which are used to describe nondrug-eluting intracoronary stent placement procedures and replacing them with new CPT codes.

The creation of new CPT codes involving intracoronary stent placement procedures for Calendar Year (CY) 2013 requires CMS to create nine new HCPCS C-codes and to delete two existing HCPCS G-codes in order to maintain existing OPPS policy of differentiating payment for intracoronary stent placement procedures involving nondrug-eluting and drug-eluting stents for CY 2013.

CMS is updating the "Medicare Claims Processing Manual," Chapter 4, Section 61.5 as an attachment to CR8141 to reflect these changes to the intracoronary stent placement HCPCS codes and reporting guidelines.

Since CY 2003, under the OPPS, CMS assigned coronary stent placement procedures to separate APCs based on the use of nondrug-eluting or drug-eluting stents (APC 0104 (Transcatheter Placement of Intracoronary Stents) or APC 0656 (Transcatheter Placement of Intracoronary Drug-Eluting Stents), respectively). In order to effectuate this policy, CMS created HCPCS G-codes G0290 (Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel) and G0291 (Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel) for drug-eluting intracoronary stent placement procedures that parallel existing CPT codes 92980 (Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel) and 92981 (Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel), which are used to describe nondrug-eluting intracoronary stent placement procedures. For CY 2012 and years prior, CPT codes 92980 and 92981 have been assigned to APC 0104, while HCPCS codes G0290 and G0291 have been assigned to APC 0656.

Effective January 1, 2013, the AMA's CPT Editorial Panel is deleting CPT codes 92980 and 92981 and replacing them with the following new CPT codes:

- CPT code 92928 (Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch);
- CPT code 92929 (Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure));
- CPT code 92933 (Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch);
- CPT code 92934 (Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure));
- CPT code 92937(Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel);
- CPT code 92938 (Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including

distal protection when performed; each additional branch subtended by the bypass graft (List separately in addition to code for primary procedure));

- CPT code 92941 (Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel);
- CPT code 92943 (Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel); and
- CPT code 92944 (Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (List separately in addition to code for primary procedure)).

In order to maintain the existing policy of differentiating payment for intracoronary stent placement procedures involving nondrug-eluting and drug-eluting stents, CMS is deleting HCPCS codes G0290 and G0291 and replacing them with the following new HCPCS C-codes to parallel the new CPT codes:

- HCPCS code C9600 (Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch);
- HCPCS code C9601 (Percutaneous transcatheter placement of drug-eluting intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure));
- HCPCS code C9602 (Percutaneous transluminal coronary atherectomy, with drug eluting intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch);
- HCPCS code C9603 (Percutaneous transluminal coronary atherectomy, with drug-eluting intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure));
- HCPCS code C9604 (Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel);

- HCPCS code C9605 (Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (List separately in addition to code for primary procedure));
- HCPCS code C9606 (Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel);
- HCPCS code C9607 (Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; single vessel); and
- HCPCS code C9608 (Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (List separately in addition to code for primary procedure)).

CPT codes 92928, 92933, 92929, 92934, 92937, 92938, 92941, 92943, and 92944 should be used to describe nondrug-eluting intracoronary stent placement procedures and are assigned to APC 0104. HCPCS codes C9600, C9601, C9602, C9603, C9604, C9605, C9606, C9607, and C9608 are assigned to APC 0656.

Outpatient payment for Composite APC 8000 (Cardiac Electrophysiologic Evaluation and Ablation Composite)

CMS is modifying the "Medicare Claims Processing Manual," Chapter 4, Section 10.2.1 (included as an attachment to CR8141), to account for coding changes to cardiac electrophysiologic evaluation and ablation codes by the AMA's CPT Editorial Panel. The CPT Editorial Panel deleted CPT codes 93651 and 93652, effective 1/1/2013, and created new CPT codes 93653, 93654, and 93656, effective 1/1/2013.

Composite APC	Composite APC Title	Criteria for Composite Payment
8000	Cardiac Electrophysiologic Evaluation and Ablation Composite	At least one unit of CPT code 93619 or 93620 and at least one unit of CPT code 93650 on the same date of service; or, at least one unit of CPT codes 93653, 93654, or 93656 (no additional concurrent service codes required).

New 'Sometimes Therapy' Services that May Be Paid as Non-Therapy Services for Hospital Outpatients

Effective January 1, 2013, CMS is adding two HCPCS codes that are new for CY 2013 to the list of Physical Therapy/Speech-Language Pathology/Occupational Therapy (PT/SLP/OT) "sometimes therapy" services that may be paid under certain circumstances to a facility under the OPPS. They are:

HCPCS Code	Long Descriptor
G0456	Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters.
G0457	Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters.

The limited set of sometimes therapy services listed in the manual are paid under the OPPS when they are not furnished as therapy, meaning they are not furnished under a certified therapy plan of care. When a hospital furnishes these services to a hospital outpatient as non-therapy, the hospital may submit a claim for facility payment for the services to the OPPS.

