CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1882	**Date: December 21, 2009**
	Change Request 6751

CORRECTION

Transmittal 1871, dated December 11, 2009, is being rescinded and replaced by Transmital 1882, because of an error in the reporting requirements for the Hospital Outpatient Quality Data Report Program (HOP QDRP). FIs and MACs should indicate hospitals failing to meet the HOP QDRP requirements by leaving a blank space in the appropriate field, while those hospitals meeting the reporting requirements will continue to be indicated with a "1." In addition, we have provided a new Table 12 with the correct wage index values for providers to replace the table currently in the original CR.

SUBJECT: January 2010 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 January 2010 OPPS update. It affects Chapter 3, Section 90.3.3; Chapter 4, Sections: 20.5, 50, 200, 231, and 290; and Chapter 32, Section 140. CMS is re-organizing information in these sections. CMS is deleting sections 290.3.1, 290.3.2, and 290.3.3 from Chapter 4 because they are obsolete. The January 2010 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.

NEW / REVISED MATERIAL
EFFECTIVE DATE: *January 1, 2010
IMPLEMENTATION DATE: January 4, 2010

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	3/90/90.3.3/Billing for Stem Cell Transplantation
R	4/Table of Contents
D	4/20/20.5.1.4/Revenue Codes for Sometimes Therapy Services
R	4/50/50.7/Changes to the OPPS Pricer Logic, Effective January 1, 2003 Through

	January 1, 2006
N	4/50/50.8/Annual Updates to the OPPS Pricer for Calendar Year (CY) 2007 and Later
R	4/200/200.5/Reserved
N	4/200/200.9/Billing for “Sometimes Therapy” Services that May be Paid as Non-Therapy Services for Hospital Outpatients
R	4/231/231.10/Billing for Autologous Stem Cell Transplants
R	4/231/231.11/Billing for Allogeneic Stem Cell Transplants
N	4/231/231.12/Correct Coding Initiative (CCI) Edits
R	4/290/290.3/Reserved
D	4/290/290.3.1/Billing and Payment for Packaged Observation Services Furnished Between August 1, 2000 and December 31, 2005
D	4/290/290.3.2/Billing and Payment for Separately Payable Observation Services Furnished Between April 1, 2002, and December 31, 2005
D	4/290/290.3.3/Billing and Payment for Direct Admission to Observation Services Furnished Between January 1, 2003 and December 31, 2005
R	4/290/290.5.2 /Billing and Payment for Direct Referral for Observation Care Furnished Beginning January 1, 2008
R	32/Table of Contents
R	32/140/Cardiac Rehabilitation Programs, Intensive Cardiac Rehabilitation Programs, and Pulmonary Rehabilitation Programs
R	32/140/140.1/Cardiac Rehabilitation Program Services Furnished On or Before Dec. 31, 2009
N	32/140/140.1.1 /Coding Requirements for Cardiac Rehabilitation Services Furnished On or Before Dec. 31, 2009
N	32/140/140.2/Cardiac Rehabilitation Program Services Furnished On or After January 1, 2010
N	32/140/140.2.1/Coding Requirements for Cardiac Rehabilitation Services Furnished On or After January 1, 2010
N	32/140/140.3/Intensive Cardiac Rehabilitation Program Services Furnished On or After January 1, 2010
N	32/140/140.3.1/Coding Requirements for Intensive Cardiac Rehabilitation Services Furnished On or After January 1, 2010
N	32/140/140.4/Pulmonary Rehabilitation Program Services Furnished On or After January 1, 2010
N	32/140/140.4.1/Coding Requirements for Pulmonary Rehabilitation Services Furnished On or After January 1, 2010

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:

Manual Instruction
Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1882	Date: December 21, 2009	Change Request: 6751

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SUBJECT: January 2010 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Effective Date: January 1, 2010

Implementation Date: January 4, 2010

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the January 2010 OPPS update. The January 2010 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).

The January 2010 revisions to the I/OCE data files, instructions, and specifications are provided in CR 6761, "January 2010 Integrated Outpatient Code Editor (I/OCE) Specifications Version 11.0."

B. Policy:

1. Changes to Device Edits for January 2010

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

Since January 1, 2007, CMS also has required that a claim that contains one of a specified set of device codes be returned to the provider if it fails to contain an appropriate procedure code. CMS has determined that the devices contained in this list cannot be correctly reported without one of the specified procedure codes also being reported on the same claim. Where these devices were billed without an appropriate procedure code prior to January 1, 2007, the cost of the device was being packaged into the median cost for an incorrect procedure code and therefore inflated the payment for the incorrect procedure code. In addition, hospitals billing devices without the appropriate procedure code were being incorrectly paid. The device-to-procedure edits are designed to ensure that the costs of these devices are assigned to the appropriate APC in OPPS ratesetting.

The most current edits for both types of device edits can be found at www.cms.hhs.gov/HospitalOutpatientPPS/. Failure to pass these edits will result in the claim being returned to the provider.

2. Billing for "Sometimes Therapy" Services that May be Paid as Non-Therapy Services for Hospital Outpatients

Section 1834(k) of the Act, as added by Section 4541 of the BBA, allows payment at 80 percent of the lesser of the actual charge for the services or the applicable fee schedule amount for all outpatient therapy services; that is, physical therapy services, speech-language pathology services, and occupational therapy services. As provided under Section 1834(k)(5) of the Act, a therapy code list was created based on a uniform coding system (that is, the HCPCS) to identify and track these outpatient therapy services paid under the Medicare Physician Fee Schedule (MPFS).

The list of therapy codes, along with their respective designation, can be found on the CMS website, specifically at http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage. Two of the designations that are used for therapy services are: "always therapy" and "sometimes therapy." An "always therapy" service must be performed by a qualified therapist under a certified therapy plan of care, and a "sometimes therapy" service may be performed by an individual outside of a certified therapy plan of care.

Under the OPPS, separate payment is provided for certain services designated as "sometimes therapy" services if these services are furnished to hospital outpatients as a non-therapy service, that is, without a certified therapy plan of care. Specifically, to be paid under the OPPS for a non-therapy service, hospitals SHOULD NOT append the therapy modifier GP (physical therapy), GO (occupational therapy), or GN (speech language pathology), or report a therapy revenue code 042x, 043x, or 044x in association with the "sometimes therapy" codes listed in the table below.

To receive payment under the MPFS, when "sometimes therapy" services are performed by a qualified therapist under a certified therapy plan of care, providers should append the appropriate therapy modifier GP, GO, or GN, and report the charges under an appropriate therapy revenue code, specifically 042x, 043x, or 044x. This instruction does not apply to claims for "sometimes therapy" codes furnished as therapy services in the hospital outpatient department and paid under the MPFS.

Effective January 1, 2010, CPT code 92520 (Laryngeal function studies (i.e., aerodynamic testing and acoustic testing)), is newly designated as a "sometimes therapy" service under the MPFS. CPT code 92520 is not a new code, however, its "sometimes therapy" designation is new and effective January 1, 2010. Under the OPPS, hospitals will receive separate payment when they bill CPT code 92520 as a non-therapy service.

The list of HCPCS codes designated as "sometimes therapy" services that may be paid as non-therapy services when furnished to hospital outpatients as of January 1, 2010 is displayed in the table below.

Table 1-Services Designated as "Sometimes Therapy" that May be Paid as Non-Therapy Services for Hospital Outpatients as of January 1, 2010

HCPCS Code	Long Descriptor
92520	Laryngeal function studies (i.e., aerodynamic testing and acoustic testing)
97597	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters
97598	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area greater than 20 square centimeters
97602	Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (e.g., wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session
97605	Negative pressure wound therapy (e.g., vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters
97606	Negative pressure wound therapy (e.g, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters
0183T	Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day

3. Partial Hospitalization APCs (APC 0172 and APC 0173)

For CY 2010, CMS is updating the two Partial Hospitalization Program (PHP) per diem payment rates: APC 0172 (Level I Partial Hospitalization (3 services)) and APC 0173 (Level II Partial Hospitalization (4 or more services)). When a community mental health center (CMHC) or hospital outpatient department provides three units of partial hospitalization services and meets all other partial hospitalization payment criteria, the CMHC or hospital would be paid through APC 0172. When the CMHC or hospital outpatient department provides four or more units of partial hospitalization services and meets all other partial hospitalization payment criteria, the hospital would be paid through APC 0173.

The table below provides the updated per diem payment rates.

Table 2-Updated Per Diem Payment Rates for Partial Hospitalization APCs

2010 APC	2010 Long Descriptor	Payment Rate
0172	(Level I Partial Hospitalization (3 units of service))	$149.84
0173	(Level II Partial Hospitalization (4 units or more units of service))	$210.89

4. Payment for Multiple Imaging Composite APCs

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

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

CMS has updated the list of specified HCPCS codes within the three imaging families and five composite APCs to reflect HCPCS coding changes for CY 2010. Specifically, we added CPT code 74261 (Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material) and CPT code 74262 (Computed tomographic (CT) colonography, diagnostic, including image postprocessing, with contrast materials(s) including non-contrast images, if performed) to the CT and CTA family, and removed CPT code 0067T (Computed tomographic (CT) colonography (ie, virtual colonoscopy); diagnostic), which was replaced by these CPT codes.