Coding Changes for Partial Hospitalization Program (PHP) Services

In the "Medicare Claims Processing Manual" (Chapter 4, Sections 260.1 and 260.1.1; included as an attachment to CR8141), several revisions are being made to the PHP billing code set. Effective January 1, 2013, the AMA's CPT Editorial Panel deleted 28 psychiatric CPT codes, including those related to PHP services, and replaced them with 12 new CPT codes. As a result of the AMA's CPT coding changes to the psychiatric CPT codes, CMS is making corresponding changes to the PHP code set that is used for billing and documenting PHP services.

Drugs, Biologicals, and Radiopharmaceuticals

New CY 2013 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

For CY 2013, several new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. These new codes are listed in the following:

Table 1 – New CY 2013 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2013 HCPCS Code	CY 2013 Long Descriptor	CY 2013 SI	CY 2013 APC
C9294	Injection, taliglucerase alfa, 10 units	G	9294
C9295	Injection, carfilzomib, 1 mg	G	9295
C9296	Injection, ziv-aflibercept, 1 mg	G	9296
J1744	Injection, icatibant, 1 mg	K	1443
J2212	Injection, methylnaltrexone, 0.1 mg	K	1445
J7315	Mitomycin, ophthalmic, 0.2 mg	N	
Q4134	Hmatrix, per square centimeter	E	
Q4135	Mediskin, per square centimeter	E	
Q4136	Ez-derm, per square centimeter	E	
Q9969	Tc-99m from non highly-enriched uranium source, full cost recovery add-on, per study dose	K	1442

Other Changes to CY 2013 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 2013. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2012, and replaced with permanent HCPCS codes in CY 2013. 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 2013 HCPCS and CPT codes.

Table 2 below (also included in Attachment A, CR8141) notes those drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS/CPT code, their long descriptor, or both. Each product's CY 2012 HCPCS/CPT code and long descriptor are noted in the two left hand columns and the CY 2013 HCPCS/CPT code and long descriptor are noted in the adjacent right hand columns.

Table 2 – Other CY 2013 HCPCS and CPT Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2012 HCPCS/ CPT code	CY 2012 Long Descriptor	CY 2013 HCPCS/ CPT Code	CY 2013 Long Descriptor
C9279	Injection, ibuprofen, 100 mg	J1741	Injection, ibuprofen, 100 mg
C9286	Injection, belatacept, 1 mg	J0485	Injection, belataccept, 1 mg
C9287	Injection, brentuximab vedotin, 1 mg	J9042	Injection, brentuximab vedotin, 1 mg
C9288	Injection, centruroides (scorpion) immune f(ab)2 (equine), 1 vial	J0716	Injection, centruroides immune f(ab)2, up to 120 milligrams
C9289	Injection, asparaginase erwinia chrysanthemi, 1,000 international units (i.u.)	J9019	Injection, asparaginase (Erwinaze), 1,000 IU
C9366	EpiFix, per square centimeter	Q4131	Epifix, per square centimeter
C9368	Grafix core, per square centimeter	Q4132	Grafix core, per square centimeter
C9369	Grafix prime, per square centimeter	Q4133	Grafix prime, per square centimeter
J1051	Injection, medroxyprogesterone acetate, 50 mg	J1050	Injection, medroxyprogesterone acetate, 1 mg
J8561	Everolimus, oral, 0.25 mg	J7527	Everolimus, oral, 0.25 mg
J9020	Injection, asparaginase, 10,000 units	J9020	Injection, Asparaginase, Not Otherwise Specified, 10,000 Units
J9280	Mitomycin, 5 mg	J9280	Injection, mitomycin, 5 mg
Q2045*	Injection, human fibrinogen concentrate, 1 mg	J7178	Injection, human fibrinogen concentrate, 1 mg
Q2046*	Injection, aflibercept, 1 mg	J0178	Injection, aflibercept, 1 mg
Q2047	Injection, peginesatide, 0.1 mg (for esrd on dialysis)	J0890	Injection, peginesatide, 0.1 mg (for esrd on dialysis)
Q2048*	Injection, doxorubicin hydrochloride, liposomal, doxil, 10 mg	J9002	Injection, doxorubicin hydrochloride, liposomal, doxil, 10 mg
Q4119	Matristem wound matrix, per square centimeter	Q4119	Matristem wound matrix, psmx, rs, or psm, per square centimeter
Q4126	Memoderm, per square centimeter	Q4126	Memoderm, dermaspan, tranzgraft or integuply, per square centimeter

CY 2012 HCPCS/ CPT code	CY 2012 Long Descriptor	CY 2013 HCPCS/ CPT Code	CY 2013 Long Descriptor
Q4128	Flexhd or allopatch hd, per square centimeter	Q4128	Flex hd, allopatch hd, or matrix hd, per square centimeter

*HCPCS code J1680 was replaced with HCPCS code Q2045 effective July 1, 2012. HCPCS code Q2045 was subsequently replaced with HCPCS code J7178, effective January 1, 2013.

*HCPCS code C9291 was replaced with HCPCS code Q2046 effective July 1, 2012. HCPCS code Q2046 was subsequently replaced with HCPCS code J0178, effective January 1, 2013.