The specified HCPCS codes within the three imaging families and five composite APCs for CY 2010 are provided below:

Table 3- The Specified HCPCS Codes Within the Three Imaging Families and Five Composite APCs for CY 2010

Family 1 - Ultrasound	
APC 8004 (Ultrasound Composite)	
76604	Us exam, chest
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp

76775	Us exam abdo back wall, lim
76776	Us exam k transpl w/doppler
76831	Echo exam, uterus
76856	Us exam, pelvic, complete
76870	Us exam, scrotum
76857	Us exam, pelvic, limited

Family 2 - CT and CTA with and without Contrast	
APC 8005 (CT and CTA without Contrast Composite)*	
70450	Ct head/brain w/o dye
70480	Ct orbit/ear/fossa w/o dye
70486	Ct maxillofacial w/o dye
70490	Ct soft tissue neck w/o dye
71250	Ct thorax w/o dye
72125	Ct neck spine w/o dye
72128	Ct chest spine w/o dye
72131	Ct lumbar spine w/o dye
72192	Ct pelvis w/o dye
73200	Ct upper extremity w/o dye
73700	Ct lower extremity w/o dye
74150	Ct abdomen w/o dye
74261	Ct colonography, w/o dye
APC 8006 (CT and CTA with Contrast Composite)	
70487	Ct maxillofacial w/dye
70460	Ct head/brain w/dye
70470	Ct head/brain w/o & w/dye
70481	Ct orbit/ear/fossa w/dye
70482	Ct orbit/ear/fossa w/o&w/dye
70488	Ct maxillofacial w/o & w/dye
70491	Ct soft tissue neck w/dye
70492	Ct sft tsue nck w/o & w/dye
70496	Ct angiography, head
70498	Ct angiography, neck
71260	Ct thorax w/dye
71270	Ct thorax w/o & w/dye
71275	Ct angiography, chest
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye

72191	Ct angiograph pelv w/o&w/dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o&w/dye
73206	Ct angio upr extrm w/o&w/dye
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o&w/dye
73706	Ct angio lwr extr w/o&w/dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o & w/dye
74175	Ct angio abdom w/o & w/dye
74262	Ct colonography, w/dye
75635	Ct angio abdominal arteries
* If a "without contrast" CT or CTA procedure is performed during the same session as a "with contrast" CT or CTA procedure, assign APC 8006 rather than 8005.	
Family 3 - MRI and MRA with and without Contrast	
APC 8007 (MRI and MRA without Contrast Composite)*	
70336	Magnetic image, jaw joint
70540	Mri orbit/face/neck w/o dye
70544	Mr angiography head w/o dye
70547	Mr angiography neck w/o dye
70551	Mri brain w/o dye
70554	Fmri brain by tech
71550	Mri chest w/o dye
72141	Mri neck spine w/o dye
72146	Mri chest spine w/o dye
72148	Mri lumbar spine w/o dye
72195	Mri pelvis w/o dye
73218	Mri upper extremity w/o dye
73221	Mri joint upr extrem w/o dye
73718	Mri lower extremity w/o dye
73721	Mri jnt of lwr extre w/o dye
74181	Mri abdomen w/o dye
75557	Cardiac mri for morph
75559	Cardiac mri w/stress img
C8901	MRA w/o cont, abd
C8904	MRI w/o cont, breast, uni
C8907	MRI w/o cont, breast, bi
C8910	MRA w/o cont, chest
C8913	MRA w/o cont, lwr ext
C8919	MRA w/o cont, pelvis

APC 8008 (MRI and MRA with Contrast Composite)	
70549	Mr angiograph neck w/o&w/dye
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w/dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o&w/dye
70548	Mr angiography neck w/dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
72142	Mri neck spine w/dye
72147	Mri chest spine w/dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o&w/dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o&w/dye
73719	Mri lower extremity w/dye
73720	Mri lwr extremity w/o&w/dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o&w/dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
75561	Cardiac mri for morph w/dye
75563	Card mri w/stress img & dye
C8900	MRA w/cont, abd
C8902	MRA w/o fol w/cont, abd
C8903	MRI w/cont, breast, uni
C8905	MRI w/o fol w/cont, brst, un
C8906	MRI w/cont, breast, bi
C8908	MRI w/o fol w/cont, breast,
C8909	MRA w/cont, chest
C8911	MRA w/o fol w/cont, chest
C8912	MRA w/cont, lwr ext
C8914	MRA w/o fol w/cont, lwr ext
C8918	MRA w/cont, pelvis
C8920	MRA w/o fol w/cont, pelvis

* If a "without contrast" MRI or MRA procedure is performed during the same session as a "with contrast" MRI or MRA procedure, assign APC 8008 rather than 8007.

5. Cardiac Rehabilitation Services

CMS deleted Section 200.5 of Chapter 4 of the Medicare Claims Processing Manual, Pub. 100-04, and reserved it for future use. The coding requirements for cardiac rehabilitation services have been moved to Chapter 32 (Billing Requirements for Special Services), Section 140 (Cardiac Rehabilitation Programs, Intensive Cardiac Rehabilitation Programs, and Pulmonary Rehabilitation Programs). Section 140.1 contains coverage and coding requirements for cardiac rehabilitation services furnished on or before December 31, 2009. Sections 140.2 and 140.3 have been added and include coverage and coding requirements for cardiac rehabilitation and intensive cardiac rehabilitation services beginning January 1, 2010.

6. Pulmonary Rehabilitation Services

CMS added Section 140.4 to Chapter 32 (Billing Requirements for Special Services), Section 140 (Cardiac Rehabilitation Programs, Intensive Cardiac Rehabilitation Programs, and Pulmonary Rehabilitation Programs). It includes coverage and coding requirements for pulmonary rehabilitation services beginning January 1, 2010.

7. Outpatient Observation Services

CMS deleted Section 290.3 of Chapter 4 of the Medicare Claims Processing Manual, Pub. 100-04, and reserved it for future use. This section, "Billing and Payment for Observation Services Furnished Prior to January 1, 2006," is no longer relevant for claims processing purposes. In addition, CMS is making minor revisions to Section 290.5.2 (Billing and Payment for Direct Referral for Observation Care Furnished Beginning January 1, 2008) to reflect the change in the code descriptor of HCPCS code G0379 (Direct referral for hospital observation care), which is effective January 1, 2010.

8. Kidney Disease Education

Section 152(b) of MIPPA added kidney disease education (KDE) as a Medicare Part B covered benefit effective January 1, 2010, for beneficiaries diagnosed with Stage IV chronic kidney disease (CKD). Medicare will cover up to and including six KDE sessions for beneficiaries referred by the physician managing the beneficiary's kidney condition when the beneficiary has been diagnosed with Stage IV CKD. To be covered, these services must be furnished by a "qualified person". A qualified person is a physician, physician assistant, nurse practitioner, or clinical nurse specialist or a provider of services located in a rural area; or a hospital or critical access hospital (CAH) that is treated as being located in a rural area under §412.103 of the Code of Federal Regulations. Renal dialysis facilities and providers of services located outside a rural area, except for hospitals or CAHs that are treated as being located in a rural area under §412.103, are excluded from the definition of a "qualified person."

KDE services furnished by rural providers of services, including a hospital or CAH that is treated as being located in a rural area under §412.103, are paid under the Medicare Physician Fee Schedule. KDE services should be reported using the HCPCS codes G0420 **(**Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour) and G0421 (Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour). Further information on billing, coverage, and payment of KDE services can be found in the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, Section 310 and the Medicare Claims Processing Manual, Pub. 100-04, Chapter 32, Section 20, as discussed in CR 6557.

9. Billing for Allogeneic and Autologous Stem Cell Transplant Procedures

CMS added Section 231.11 to the Medicare Claims Processing Manual, Pub. 100-04, Chapter 4, to clarify billing for allogeneic stem cell transplant procedures when provided in the outpatient setting. Allogeneic stem cell transplant procedures are payable under Part A or Part B depending upon whether the transplant takes place in the inpatient or outpatient setting. Payment for allogeneic stem cell acquisition services (including harvesting procedures) is packaged into the payment for the transplant procedure when provided in the outpatient setting. CMS also updated Chapter 4, Section 231.10 and Chapter 3, Section 90.3.3 to reflect that allogeneic stem cell transplant procedures may be billed and paid under Part B when provided in the hospital outpatient setting.

10. Payment for Brachytherapy Sources

For CY 2010, CMS proposed and finalized payment for brachytherapy sources using prospective rates based on Medicare claims data. For CY 2009 and most previous years, brachytherapy sources have been paid based on charges adjusted to a hospital's cost. The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) requires CMS to pay for brachytherapy sources for the period of July 1, 2008 through December 31, 2009 at hospitals' charges adjusted to the costs. CMS, therefore, has continued paying brachytherapy sources based on charges adjusted to cost for CY 2009. The status indicators of separately payable brachytherapy source HCPCS codes (except HCPCS code C2637) that were previously paid at charges adjusted to cost remain "U," which is the status indicator for separately payable brachytherapy sources irrespective of the payment methodology applied. CMS established status indicator "U" effective January 1, 2009.

These changes are reflected in the table below for all sources (with the exception of HCPCS code C2637, which is non-payable). In addition, because they will be paid prospectively beginning on January 1, 2010, brachytherapy sources will be eligible for outlier payments and for the rural sole community hospital (SCH) adjustment. The HCPCS codes for brachytherapy sources, long descriptors, status indicators, and APCs for CY 2010 are listed in Table 4, the comprehensive brachytherapy source table below.

NOTE: When billing for stranded sources, providers should bill the number of units of the appropriate source HCPCS C-code according to the number of brachytherapy sources in the strand, and should not bill as one unit per strand. See Transmittal 1259, CR 5623, issued June 1, 2007, for further information on billing for brachytherapy sources and the OPPS coding changes made for brachytherapy sources effective July 1, 2007.

Table 4- Comprehensive List of Brachytherapy Source HCPCS Codes as of January 1, 2010

CY 2010 HCPCS Code	CY 2010 Long Descriptor	CY 2010 SI	CY 2010 APC
A9527	Iodine I-125, sodium iodide solution, therapeutic, per millicurie	U	2632
C1716	Brachytherapy source, non-stranded, Gold-198, per source	U	1716
C1717	Brachytherapy source, non-stranded, High Dose Rate Iridium-192, per source	U	1717
C1719	Brachytherapy source, non-stranded, Non-High Dose Rate Iridium-192, per source	U	1719
C2616	Brachytherapy source, non-stranded, Yttrium-90, per source	U	2616
C2634	Brachytherapy source, non-stranded, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source	U	2634
C2635	Brachytherapy source, non-stranded, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source	U	2635
C2636	Brachytherapy linear source, non-stranded, Palladium-103, per 1MM	U	2636
C2637	Brachytherapy source, non-stranded, Ytterbium-169, per source	B	N/A

CY 2010 HCPCS Code	CY 2010 Long Descriptor	CY 2010 SI	CY 2010 APC
C2638	Brachytherapy source, stranded, Iodine-125, per source	U	2638
C2639	Brachytherapy source, non-stranded, Iodine-125, per source	U	2639
C2640	Brachytherapy source, stranded, Palladium-103, per source	U	2640
C2641	Brachytherapy source, non-stranded, Palladium-103, per source	U	2641
C2642	Brachytherapy source, stranded, Cesium-131, per source	U	2642
C2643	Brachytherapy source, non-stranded, Cesium-131, per source	U	2643
C2698	Brachytherapy source, stranded, not otherwise specified, per source	U	2698
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source	U	2699

11. Billing for Drugs, Biologicals, and Radiopharmaceuticals

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

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

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

CMS' longstanding policy under the OPPS is to refrain from instructing hospitals on the appropriate revenue code to use to charge for specific services. CMS believes that this allows hospital flexibility in their billing and accounting systems and provides the necessary autonomy for hospitals to manage the many variations that are possible when creating a hospital chargemaster for multiple payers and to manage the accumulation of costs and charges for completing their Medicare hospital cost report. While we do not require hospitals to use revenue code 0636 (Pharmacy-Extension of 025x; Drugs Requiring Detailed coding (a)) when billing for drugs and biologicals that have HCPCS codes, whether they are separately payable or packaged, we believe that a practice of billing all drugs and biologicals with HCPCS codes under revenue code 0636 would be consistent with National Uniform Billing Committee (NUBC) billing guidelines and would provide us with the most complete and detailed information for future ratesetting. CMS notes that we make 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 our standard ratesetting methodology to rely on hospital cost and charge information as it is reported to us 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.

b. New CY 2010 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

For CY 2010, 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 5 below.

Table 5- New CY 2010 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2010 HCPCS Code	CY 2010 Long Descriptor	CY 2010 SI	CY 2010 APC
A9583	Injection, gadofosveset trisodium, 1 ml	G	1299
C9254	Injection, lacosamide, 1 mg	K	9254
C9255	Injection, paliperidone palmitate, 1 mg	G	9255
C9256	Injection, dexamethasone intravitreal implant, 0.1 mg	G	9256
J0586	Injection, abobotulinumtoxintypeA, 5 units	K	1289
J1680*	Injection, human fibrinogen concentrate, 100 mg	G	1290
J2793	Injection, Rilonacept	K	1291
J9155	Injection, degarelix, 1 mg	G	1296
Q0138	Injection, Ferumoxytol, for treatment of iron deficiency anemia, 1 mg	G	1297

*__NOTE__: HCPCS code J1680 is identified as a blood clotting factor and, as such, is subject to the CY 2010 blood clotting factor furnishing fee.

c. Other Changes to CY 2010 HCPCS Codes for Certain Drugs, Biologicals, and Radipharmaceuticals

Many HCPCS codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS code descriptors that will be effective in CY 2010. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2009, and replaced with permanent HCPCS codes in CY 2010. 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 2010 HCPCS codes.

Table 6- Other CY 2010 HCPCS Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2009	CY 2009 Long Descriptor	CY 2010 HCPCS	CY 2010 Long Descriptor

HCPCS code		Code	
90378	Respiratory syncytial virus immune globulin (RSV-IgIM), for intramuscular use, 50 mg, each	90378	Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each
90663	Influenza virus vaccine, pandemic formulation	90663	Influenza virus vaccine, pandemic formulation, H1N1
90669	Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use	90669	Pneumococcal conjugate vaccine, 7 valent, for intramuscular use
A9500	Technetium tc-99m sestamibi, diagnostic, per study dose, up to 40 millicuries	A9500	Technetium tc-99m sestamibi, diagnostic, per study dose
A9535	Injection, methylene blue, 1 ml	Q9968	Injection, non-radioactive, non-contrast, visualization adjunct (e.g., methylene blue, isosulfan blue), 1 mg
A9605	Samarium sm-153 lexidronamm, therapeutic, per 50 millicuries	A9604	Samarium SM-153 lexidronam, therapeutic, per treatment dose, up to 150 millicuries
C9245	Injection, romiplostim, 10 mcg	J2796	Injection, Romiplostim, 10 micrograms
C9246	Injection, gadoxetate disodium, per ml	A9581	Injection, gadoxetate disodium, 1 ml
C9247	Iobenguane, I-123, diagnostic, per study dose, up to 10 millicuries	A9582	Iodine I-123 iobenguane, diagnostic, per study dose, up to 15 millicuries
C9249	Injection, certolizumab pegol, 1 mg	J0718	Injection, certolizumab pegol, 1 mg
C9251	Injection, C1 esterase inhibitor (human), 10 units	J0598	Injection, C1 esterase inhibitor (human), 10 units
C9252	Injection, plerixafor, 1 mg	J2562	Injection, Plerixafor, 1 mg
C9253	Injection, temozolomide, 1 mg	J9328	Injection, temozolomide, 1 mg
C9358	Dermal substitute, native, nondenatured collagen (SurgiMend Collagen Matrix), per 0.5 square cm	C9358	Dermal substitute, native, non-denatured collagen, fetal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters
C9359	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Putty, Integra OS Osteoconductive Scaffold Putty), per 0.5 cc	C9359	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Putty, Integra OS Osteoconductive Scaffold Putty), per 0.5 cc
J0460	Injection, atropine sulfate, up to 0.3 mg	J0461	Injection, atropine sulfate, 0.01 mg
J0530	Injection, penicillin g benzathine and penicillin g procaine, up to 600,000 units	J0559	Injection, penicillin G benzathine and penicillin G procaine, 2500 units
J0540	Injection, penicillin g benzathine and penicillin g procaine, up to 1,200,000 units	J0559	Injection, penicillin G benzathine and penicillin G procaine, 2500 units
J0550	Injection, penicillin g benzathine	J0559	Injection, penicillin G benzathine and

	and penicillin g procaine, up to 2,400,000 units		penicillin G procaine, 2500 units
J0585	Botulinum toxin type a, per unit.	J0585	Injection, onabotulinumtoxina, 1 unit
J0587	Botulinum toxin type b, per 100 units	J0587	Injection, rimabotulinumtoxinb, 100 units
J0835	Injection, cosyntropin, per 0.25 mg	J0833	Injection, cosyntropin, not otherwise specified, 0.25 mg
J0835	Injection, cosyntropin, per 0.25 mg	J0834	Injection, cosyntropin (cortrosyn), 0.25 mg
J1565	Injection, respiratory syncytial virus immune globulin, intravenous, 50 mg	90379	Respiratory syncytial virus immune globulin (rsv-igiv), human, for intravenous use
J7192	Factor viii (antihemophilic factor, recombinant) per i.u.	J7192	Factor viii (antihemophilic factor, recombinant) per i.u., not otherwise specified
J7322	Hyaluronan or derivative, synvisc, for intra-articular injection, per dose	J7325	Hyaluronan or derivative, synvisc or synvisc-one, for intra-articular injection, 1 mg
J9170	Injection, docetaxel, 20 mg	J9171	Injection, docetaxel, 1 mg
Q2009	Injection, fosphenytoin, 50 mg	Q2009	Injection, Fosphenytoin, 50 mg phenytoin equivalent
Q2023	Injection, factor viii (antihemophilic factor, recombinant) (Xyntha), per i.u.	J7185	Injection, factor viii (antihemophilic factor, recombinant) (xyntha), per i.u.
Q2024	Injection, bevacizumab, 0.25 mg	C9257	Injection, bevacizumab, 0.25 mg

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

For CY 2010, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 4 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2010, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. CMS notes that for the first quarter of CY 2010, payment for drugs and biologicals with pass-through status is not made at the Part B Drug Competitive Acquisition Program (CAP) rate, as the CAP was suspended beginning January 1, 2009. Should the Part B Drug CAP be reinstituted sometime during CY 2010, 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, as required by the statute.

In the CY 2010 OPPS/ASC final rule with comment period, CMS stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as subsequent quarter ASP submissions become available. Effective January 1, 2010, payment rates for many drugs and biologicals have changed from the values published in the CY 2010 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 2009. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2010 release of the OPPS Pricer. CMS is not publishing the updated payment rates in this Change Request. However, the updated payment rates effective January 1, 2010

can be found in the January 2010 update of the OPPS Addendum A and Addendum B on the CMS Web site.

e. Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2009 through June 30, 2009

The payment rates for several HCPCS codes were incorrect in the April 2009 OPPS Pricer. The corrected payment rates are listed below and have been installed in the January 2010 OPPS Pricer, effective for services furnished on April 1, 2009, through implementation of the July 2009 update.

Table 7-Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2009 through June 30, 2009

CY 2009 HCPCS Code	CY 2009 SI	CY 2009 APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9245	G	9245	Injection, romiplostim	$44.81	$8.79
J1260	K	0750	Dolasetron mesylate	$4.54	$0.91
J2778	K	9233	Ranibizumab injection	$399.55	$79.91

f. 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 below and have been installed in the January 2010 OPPS Pricer, effective for services furnished on July 1, 2009, through implementation of the October 2009 update.

Table 8-Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2009 through September 30, 2009

CY 2009 HCPCS Code	CY 2009 SI	CY 2009 APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9354	G	9354	Veritas collagen matrix, cm2	$11.77	$2.31
C9364	G	9364	Porcine implant, Permacol	$18.46	$3.62
J1520	K	0921	Gamma globulin 7 CC inj	$102.15	$20.43

g. Correct Reporting of Biologicals When Used As Implantable Devices

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

When billing for biologicals where the HCPCS code describes a product that may either be surgically implanted or inserted or otherwise applied in the care of a patient, hospitals should not separately report

the biological HCPCS codes, with the exception of biologicals with pass-through status, when using these items as implantable devices (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures. Under the OPPS, hospitals are provided a packaged APC payment for surgical procedures that includes the cost of supportive items, including implantable devices without pass-through status. When using biologicals during surgical procedures as implantable devices, hospitals may include the charges for these items in their charge for the procedure, report the charge on an uncoded revenue center line, or report the charge under a device HCPCS code (if one exists) so these costs would appropriately contribute to the future median setting for the associated surgical procedure.

h. Correct Reporting of Units for Drugs

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

i. Payment for Therapeutic Radiopharmaceuticals

Beginning in CY 2010, nonpass-through separately payable therapeutic radiopharmaceuticals are paid under the OPPS based upon the ASP. If ASP data are unavailable, payment for therapeutic radiopharmaceuticals will be provided based on the most recent hospital mean unit cost data. Therefore, effective January 1, 2010, the status indicator for separately payable therapeutic radiopharmaceuticals is "K" to reflect their separately payable status under the OPPS. Similar to payment for other separately payable drugs and biologicals, the payment rates for nonpass-through separately payable therapeutic radiopharmaceuticals will be updated on a quarterly basis.

Table 9 -Nonpass-Through Separately Payable Therapeutic Radiopharmaceuticals Effective January 1, 2010

CY 2010 HCPCS Code	CY 2010 Long Descriptor	Final CY 2010 APC	Final CY 2010 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	1675	K

CY 2010 HCPCS Code	CY 2010 Long Descriptor	Final CY 2010 APC	Final CY 2010 SI
	millicurie		
A9564	Chromic phosphate P-32 suspension, therapeutic, per millicurie	1676	K
A9600	Strontium Sr-89 chloride, therapeutic, per millicurie	0701	K
A9604	Samarium SM-153 lexidronam, therapeutic, per treatment dose, up to 150 millicuries	1295	K

j. Reporting of Outpatient Diagnostic Nuclear Medicine Procedures

CMS applies nuclear medicine procedure-to-radiolabeled product edits in the I/OCE effective January 2008 that require a radiolabeled product to be present on the same claim as a nuclear medicine procedure for payment under the OPPS to be made. These edits have been revised quarterly, based on information provided to us by members of the public with regard to certain clinical scenarios. CMS is updating the lists of nuclear medicine procedures and radiolabeled products for CY 2010. The complete list of updated nuclear medicine procedure-to-radiolabeled product edits can be found at http://www.cms.hhs.gov/HospitalOutpatientPPS/02_device_procedure.asp#TopOfPage

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

As stated in the October 2009 OPPS update, in the rare instance when a diagnostic radiopharmaceutical may be administered to a beneficiary in a given calendar year prior to a hospital furnishing an associated nuclear medicine procedure in the subsequent calendar year, hospitals are instructed to report the date the radiolabeled product is furnished to the beneficiary as the same date that the nuclear medicine procedure is performed. CMS believes that this situation is extremely rare and we expect that the majority of hospitals will not encounter this situation.