*HCPCS code J9001 was replaced with HCPCS code Q2048 effective July 1, 2012. HCPCS code Q2048 was subsequently replaced with HCPCS code J9002, effective January 1, 2013.

Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective January 1, 2013

For CY 2013, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2013, 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. 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, 2013, payment rates for many drugs and biologicals have changed from the values published in the CY 2013 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 2012. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2013 release of the OPPS Pricer. CMS is not publishing the updated payment rates in this Change Request implementing the January 2013 update of the OPPS. However, the updated payment rates effective January 1, 2013, can be found in the January 2013 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 Rate for a HCPCS Code Effective April 1, 2012, through June 30, 2012

The payment rate for one HCPCS code was incorrect in the April 2012 OPPS Pricer. The corrected payment rate is listed in Table 3 below and has been installed in the January 2013 OPPS Pricer, effective for services furnished on April 1, 2012, through June 30, 2012.

Table 3 – Updated payment Rates for Certain HCPCS Codes Effective April 1, 2012, through June 30, 2012

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
Q4112	K	1250	Cymetra allograft	$271.12	$54.22

If you had claims incorrectly processed due to the incorrect rate, your Medicare contractor will adjust the claims if you bring them to the contractor's attention.

Updated Payment Rate for a HCPCS Code Effective July 1, 2012, through September 30, 2012

The payment rate for one HCPCS code was incorrect in the July 2012 OPPS Pricer. The corrected payment rate is listed in Table 4 below and has been installed in the January 2013 OPPS Pricer, effective for services furnished on July 1, 2012, through September 30, 2012.

Table 4 – Updated payment Rates for Certain HCPCS Codes Effective July 1, 2012, through September 30, 2012

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
Q4112	K	1250	Cymetra allograft	$323.65	$64.73

If you had claims incorrectly processed due to the incorrect rate, your Medicare contractor will adjust the claims if you bring them to the contractor's attention.

CY 2013 OPPS Payment Adjustment for Certain Cancer Hospitals

Consistent with Section 3138 of the Affordable Care Act, CMS adopted a policy beginning in CY 2012 to provide additional payments to each of the 11 cancer hospitals so that each cancer hospital's final Payment to Cost Ratio (PCR) for services provided in a given calendar year is equal to the weighted average PCR (which CMS refers to as the "target PCR") for other hospitals paid under the OPPS. The target PCR is set in advance of the calendar year and is calculated using the most recent submitted or settled cost report data that are available at the time of final rulemaking for the calendar year. CMS is updating the "Medicare Claims Processing Manual" (Chapter 4, Section 10.6.3.1) to reflect that the target PCR for CY 2013, for purposes of the cancer hospital payment adjustment, is 0.91 for outpatient services furnished on or after January 1, 2013, through December 31, 2013.

Changes to OPPS Pricer Logic

- 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 2013. 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 Act, as added by section 411 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).
- New OPPS payment rates and copayment amounts will be effective January 1, 2013. All copayment amounts will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the CY 2013 inpatient deductible.
- For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2013. 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.
- There will be no change in the fixed-dollar threshold in CY 2013. The estimated cost of a service must be greater than the APC payment amount plus $2,025 in order to qualify for outlier payments.
- For outliers for Community Mental Health Centers (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.
- Effective January 1, 2013, 3 devices are eligible for pass-through payment in the OPPS Pricer logic. Category C1830 (Powered bone marrow biopsy needle), has an offset amount of $0, because CMS is not able to identify portions of the APC payment amounts associated with the cost of the device. Category C1840 (Lens, intraocular (implantable)) and C1886 (Catheter, extravascular tissue ablation, any modality (insertable)) have offset amounts included in the Pricer for CY 2013. Pass-through offset amounts are adjusted annually. For outlier purposes, when C1830, C1840, or C1886 are billed with a service included in APC 0003, APC 0234 or APC 0415, respectively, they will be associated with a specific HCPCS code in those APCs for outlier eligibility and payment.
- Effective January 1, 2013, 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.

- Effective January 1, 2013, there will be one diagnostic radiopharmaceutical receiving pass-through payment in the OPPS Pricer logic. For APCs containing nuclear medicine procedures, Pricer will reduce the amount of the pass-through diagnostic radiopharmaceutical payment by the wage-adjusted offset for the APC with the highest offset amount when the radiopharmaceutical with pass-through appears on a claim with a nuclear procedure. The offset will cease to apply when the diagnostic radiopharmaceutical expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals are the "policy-packaged" portions of the CY 2013 APC payments for nuclear medicine procedures and may be found on the CMS website.
- 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.
- Effective January 1, 2013, CMS is adopting the FY 2013 IPPS post-reclassification wage index values with application of out-commuting adjustment authorized by Section 505 of the MMA to non-IPPS hospitals. Further discussion of this is available in CR8141 at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2611CP.pdf** on the CMS website.

Medicare Coverage for Drugs, Devices, Procedures, and Services

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. FIs/MACs determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, FIs/MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Additional Information

The official instruction, CR8141 issued to your FIs, RHHIs, A/B MACs regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2611CP.pdf** on the CMS website.

If you have any questions, please contact your FIs, RHHIs, and/or A/B MACs 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.