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 Transmittal 1702, CR 6416, issued March 13, 2009, pass-through payment for a diagnostic radiopharmaceutical is the difference between the payment for the pass-through product and the payment for the predecessor product that, in the case of diagnostic radiopharmaceuticals, is packaged into the payment for the nuclear medicine procedure in which the diagnostic radiopharmaceutical is used.

Effective April 1, 2009, the diagnostic radiopharmaceutical reported with HCPCS code C9247 (Iobenguane, I-123, diagnostic, per study dose, up to 10 millicuries) was granted pass-through status under the OPPS and assigned status indicator "G." Therefore, in CY 2009, when HCPCS code C9247 is billed on the same claim with a nuclear medicine procedure, CMS reduces the amount of payment for

the pass-through diagnostic radiopharmaceutical reported with HCPCS code C9247 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.

For CY 2010, HCPCS code C9247 is being replaced with HCPCS code A9582 (Iodine I-123 iobenguane, diagnostic, per study dose, up to 15 millicuries) and HCPCS code A9582 will continue on pass-through status for CY 2010. Therefore, for CY 2010, HCPCS code A9582 will be assigned status indicator "G" and will be subject to the pass-through payment offset for pass-through diagnostic radiopharmaceuticals. The offset will cease to apply when this diagnostic radiopharmaceutical expires from pass-through status.

The "policy-packaged" portions of the CY 2010 APC payments for nuclear medicine procedures may be found on the CMS Web site at: http://www.cms.hhs.gov/HospitalOutpatientPPS/APF/list.asp#TopOfPage in the download file labeled 2010 OPPS Offset Amounts by APC.

CY 2010 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 Table 10 below.

Table 10-APCs to Which Nuclear Medicine Procedures are Assigned for CY 2010

CY 2010 APC	CY 2010 APC Title
0307	Myocardial Positron Emission Tomography (PET) imaging
0308	Non-Myocardial Positron Emission Tomography (PET) imaging
0377	Level II Cardiac Imaging
0378	Level II Pulmonary Imaging
0389	Level I Non-imaging Nuclear Medicine
0390	Level I Endocrine Imaging
0391	Level II Endocrine Imaging
0392	Level II Non-imaging Nuclear Medicine
0393	Hematologic Processing & Studies
0394	Hepatobiliary Imaging
0395	GI Tract Imaging
0396	Bone Imaging
0397	Vascular Imaging
0398	Level I Cardiac Imaging
0400	Hematopoietic Imaging
0401	Level I Pulmonary Imaging
0402	Level II Nervous System Imaging
0403	Level I Nervous System Imaging
0404	Renal and Genitourinary Studies
0406	Level I Tumor/Infection Imaging
0408	Level III Tumor/Infection Imaging
0414	Level II Tumor/Infection Imaging

l. Introduction of Payment Offset for Pass-Through Contrast Agents

As discussed in the CY 2010 OPPS/ASC final rule with comment period, effective for pass-through contrast agents furnished on and after January 1, 2010, when a contrast-enhanced procedure that is

assigned to a procedural APC with a "policy-packaged" drug amount greater than $20 (that is not an APC containing nuclear medicine procedures) is billed on the same claim with a pass-through contrast agent on the same date of service, CMS will reduce the amount of payment for the contrast agent by the corresponding contrast-enhanced procedure's portion of its APC payment associated with "policy-packaged" drugs (offset amount) so no duplicate contrast agent payment is made.

CY 2010 procedural APCs for which CMS expects a contrast agent payment offset could be applicable in the case of a pass-through contrast agent are identified in Table 11 below. 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 2010, when a contrast agent with pass-through status is billed with a contrast-enhanced procedure assigned to any procedural APC listed in Table 11 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.

Effective January 1, 2009, contrast agent HCPCS code C9246 (Injection, gadoxetate disodium, per ml) was granted pass-through status under the OPPS and was assigned status indicator "G." As the pass-through offset methodology was not in place for contrast agents in CY 2009, payments for HCPCS code C9246 were not reduced by the corresponding contrast-enhanced procedure's portion of its APC payment associated with "policy-packaged" drugs (offset amount).

For CY 2010, HCPCS code C9246 is being replaced with HCPCS code A9581 (Injection, gadoxetate disodium, 1 ml) and HCPCS code A9581 will continue on pass-through status for CY 2010. In addition, HCPCS code A9583 (Injection, gadofosveset trisodium, 1 ml) describes a contrast agent that has been granted pass-through status beginning January 1, 2010. Both HCPCS codes A9581 and A9583 will be assigned status indicator "G" and will be subject to the payment offset methodology for contrast agents. Therefore, in CY 2010 CMS will reduce the payment for HCPCS codes A9581 and A9583 by the estimated amount of payment that is attributable to the predecessor contrast agent that is packaged into payment for the associated contrast-enhanced procedure reported on the same claim on the same date as HCPCS code A9581 or A9583 if the contrast-enhanced procedure is assigned to one of the APCs listed in Table 11 below. The "policy-packaged" portions of the CY 2010 APC payments that are the offset amounts may be found on the CMS Web site at: http://www.cms.hhs.gov/HospitalOutpatientPPS/06_Annual_Policy_File.asp#TopOfPage in the download file labeled 2010 OPPS Offset Amounts by APC.

When HCPCS code A9581 or A9583 is billed on a claim on the same date of service as one or more procedures assigned to an APC listed in Table 11, the OPPS Pricer will identify the offset amount or amounts that apply to the contrast-enhanced procedures that are reported on the claim. Where there is a single contrast-enhanced procedure reported on the claim with a single occurrence of either HCPCS code A9581 or A9583, the OPPS Pricer will identify a single offset amount for the procedure billed and adjust the offset by the wage index value that applies to the hospital submitting the claim. Where there are multiple contrast procedures on the claim with a single occurrence of the pass-through contrast agent, the OPPS Pricer will select the contrast-enhanced procedure with the single highest offset amount and adjust the selected offset amount by the wage index value of the hospital submitting the claim. When a claim has more than one occurrence of either HCPCS code A9581 or A9583, the OPPS Pricer will rank potential offset amounts associated with the units of contrast-enhanced procedures on the claim and identify a total offset amount that takes into account the number of occurrences of the pass-through contrast agent on the claim and adjust the total offset amount by the wage index value of the hospital submitting the claim. The adjusted offset amount will be subtracted from the APC payment for the pass-through contrast agent reported with either HCPCS code A9581 or A9583. The offset will cease to apply when each of these contrast agents expires from pass-through status.

Table 11-APCs to Which a Pass-Through Contrast Agent Offset May Be Applicable for CY 2010

CY 2010 APC	CY 2010 APC Title
0080	Diagnostic Cardiac Catheterization
0082	Coronary or Non-Coronary Atherectomy
0083	Coronary or Non-Coronary Angioplasty and Percutaneous Valvuloplasty
0093	Vascular Reconstruction/Fistula Repair without Device
0104	Transcatheter Placement of Intracoronary Stents
0128	Echocardiogram with Contrast
0152	Level I Percutaneous Abdominal and Biliary Procedures
0229	Transcatheter Placement of Intravascular Shunts
0278	Diagnostic Urography
0279	Level II Angiography and Venography
0280	Level III Angiography and Venography
0283	Computed Tomography with Contrast
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast
0333	Computed Tomography without Contrast followed by Contrast
0337	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast followed by Contrast
0375	Ancillary Outpatient Services When Patient Expires
0383	Cardiac Computed Tomographic Imaging
0388	Discography
0418	Insertion of Left Ventricular Pacing Elect.
0442	Dosimetric Drug Administration
0653	Vascular Reconstruction/Fistula Repair with Device
0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents
0662	CT Angiography
0668	Level I Angiography and Venography
8006	CT and CTA with Contrast Composite
8008	MRI and MRA with Contrast Composite

12. Drug Administration Services

As discussed in the CY 2010 OPPS/ASC final rule with comment period, drug administration services will continue to be reported using the full set of drug administration CPT codes with the following exception. CMS notes that new CPT code 90470 (H1N1 immunization administration (intramuscular, intranasal), including counseling when performed) has been created by CPT for administration of the H1N1 vaccine for CY 2010. CMS is assigning this code status indicator "E" for OPPS payment purposes in CY 2010. Hospitals that administer the H1N1 vaccine should continue to use HCPCS code G9141 (Influenza A (H1N1) drug administration (includes the physician counseling the patient/family) for services furnished on or after September 1, 2009. Further information related to H1N1 codes can be found in Transmittal 547, CR 6633, issued August 28, 2009.

13. 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 2010. 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 Pub. L. 108-173.

b. New OPPS payment rates and copayment amounts will be effective January 1, 2010. All coinsurance rates will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the inpatient deductible of $1,100.

c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2010. 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. However, there will be a change in the fixed-dollar threshold in CY 2010. The estimated cost of a service must be greater than the APC payment amount plus $2,175 in order to qualify for outlier payments. The previous fixed-dollar threshold for CY 2009 was $1,800.

e. For outliers for Community Mental Health Centers (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2010. 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, 2010, MIPPA provisions authorizing payment for brachytherapy sources (status indicator "U") at charges reduced to cost expire, and Pricer will make payment based on final CY 2010 prospective payment rates. Note that the payment and copayment reduction for the HOP QDRP program (section j.) will apply to brachytherapy sources beginning January 1, 2010. Brachytherapy sources are eligible to receive outlier payments. Brachytherapy sources are not subject to the wage adjustment, but do receive the adjustment for rural sole community hospitals and essential access community hospitals.

g. Effective January 1, 2010, MIPPA provisions authorizing payment for therapeutic radiopharmaceuticals at charges reduced to cost expire, and Pricer will make prospective payment based either on the ASP for those therapeutic radiopharmaceuticals for which manufacturers submit ASP data or on mean unit cost. Therapeutic radiopharmaceuticals without pass-through status will have a status indicator of "K" beginning in CY 2010. Like other drugs and biologicals, therapeutic radiopharmaceuticals are not eligible to receive outlier payments or the adjustment for rural sole community hospitals and essential access hospitals, and are not wage-adjusted.

h. Effective January 1, 2009, status indicator "R" is used to denote blood and blood products for payment purposes. Blood and blood products are eligible to receive outlier payments. Blood and blood products are not subject to wage adjustment, but do receive the adjustment for rural sole community hospitals and essential access community hospitals.

i. Effective January 1, 2010, no devices are eligible for pass-through payment in the OPPS Pricer logic. There are no associated APC offset amounts or specific logic assigning device payment to associated APC payment for determining outlier eligibility and payment.

j. Effective January 1, 2010, 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.

k. Effective January 1, 2010 there will be 1 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 2010 APC payments for nuclear medicine procedures and may be found on the CMS Web site.

l. Effective January 1, 2010 there will be 2 contrast agents receiving pass-through payments in the OPPS Pricer logic. For a specific set of APCs identified elsewhere in this update, Pricer will reduce the amount of the pass-through contrast agent by the wage-adjusted offset for the APC with the highest offset amount when the contrast agent with pass-through status appears on a claim on the same date of service with a procedure from the identified list of APCs with procedures using 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 2010 APC payments for procedures using contrast agents and may be found on the CMS Web site.

m. Pricer will update the payment rates for drugs, biologicals, and therapeutic radiopharmaceuticals when those payment rates are based on ASP on a quarterly basis.

n. Effective January 1, 2010, CMS is adopting the FY 2010 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.

14. Update the Outpatient Provider Specific File (OPSF)

For January 1, 2010, contractors shall maintain the accuracy of the provider records in the Outpatient Provider Specific File (OPSF) as changes occur in data element values.

Update the OPSF for New Core-Based Statistical Area (CBSA) and Wage Indices for Non-IPPS Hospitals Eligible for the Out-Commuting Adjustment Authorized by Section 505 of Pub. L. 108-173

This includes updating the CBSA in the provider records, as well as updating the "special wage index" value for those providers who qualify for the Section 505 adjustment as annotated in Table 12. CMS notes that reclassification wage index values under Section 508 of Pub. L. 108-173 expired on September 30, 2009. As always, the OPPS applies the IPPS fiscal year 2010 post-reclassification wage index values to all hospitals and community mental health centers participating in the OPPS for the 2010 calendar year.

Contractors shall do the following to update the OPSF (effective January 1, 2010):

1. Update the CBSA value for each provider in Table 12;

2. For non-IPPS providers who qualify for the 505 adjustment in CY 2010 (Table 12.);

   a) Enter a value of "1" in the Special Payment Indicator field on the OPSF; and

   b) Enter the final wage index value (given for the provider in Table 12.) in the Special Wage Index field in the OPSF.

3. For non-IPPS providers who received a special wage index in CY 2009, but no longer receive it in CY 2010;
   a) Create a new provider record, effective January 1, 2010; and

   b) Enter a blank in the Special Payment Indicator field; and

   c) Enter zeroes in the special wage index field.

NOTE: Although the Section 505 adjustment is static for each qualifying county for 3 years, the special wage index will need to be updated (using the final wage index in Table 12.) because the post-reclassification CBSA wage index has changed.

NOTE: Payment for Distinct Part Units (DPUs) located in an acute care hospital is based on the wage index for the labor market area where the hospital is located, even if the hospital has a reclassified wage index. If the DPU falls in a CBSA eligible to receive the section 505 out-commuting adjustment, the DPU's final wage index should consist of the geographic wage index plus the appropriate out-commuting adjustment.

Table 12-Wage Index by CBSA for Non-IPPS Hospitals that are Eligible for the Section 505 Out-Commuting Adjustment

Provider	CBSA	Section 505 Out - Commuting Adjustment	Final Wage Index for Calendar Year
012011	11500	YES	0.7650
013027	01	YES	0.7523

Provider	CBSA	Section 505 Out - Commuting Adjustment	Final Wage Index for Calendar Year
013032	23460	YES	0.8411
014006	23460	YES	0.8411
042007	38220	YES	0.7916
042011	04	YES	0.7758
043034	04	YES	0.7595
052034	36084	YES	1.5867
052035	42044	YES	1.1844
052037	40140	YES	1.1842
052039	42044	YES	1.1844
052040	40140	YES	1.1842
052053	42044	YES	1.1844
053034	42044	YES	1.1844
053037	40140	YES	1.1842
053301	36084	YES	1.5867
053304	42044	YES	1.1844
053306	42044	YES	1.1844
053308	42044	YES	1.1844
054074	46700	YES	1.4644
054093	40140	YES	1.1842
054110	36084	YES	1.5867
054111	40140	YES	1.1842
054122	34900	YES	1.4420
054123	44700	YES	1.2377
054135	42044	YES	1.1844
054141	46700	YES	1.4644
063033	24540	YES	0.9686
064007	14500	YES	1.0313
074000	14860	YES	1.2637
074012	14860	YES	1.2637
074014	14860	YES	1.2637
082000	48864	YES	1.0786
083300	48864	YES	1.0786
084001	48864	YES	1.0786
084002	48864	YES	1.0786
084003	48864	YES	1.0786
092002	47894	YES	1.0733
092003	47894	YES	1.0733
093025	47894	YES	1.0733
093300	47894	YES	1.0733
094001	47894	YES	1.0733
094004	47894	YES	1.0733
114018	11	YES	0.8046

Provider	CBSA	Section 505 Out - Commuting Adjustment	Final Wage Index for Calendar Year
132001	17660	YES	0.9380
134010	13	YES	0.8368
153040	15	YES	0.8728
154014	15	YES	0.8706
154035	15	YES	0.8618
154047	15	YES	0.8728
183028	21060	YES	0.8369
184012	21060	YES	0.8369
192022	19	YES	0.7885
192026	19	YES	0.8211
192034	19	YES	0.8011
192036	19	YES	0.8067
192040	19	YES	0.8067
192050	19	YES	0.8085
193036	19	YES	0.8011
193044	19	YES	0.8067
193047	19	YES	0.8013
193049	19	YES	0.8013
193055	19	YES	0.7899
193058	19	YES	0.7909
193063	19	YES	0.8067
193067	19	YES	0.7925
193068	19	YES	0.8067
193069	19	YES	0.7909
193073	19	YES	0.8011
193079	19	YES	0.8067
193081	19	YES	0.8085
193088	19	YES	0.8085
193091	19	YES	0.7909
194047	19	YES	0.8211
194065	19	YES	0.7885
194075	19	YES	0.7925
194077	19	YES	0.7885
194081	19	YES	0.7868
194082	19	YES	0.7925
194083	19	YES	0.7909
194085	19	YES	0.8085
194087	19	YES	0.7885
194091	19	YES	0.8067
194092	19	YES	0.7859
212002	25180	YES	0.9433
214001	12580	YES	1.0227

Provider	CBSA	Section 505 Out - Commuting Adjustment	Final Wage Index for Calendar Year
214003	25180	YES	0.9433
214015	21	YES	0.9434
222000	15764	YES	1.1557
222003	15764	YES	1.1557
222024	15764	YES	1.1557
222026	37764	YES	1.1237
222044	37764	YES	1.1237
222047	37764	YES	1.1237
222048	49340	YES	1.1323
223026	15764	YES	1.1557
223028	37764	YES	1.1237
223029	49340	YES	1.1323
223033	49340	YES	1.1323
224007	15764	YES	1.1557
224026	49340	YES	1.1323
224032	49340	YES	1.1323
224033	37764	YES	1.1237
224038	15764	YES	1.1557
224039	37764	YES	1.1237
232019	19804	YES	0.9820
232020	13020	YES	0.9498
232023	47644	YES	0.9879
232025	35660	YES	0.9093
232027	19804	YES	0.9820
232028	12980	YES	1.0121
232030	47644	YES	0.9883
232031	19804	YES	0.9820
232032	19804	YES	0.9820
232034	23	YES	0.9232
232036	27100	YES	0.9020
232038	19804	YES	0.9820
233025	12980	YES	1.0121
233027	19804	YES	0.9820
233028	47644	YES	0.9883
233300	19804	YES	0.9820
234011	47644	YES	0.9883
234021	47644	YES	0.9879
234023	47644	YES	0.9883
234025	23	YES	0.9073
234028	19804	YES	0.9820
234034	19804	YES	0.9820
234035	19804	YES	0.9820

Provider	CBSA	Section 505 Out - Commuting Adjustment	Final Wage Index for Calendar Year
234038	19804	YES	0.9820
234039	47644	YES	0.9879
252011	25	YES	0.8163
264005	26	YES	0.8251
264027	26	YES	0.8251
303026	40484	YES	1.0600
304001	40484	YES	1.0600
312018	20764	YES	1.1550
312020	35084	YES	1.1540
313025	35084	YES	1.1609
313300	20764	YES	1.1550
314010	35084	YES	1.1609
314011	20764	YES	1.1550
314016	35084	YES	1.1540
314020	35084	YES	1.1609
322004	29740	YES	0.8988
323025	32	YES	0.9444
323032	29740	YES	0.8988
324007	29740	YES	0.8988
324010	29740	YES	0.8988
324012	29740	YES	0.8988
334017	39100	YES	1.1908
334061	39100	YES	1.1908
344011	39580	YES	0.9550
344014	39580	YES	0.9550
362016	15940	YES	0.8666
362032	15940	YES	0.8666
363026	49660	YES	0.8673
364031	15940	YES	0.8666
364040	44220	YES	0.9125
364043	36	YES	0.8550
372017	37	YES	0.7907
372019	37	YES	0.8109
373032	37	YES	0.7907
384011	38	YES	1.0342
392030	39	YES	0.8895
392031	27780	YES	0.8469
392034	10900	YES	1.1558
393026	39740	YES	0.9403
393050	10900	YES	1.1558
394014	39740	YES	0.9403
394016	39	YES	0.8385

Provider	CBSA	Section 505 Out - Commuting Adjustment	Final Wage Index for Calendar Year
394020	30140	YES	0.8819
394052	39740	YES	0.9403
422004	43900	YES	0.9165
423028	16740	YES	0.9321
423029	11340	YES	0.9238
424011	11340	YES	0.9238
442016	28700	YES	0.8120
443027	28700	YES	0.8120
444006	27740	YES	0.7923
444008	44	YES	0.8255
452018	23104	YES	0.9458
452019	23104	YES	0.9458
452028	23104	YES	0.9458
452088	23104	YES	0.9458
452099	23104	YES	0.9458
452106	41700	YES	0.8988
452110	23104	YES	0.9458
453040	23104	YES	0.9458
453041	23104	YES	0.9458
453042	23104	YES	0.9458
453089	45	YES	0.8070
453094	23104	YES	0.9458
453300	23104	YES	0.9458
453303	23104	YES	0.9458
454009	45	YES	0.8157
454012	23104	YES	0.9458
454051	23104	YES	0.9458
454052	23104	YES	0.9458
454061	23104	YES	0.9458
454072	23104	YES	0.9458
454086	23104	YES	0.9458
454101	45	YES	0.8011
462005	39340	YES	0.9444
494029	49	YES	0.8104
522005	39540	YES	0.9601
523302	36780	YES	0.9248
524002	36780	YES	0.9248
673026	41700	YES	0.8988
673035	23104	YES	0.9458

a) Updating the OPSF for CY 2010 Transitional Outpatient Payments (TOPs)

Section 5105 of the Deficit Reduction Act of 2005 (DRA) extended hold harmless transitional outpatient payments (TOPs) through December 31, 2008 for rural hospitals having 100 or fewer beds that are not sole community hospitals (SCHs). Hospitals received 95 percent of the hold harmless amount for services furnished in CY 2006, 90 percent in CY 2007, and 85 percent in CY 2008. Section 147 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) extended the hold harmless provision for small rural hospitals with 100 or fewer beds through December 31, 2009, at 85 percent of the hold harmless amount. Section 147 also provided 85 percent of the hold harmless amount from January 1, 2009 through December 31, 2009 to SCHs with 100 or fewer beds, per CR 6320.

Note: Essential Access Community Hospitals (EACHs) are considered SCHs for purposes of the TOPs adjustment.

For CY 2010, small rural hospitals with 100 or fewer beds and sole community hospitals (and essential access community hospitals) with 100 or fewer beds are no longer eligible for a TOPS adjustment, so the TOPS indicator for these hospitals must be set to 'N'. Cancer and children's hospitals continue to receive hold harmless TOPs permanently.

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

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

For January 1, 2010, contractors shall maintain the accuracy of the provider records in the OPSF by updating the Hospital Quality Indicator field. CMS will release a Joint Signature Memorandum/Technical Direction Letter that lists Subsection (d) hospitals that are subject to and fail to meet the HOP QDRP requirements. Once this list is released, FIs/MACs will update the OPSF by removing the '1', (that is, ensure that the Hospital Quality Indicator field is blank) for all hospitals identified on the list and will ensure that the OPSF Hospital Quality Indicator field contains '1' for all hospitals that are not on the list. CMS notes that if these hospitals are later determined to have met the HOP QDRP requirements, FIs/MACs shall update the OPSF. For greater detail regarding updating the OPSF for the HOP QDRP requirements, please see Transmittal 368, CR 6072, issued on August 15, 2008.

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

As stated in section 50.1 of the Medicare Claims Processing Manual, contractors must maintain the accuracy of the data and update the OPSF as changes occur in data element values, including changes to provider cost–to-charge ratios. The file of OPPS hospital upper limit CCRs and the file of Statewide CCRs are located on the CMS Web site at www.cms.hhs.gov/HospitalOutpatientPPS/ under "*Annual Policy Files*." A spreadsheet listing the Statewide CCRs *also* can be found in the file containing the preamble tables that appears in the most recent OPPS/ASC final rule.

15. 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	
6751.1	Medicare contractors shall install the January 2010 OPPS Pricer.	X		X		X	X				COBC
6751.2	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service that fall on or after April 1, 2009, but prior to July 1, 2009; 2) Contain HCPCS code listed in Table 7; and 3) Were originally processed prior to the installation of the January 2010 OPPS Pricer.	X		X		X					COBC
6751.3	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service that fall on or after July 1, 2009, but prior to October 1, 2009; 2) Contain HCPCS code listed in Table 8; and 3) Were originally processed prior to the installation of the January 2010 OPPS Pricer.	X		X		X					COBC
6751.4	As specified in Chapter 4, Section 50.1, Medicare contractors shall maintain the accuracy of the data and update the OPSF file as changes occur in data element values. For CY 2010, this includes all changes to the OPSF identified in Section 14 of this transmittal.	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	
6751.5	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 the box below: None
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	None

Section B: For all other recommendations and supporting information:
Please refer to CR 6761 “January 2010 Integrated Outpatient Code Editor (I/OCE) Specifications Version 11.0” for supporting information.

V. CONTACTS

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

Post-Implementation Contact(s): 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 3 - Inpatient Hospital Billing

90.3.3 - Billing for Stem Cell Transplantation

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

A. Billing for Allogeneic Stem Cell Transplants

1. Definition of Acquisition Charges for Allogeneic Stem Cell Transplants

Acquisition charges for allogeneic stem cell transplants include, but are not limited to, charges for the costs of the following services:

- National Marrow Donor Program fees, if applicable, for stem cells from an unrelated donor;
- Tissue typing of donor and recipient;
- Donor evaluation;
- Physician pre-admission/pre-procedure donor evaluation services;
- Costs associated with harvesting procedure (e.g., general routine and special care services, procedure/operating room and other ancillary services, apheresis services, etc.);
- Post-operative/post-procedure evaluation of donor; and
- Preparation and processing of stem cells.

Payment for these acquisition services is included in the MS-DRG payment for the allogeneic stem cell transplant *when the transplant occurs in the inpatient setting, and in the OPPS APC payment for the allogeneic stem cell transplant when the transplant occurs in the outpatient setting*. The Medicare contractor does not make separate payment for these acquisition services, because hospitals may bill and receive payment only for services provided to the Medicare beneficiary who is the recipient of the stem cell transplant and whose illness is being treated with the stem cell transplant. Unlike the acquisition costs of solid organs for transplant (e.g., hearts and kidneys), which are paid on a reasonable cost basis, acquisition costs for allogeneic stem cells are included in prospective payment.

Acquisition charges for stem cell transplants apply only to allogeneic transplants, for which stem cells are obtained from a donor (other than the recipient himself or herself). Acquisition charges do not apply to autologous transplants (transplanted stem cells are obtained from the recipient himself or herself), because autologous transplants involve services provided to the beneficiary only (and not to a donor), for which the hospital may bill and receive payment (*see Pub. 100-04, chapter 4, §231.10 and* paragraph B of this section *for information regarding billing for autologous stem cell transplants*).

2. Billing for Acquisition Services

The hospital bills and shows acquisition charges for allogeneic stem cell transplants based on the status of the patient (i.e., inpatient or outpatient) when the transplant is furnished. See Pub. 100-04, chapter 4, §231.11 for instructions regarding billing for acquisition services for allogeneic stem cell transplants that are performed in the outpatient setting.

*When the allogeneic stem cell transplant occurs in the inpatient setting, t*he hospital identifies stem cell acquisition charges for allogeneic bone marrow/stem cell transplants separately in FL 42 of Form CMS-1450 (or electronic equivalent) by using revenue code 0819 (Other Organ Acquisition). Revenue code 0819 charges should include all services required to acquire stem cells from a donor, as defined above.

On the recipient's transplant bill, the hospital reports the acquisition charges, cost report days, and utilization days for the donor's hospital stay (if applicable) and/or charges for other encounters in which the stem cells were obtained from the donor. The donor is covered for medically necessary inpatient hospital days of care or outpatient care provided in connection with the allogeneic stem cell transplant under Part A. Expenses incurred for complications are paid only if they are directly and immediately attributable to the stem cell donation procedure. The hospital reports the acquisition charges on the billing form for the recipient, as described in the first paragraph of this section. It does not charge the donor's days of care against the recipient's utilization record. For cost reporting purposes, it includes the covered donor days and charges as Medicare days and charges.

The transplant hospital keeps an itemized statement that identifies the services furnished, the charges, the person receiving the service (donor/recipient), and whether this is a potential transplant donor or recipient. These charges will be reflected in the transplant hospital's stem cell/bone marrow acquisition cost center. For allogeneic stem cell acquisition services in cases that do not result in transplant, due to death of the intended recipient or other causes, hospitals include the costs associated with the acquisition services on the Medicare cost report.

The hospital shows charges for the transplant itself in revenue center code 0362 or another appropriate cost center. Selection of the cost center is up to the hospital.

B. Billing for Autologous Stem Cell Transplants

The hospital bills and shows all charges for autologous stem cell harvesting, processing, and transplant procedures based on the status of the patient (i.e., inpatient or outpatient) when the

services are furnished. It shows charges for the actual transplant, described by the appropriate ICD-9-CM procedure or CPT codes, in revenue center code 0362 or another appropriate cost center.

The CPT codes describing autologous stem cell harvesting procedures may be billed and are separately payable under the OPPS when provided in the hospital outpatient setting of care. Autologous harvesting procedures are distinct from the acquisition services described in *Pub. 100-04, chapter 4, §231.11 and* section A. above for allogeneic stem cell transplants, which include services provided when stem cells are obtained from a donor and not from the patient undergoing the stem cell transplant. The CPT codes describing autologous stem cell processing procedures also may be billed and are separately payable under the OPPS when provided to hospital outpatients.

Payment for *autologous* stem cell harvesting procedures performed in the hospital inpatient setting of care, with transplant also occurring in the inpatient setting of care, is included in the MS-DRG payment for the autologous stem cell transplant.

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

Table of Contents

(Rev. 1882, 12-21-09)

50.7 - Changes to the OPPS Pricer Logic, Effective January 1, 2003 *Through January 1, 2006*

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

For January Pricers occurring between CY 2003 and *2006*, you may find the updates outlined in the following CRs:

January 2004 – CR 3007, http://www.cms.hhs.gov/Transmittals/Downloads/R32OTN.pdf
January 2005 – CR 3586, http://www.cms.hhs.gov/transmittals/Downloads/R385CP.pdf
January 2006 – CR 4250, http://www.cms.hhs.gov/transmittals/downloads/R804CP.pdf

50.8 – Annual Updates to the OPPS Pricer for Calendar Year (CY) 2007 and Later

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

Starting with the January 2007 update, all annual updates within the OPPS Pricer are explained within recurring update notifications located at the Hospital OPPS Transmittals Web site found at: http://www.cms.hhs.gov/HospitalOutpatientPPS/HOPPSTrans/.

200.5 – *Reserved*

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

200.9 - Billing for "Sometimes Therapy" Services that May be Paid as Non-Therapy Services for Hospital Outpatients

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

Section 1834(k) of the Act, as added by Section 4541 of the BBA, allows payment at 80 percent of the lesser of the actual charge for the services or the applicable fee schedule amount for all outpatient therapy services; that is, physical therapy services, speech-language pathology services, and occupational therapy services. As provided under Section 1834(k)(5) of the Act, a therapy code list was created based on a uniform coding system (that is, the HCPCS) to identify and track these outpatient therapy services paid under the Medicare Physician Fee Schedule (MPFS).

The list of therapy codes, along with their respective designation, can be found on the CMS Website, specifically at http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage. Two of the designations that are used for therapy services are: "always therapy" and "sometimes

therapy." An "always therapy" service must be performed by a qualified therapist under a certified therapy plan of care, and a "sometimes therapy" service may be performed by an individual outside of a certified therapy plan of care.
Under the OPPS, separate payment is provided for certain services designated as "sometimes therapy" services if these services are furnished to hospital outpatients as a non-therapy service, that is, without a certified therapy plan of care. Specifically, to be paid under the OPPS for a non-therapy service, hospitals SHOULD NOT append the therapy modifier GP (physical therapy), GO (occupational therapy), or GN (speech language pathology), or report a therapy revenue code 042x, 043x, or 044x in association with the "sometimes therapy" codes listed in the table below.

To receive payment under the MPFS, when "sometimes therapy" services are performed by a qualified therapist under a certified therapy plan of care, providers should append the appropriate therapy modifier GP, GO, or GN, and report the charges under an appropriate therapy revenue code, specifically 042x, 043x, or 044x. This instruction does not apply to claims for "sometimes therapy" codes furnished as therapy services in the hospital outpatient department and paid under the MPFS.

Effective January 1, 2010, CPT code 92520 (Laryngeal function studies (i.e., aerodynamic testing and acoustic testing)), is newly designated as a "sometimes therapy" service under the MPFS. CPT code 92520 is not a new code, however, its "sometimes therapy" designation is new and effective January 1, 2010. Under the OPPS, hospitals will receive separate payment when they bill CPT code 92520 as a non-therapy service.

The list of HCPCS codes designated as "sometimes therapy" services that may be paid as non-therapy services when furnished to hospital outpatients as of January 1, 2010, is displayed in the table below.

Services Designated as "Sometimes Therapy" that May be Paid as Non-Therapy Services for Hospital Outpatients as of January 1, 2010

HCPCS Code	*Long Descriptor*
92520	*Laryngeal function studies (i.e., aerodynamic testing and acoustic testing)*
97597	*Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters*
97598	*Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area greater than 20 square centimeters*
97602	*Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (e.g., wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session*
97605	*Negative pressure wound therapy (e.g., vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters*
97606	*Negative pressure wound therapy (eg., vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters*
0183T	*Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day*

231.10 - Billing for Autologous Stem Cell Transplants

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

The hospital bills and shows all charges for autologous stem cell harvesting, processing, and transplant procedures based on the status of the patient (i.e., inpatient or outpatient) when the services are furnished. It shows charges for the actual transplant, described by the appropriate ICD-9-CM procedure or CPT codes, in revenue center code 0362 *(Operating Room Services; Organ Transplant, Other than Kidney)* or another appropriate cost center.

The CPT codes describing autologous stem cell harvesting procedures may be billed and are separately payable under the Outpatient Prospective Payment System (OPPS) when provided in the hospital outpatient setting of care. Autologous harvesting procedures are distinct from the acquisition services described in Pub. 100-04, Chapter 3, §90.3.3 *and §231.11 of this chapter* for allogeneic stem cell transplants, which include services provided when stem cells are obtained from a donor and not from the patient undergoing the stem cell transplant.

The CPT codes describing autologous stem cell processing procedures also may be billed and are separately payable under the OPPS when provided to hospital outpatients.

231.11 - Billing for Allogeneic Stem Cell Transplants

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

1. Definition of Acquisition Charges for Allogeneic Stem Cell Transplants

Acquisition charges for allogeneic stem cell transplants include, but are not limited to, charges for the costs of the following services:

- *National Marrow Donor Program fees, if applicable, for stem cells from an unrelated donor;*
- *Tissue typing of donor and recipient;*
- *Donor evaluation;*
- *Physician pre-procedure donor evaluation services;*
- *Costs associated with harvesting procedure (e.g., general routine and special care services, procedure/operating room and other ancillary services, apheresis services, etc.);*

- *Post-operative/post-procedure evaluation of donor; and*

- *Preparation and processing of stem cells.*

Payment for these acquisition services is included in the OPPS APC payment for the allogeneic stem cell transplant when the transplant occurs in the hospital outpatient setting, and in the MS-DRG payment for the allogeneic stem cell transplant when the transplant occurs in the inpatient setting. The Medicare contractor does not make separate payment for these acquisition services, because hospitals may bill and receive payment only for services provided to the Medicare beneficiary who is the recipient of the stem cell transplant and whose illness is being treated with the stem cell transplant. Unlike the acquisition costs of solid organs for transplant (e.g., hearts and kidneys), which are paid on a reasonable cost basis, acquisition costs for allogeneic stem cells are included in prospective payment.

Acquisition charges for stem cell transplants apply only to allogeneic transplants, for which stem cells are obtained from a donor (other than the recipient himself or herself). Acquisition charges do not apply to autologous transplants (transplanted stem cells are obtained from the recipient himself or herself), because autologous transplants involve services provided to the beneficiary only (and not to a donor), for which the hospital may bill and receive payment (see Pub. 100-04, Chapter 3, §90.3.3 and §231.10 of this chapter for information regarding billing for autologous stem cell transplants).

2. Billing for Acquisition Services

The hospital bills and shows acquisition charges for allogeneic stem cell transplants based on the status of the patient (i.e., inpatient or outpatient) when the transplant is furnished. See Pub. 100-04, Chapter 3, §90.3.3 for instructions regarding billing for acquisition services for allogeneic stem cell transplants that are performed in the inpatient setting.

When the allogeneic stem cell transplant occurs in the outpatient setting, the hospital identifies stem cell acquisition charges for allogeneic bone marrow/stem cell transplants separately in FL 42 of Form CMS-1450 (or electronic equivalent) by using revenue code 0819 (Other Organ Acquisition). Revenue code 0819 charges should include all services required to acquire stem cells from a donor, as defined above.

The transplant hospital keeps an itemized statement that identifies the services furnished, the charges, the person receiving the service (donor/recipient), and whether this is a potential transplant donor or recipient. These charges will be reflected in the transplant hospital's stem cell/bone marrow acquisition cost center. For allogeneic stem cell acquisition services in cases that do not result in transplant, due to death of the intended recipient or other causes, hospitals include the costs associated with the acquisition services on the Medicare cost report.

In the case of an allogeneic transplant in the hospital outpatient setting, the hospital reports the transplant itself with the appropriate CPT code, and a charge under revenue center code 0362 or another appropriate cost center. Selection of the cost center is up to the hospital.

231.12 - Correct Coding Initiative (CCI) Edits

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

The OPPS providers should be aware that certain CCI edits may apply when billing for blood and blood product services. The OPPS providers should consult the most current list of CCI edits to determine whether they apply to the services or HCPCS blood product codes being reported. A file with the most current list of CCI edits applicable to Medicare Part B services paid by fiscal intermediaries under the OPPS is available at:

http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHOPPS/list.asp

290.3 – *Reserved*

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

290.5.2 - Billing and Payment for Direct Referral for Observation Care Furnished Beginning January 1, 2008

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

Direct referral for observation *is* reported using HCPCS code G0379 (Direct *referral* for hospital observation care). *Note: Prior to January 1, 2010, the code descriptor for HCPCS code G0379 was (Direct admission of patient for hospital observation care).* Hospitals should report G0379 when observation services are the result of a direct referral for observation care without an associated emergency room visit, hospital outpatient clinic visit, or critical care service on the day of initiation of observation services. Hospitals should only report HCPCS code G0379 when a patient is referred directly to observation care after being seen by a physician in the community.

Payment for direct referral for observation care will be made either separately as a low level hospital clinic visit under APC 0604 or packaged into payment for composite APC 8002 (Level I Prolonged Assessment and Management Composite) or packaged into the payment for other separately payable services provided in the same encounter. For information about payment for extended assessment and management composite APCs, see, §10.2.1 (Composite APCs) of this chapter.

The criteria for payment of HCPCS code G0379 under either APC 0604 or APC 8002 include:

1. Both HCPCS codes G0378 (Hospital observation services, per hr.) and G0379 (*Direct referral* for hospital observation care) are reported with the same date of service.

2. No service with a status indicator of T or V or Critical Care (APC 0617) is provided on the same day of service as HCPCS code G0379.

If either of the above criteria is not met, HCPCS code G0379 will be assigned status indicator N and will be packaged into payment for other separately payable services provided in the same encounter.

Only a direct referral for observation services billed on a 13X bill type may be considered for a composite APC payment

Medicare Claims Processing Manual

Chapter 32 – Billing Requirements for Special Services

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(Rev. 1882, 12-21-09)

140 - *Cardiac Rehabilitation Programs, Intensive Cardiac Rehabilitation Programs, and Pulmonary Rehabilitation Programs*

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

140.1 – Cardiac Rehabilitation Program Services Furnished On or Before December 31, 2009

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

Medicare covers cardiac rehabilitation exercise programs for patients who meet the following criteria:

- *Have a documented diagnosis of acute myocardial infarction within the preceding 12 months; or*
- *Have had coronary bypass surgery; or*
- *Have stable angina pectoris; or*
- *Have had heart valve repair/replacement; or*
- *Have had percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; or*
- *Have had a heart or heart-lung transplant.*

Effective for dates of services on or after March 22, 2006, services provided in connection with a cardiac rehabilitation exercise program may be considered reasonable and necessary for up to 36 sessions. Patients generally receive 2 to 3 sessions per week for 12 to 18 weeks. The contractor has discretion to cover cardiac rehabilitation services beyond 18 weeks. Coverage must not exceed a total of 72 sessions for 36 weeks.

Cardiac rehabilitation programs shall be performed incident to physician's services in outpatient hospitals, or outpatient settings such as clinics or offices. Follow the policies for services incident to the services of a physician as they apply in each setting. For example, see Pub. 100-02, Chapter 6, §2.4.1, and Pub. 100-02, Chapter 15, §60.1. (Refer to Publication 100-03, §20.10 for further coverage guidelines.)

140.1.1 - Coding Requirements for Cardiac Rehabilitation Services Furnished On or Before Dec. 31, 2009

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

The following are the applicable HCPCS codes:

93797 - Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session); and
93798 - Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session).

Effective for dates of service on or after January 1, 2008 and before January 1, 2010, providers and practitioners may report more than one unit of CPT code 93797 or 97398 for a date of service if more than one cardiac rehabilitation session lasting at least 1 hour each is provided on the same day. In order to report more than one session for a given date of service, each session must last a minimum of 60 minutes. For example, if the cardiac rehabilitation services provided on a given day total 1 hour and 50 minutes, then only one session should be billed to report the cardiac rehabilitation services provided on that day.

140.2 – Cardiac Rehabilitation Program Services Furnished On or After January 1, 2010

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

As specified at 42 CFR 410.49, Medicare covers cardiac rehabilitation items and services for patients who have experienced one or more of the following:

- *An acute myocardial infarction within the preceding 12 months; or*
- *A coronary artery bypass surgery; or*
- *Current stable angina pectoris; or*
- *Heart valve repair or replacement; or*
- *Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; or*
- *A heart or heart-lung transplant.*

Cardiac rehabilitation programs must include the following components:

- *Physician-prescribed exercise each day cardiac rehabilitation items and services are furnished;*
- *Cardiac risk factor modification, including education, counseling, and behavioral intervention at least once during the program, tailored to patients' individual needs;*
- *Psychosocial assessment;*

- *Outcomes assessment; and*

- *An individualized treatment plan detailing how components are utilized for each patient.*

Cardiac rehabilitation items and services must be furnished in a physician's office or a hospital outpatient setting. All settings must have a physician immediately available and accessible for medical consultations and emergencies at all time items and services are being furnished under the program. This provision is satisfied if the physician meets the requirements for the direct supervision of physician's office services as specified at 42 CFR 410.26 and for hospital outpatient therapeutic services as specified at 42 CFR 410.27.

As specified at 42 CFR 410.49(f)(1), cardiac rehabilitation program sessions are limited to a maximum of 2 1-hour sessions per day for up to 36 sessions over up to 36 weeks, with the option for an additional 36 sessions over an extended period of time if approved by the Medicare contractor.

140.2.1 – Coding Requirements for Cardiac Rehabilitation Services Furnished On or After January 1, 2010

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

The following are the applicable CPT codes for cardiac rehabilitation services:

93797 - Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session) and

93798 - Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)

Effective for dates of service on or after January 1, 2010, hospitals and practitioners may report a maximum of 2 1-hour sessions per day. In order to report one session of cardiac rehabilitation services in a day, the duration of treatment must be at least 31 minutes. Two sessions of cardiac rehabilitation services may only be reported in the same day if the duration of treatment is at least 91 minutes. In other words, the first session would account for 60 minutes and the second session would account for at least 31 minutes if two sessions are reported. If several shorter periods of cardiac rehabilitation services are furnished on a given day, the minutes of service during those periods must be added together for reporting in 1-hour session increments.

***Example:** If the patient receives 20 minutes of cardiac rehabilitation services in the day, no cardiac rehabilitation session may be reported because less than 31 minutes of services were furnished.*

***Example:** If a patient receives 20 minutes of cardiac rehabilitation services in the morning and 35 minutes of cardiac rehabilitation services in the afternoon of a single day, the hospital or practitioner would report 1 session of cardiac rehabilitation services under 1 unit of the appropriate CPT code for the total duration of 55 minutes of cardiac rehabilitation services on that day.*

Example: *If the patient receives 70 minutes of cardiac rehabilitation services in the morning and 25 minutes of cardiac rehabilitation services in the afternoon of a single day, the hospital or practitioner would report two sessions of cardiac rehabilitation services under the appropriate CPT code(s) because the total duration of cardiac rehabilitation services on that day of 95 minutes exceeds 90 minutes.*
Example: *If the patient receives 70 minutes of cardiac rehabilitation services in the morning and 85 minutes of cardiac rehabilitation services in the afternoon of a single day, the hospital or practitioner would report two sessions of cardiac rehabilitation services under the appropriate CPT code(s) for the total duration of cardiac rehabilitation services of 155 minutes. A maximum of two sessions per day may be reported, regardless of the total duration of cardiac rehabilitation services.*

140.3 – Intensive Cardiac Rehabilitation Program Services Furnished On or After January 1, 2010

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

As specified at 42 CFR 410.49, Medicare covers intensive cardiac rehabilitation items and services for patients who have experienced one or more of the following:

- *An acute myocardial infarction within the preceding 12 months; or*
- *A coronary artery bypass surgery; or*
- *Current stable angina pectoris; or*
- *Heart valve repair or replacement; or*
- *Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; or*
- *A heart or heart-lung transplant.*

Intensive cardiac rehabilitation programs must include the following components:

- *Physician-prescribed exercise each day cardiac rehabilitation items and services are furnished;*
- *Cardiac risk factor modification, including education, counseling, and behavioral intervention at least once during the program, tailored to patients' individual needs;*
- *Psychosocial assessment;*
- *Outcomes assessment; and*

- *An individualized treatment plan detailing how components are utilized for each patient.*

Intensive cardiac rehabilitation programs must be approved by Medicare. In order to be approved, a program must demonstrate through peer-reviewed published research that it has accomplished one or more of the following for its patients:

- *Positively affected the progression of coronary heart disease;*
- *Reduced the need for coronary bypass surgery; and*
- *Reduced the need for percutaneous coronary interventions.*

An intensive cardiac rehabilitation program must also demonstrate through peer-reviewed published research that it accomplished a statistically significant reduction in 5 or more of the following measures for patients from their levels before cardiac rehabilitation services to after cardiac rehabilitation services:

- *Low density lipoprotein;*
- *Triglycerides;*
- *Body mass index;*
- *Systolic blood pressure;*
- *Diastolic blood pressure; and*
- *The need for cholesterol, blood pressure, and diabetes medications.*

Intensive cardiac rehabilitation items and services must be furnished in a physician's office or a hospital outpatient setting. All settings must have a physician immediately available and accessible for medical consultations and emergencies at all time items and services are being furnished under the program. This provision is satisfied if the physician meets the requirements for direct supervision of physician office services as specified at 42 CFR 410.26 and for hospital outpatient therapeutic services as specified at 42 CFR 410.27.

As specified at 42 CFR 410.49(f)(2), intensive cardiac rehabilitation program sessions are limited to 72 1-hour sessions, up to 6 sessions per day, over a period of up to 18 weeks.

140.3.1 – Coding Requirements for Intensive Cardiac Rehabilitation Services Furnished On or After January 1, 2010

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

The following are the applicable HCPCS codes for intensive cardiac rehabilitation services:

G0422 (Intensive cardiac rehabilitation; with or without continuous ECG monitoring, with exercise, per hour, per session)

G0423 (Intensive cardiac rehabilitation; with or without continuous ECG monitoring, without exercise, per hour, per session)

Effective for dates of service on or after January 1, 2010, hospitals and practitioners may report a maximum of 6 1-hour sessions per day. In order to report one session of cardiac rehabilitation services in a day, the duration of treatment must be at least 31 minutes. Additional sessions of intensive cardiac rehabilitation services beyond the first session may only be reported in the same day if the duration of treatment is 31 minutes or greater beyond the hour increment. In other words, in order to report 6 sessions of intensive cardiac rehabilitation services on a given date of service, the first five sessions would account for 60 minutes each and the sixth session would account for at least 31 minutes. If several shorter periods of intensive cardiac rehabilitation services are furnished on a given day, the minutes of service during those periods must be added together for reporting in 1-hour session increments.

Example: *If the patient receives 20 minutes of intensive cardiac rehabilitation services in the day, no intensive cardiac rehabilitation session may be reported because less than 31 minutes of services were furnished.*

Example: *If a patient receives 20 minutes of intensive cardiac rehabilitation services in the morning and 35 minutes of intensive cardiac rehabilitation services in the afternoon of a single day, the hospital or practitioner would report 1 session of intensive cardiac rehabilitation services under 1 unit of the appropriate HCPCS G-code for the total duration of 55 minutes of intensive cardiac rehabilitation services on that day.*

Example: *If the patient receives 70 minutes of intensive cardiac rehabilitation services in the morning and 25 minutes of intensive cardiac rehabilitation services in the afternoon of a single day, the hospital or practitioner would report two sessions of intensive cardiac rehabilitation services under the appropriate HCPCS G-code(s) because the total duration of intensive cardiac rehabilitation services on that day of 95 minutes exceeds 90 minutes.*

Example: *If the patient receives 70 minutes of intensive cardiac rehabilitation services in the morning and 85 minutes of intensive cardiac rehabilitation services in the afternoon of a single day, the hospital or practitioner would report three sessions of intensive cardiac rehabilitation services under the appropriate HCPCS G-code(s) because the total duration of intensive cardiac rehabilitation services on that day is 155 minutes, which exceeds 150 minutes and is less than 211 minutes..*

140.4 – Pulmonary Rehabilitation Program Services Furnished On or After January 1, 2010

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

As specified in 42 CFR 410.47, Medicare covers pulmonary rehabilitation items and services for patients with moderate to very severe COPD (defined as GOLD classification II, III and IV), when referred by the physician treating the chronic respiratory disease.

Pulmonary rehabilitation programs must include the following components:

- *Physician-prescribed exercise. Some aerobic exercise must be included in each pulmonary rehabilitation session;*
- *Education or training closely and clearly related to the individual's care and treatment which is tailored to the individual's needs, including information on respiratory problem management and, if appropriate, brief smoking cessation counseling;*
- *Psychosocial assessment;*
- *Outcomes assessment; and*
- *An individualized treatment plan detailing how components are utilized for each patient.*

Pulmonary rehabilitation items and services must be furnished in a physician's office or a hospital outpatient setting. All settings must have a physician immediately available and accessible for medical consultations and emergencies at all time items and services are being furnished under the program. This provision is satisfied if the physician meets the requirements for direct supervision of physician office services as specified at 42 CFR 410.26 and for hospital outpatient therapeutic services as specified at 42 CFR 410.27.

As specified at 42 CFR 410.47(f), pulmonary rehabilitation program sessions are limited to a maximum of 2 1-hour sessions per day for up to 36 sessions, with the option for an additional 36 sessions over an extended period of time if approved by the Medicare contractor.

140.4.1 – Coding Requirements for Pulmonary Rehabilitation Services Furnished On or After January 1, 2010

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

The following is the applicable HCPCS code for pulmonary rehabilitation services:

G0424 (Pulmonary rehabilitation, including exercise (includes monitoring), per hour, per session)

Effective for dates of service on or after January 1, 2010, hospitals and practitioners may report a maximum of 2 1-hour sessions per day. In order to report one session of pulmonary rehabilitation services in a day, the duration of treatment must be at least 31 minutes. Two sessions of pulmonary rehabilitation services may only be reported in the same day if the duration of treatment is at least 91 minutes. In other words, the first session would account for 60 minutes and the second session would account for at least 31 minutes, if two sessions are reported. If several shorter periods of pulmonary rehabilitation services are furnished on a given day, the minutes of service during those periods must be added together for reporting in 1-hour session increments.

Example: *If the patient receives 20 minutes of pulmonary rehabilitation services in the day, no pulmonary rehabilitation session may be reported because less than 31 minutes of services were furnished.*

Example: *If a patient receives 20 minutes of pulmonary rehabilitation services in the morning and 35 minutes of pulmonary rehabilitation services in the afternoon of a single day, the hospital or practitioner would report 1 session of pulmonary rehabilitation services under 1 unit of the HCPCS G-code for the total duration of 55 minutes of pulmonary rehabilitation services on that day.*

Example: *If the patient receives 70 minutes of pulmonary rehabilitation services in the morning and 25 minutes of pulmonary rehabilitation services in the afternoon of a single day, the hospital or practitioner would report two sessions of pulmonary rehabilitation services under the HCPCS G-code because the total duration of pulmonary rehabilitation services on that day of 95 minutes exceeds 90 minutes.*

Example: *If the patient receives 70 minutes of pulmonary rehabilitation services in the morning and 85 minutes of pulmonary rehabilitation services in the afternoon of a single day, the hospital or practitioner would report two sessions of pulmonary rehabilitation services under the HCPCS G-code for the total duration of pulmonary rehabilitation services of 155 minutes. A maximum of two sessions per day may be reported, regardless of the total duration of pulmonary rehabilitation services.*