CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1599	**Date: September 19, 2008**
	Change Request 6196

SUBJECT: October 2008 Update of the Hospital Outpatient Prospective Payment System (OPPS)

I. SUMMARY OF CHANGES: This Recurring Update Notification describes changes to, and billing instructions for various payment policies implemented in the October 2008 OPPS update. The October 2008 Integrated 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 notification.

October 2008 revisions to I/OCE data files, instructions, and specifications are provided in Change Request (CR) 6186, October 2008 Integrated Outpatient Code Editor (I/OCE) Specifications Version 9.3.

New / Revised Material
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

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	4/20.6.6/Modifiers for Radiology Services
R	4/61.1/Requirement that Hospitals Report Device Codes on Claims on Which They Report Specified Procedures
R	4/200.8/Billing for Nuclear Medicine Procedures
R	17/80.2/Oral Anti-Emetic Drugs Used as Full Replacement for Intravenous Anti-Emetic Drugs as Part of a Cancer Chemotherapeutic Regimen
R	17/90.2/Drugs, Biologicals, and Radiopharmaceuticals

III. FUNDING:

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

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

IV. ATTACHMENTS:

Recurring Update Notification

Manual Instruction

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1599	Date: September 19, 2008	Change Request: 6196

SUBJECT: October 2008 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Effective Date: **October 1, 2008**

Implementation Date: October 6, 2008

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to, and billing instructions for various payment policies implemented in the October 2008 OPPS update. The October 2008 Integrated 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 notification.

October 2008 revisions to I/OCE data files, instructions, and specifications are provided in Change Request (CR) 6186, "October 2008 Integrated Outpatient Code Editor (I/OCE) Specifications Version 9.3."

B. Policy:

1. Revenue Code Reporting

Hospitals must continue to report HCPCS codes and charges with an appropriate UB revenue code consistent with NUBC requirements. When reporting the appropriate revenue code for services, hospitals should choose the most precise revenue code, or subcode, if appropriate. As NUBC guidelines dictate, "It is recommended that providers use the more detailed subcategory when applicable/available rather than revenue codes that end in "0" (General) or "9" (Other)."

Hospitals are required to follow the Medicare cost apportionment regulations at 42 CFR 413.53(a)(1) which convey that, under the departmental method of apportionment, the cost of each ancillary department is to be apportioned separately rather than being combined with another department. In order to comply with the requirements of this regulation, hospitals must follow the Medicare reimbursement policies in Provider Reimbursement Manual (PRM) Part I, section 2302.8 and PRM-II in order to ensure that their ancillary costs and charges are reported in the appropriate cost centers on the cost report.

We rely on hospitals to fully comply with the revenue code reporting instructions and Medicare cost apportionment policies because we use a revenue code to cost center crosswalk to estimate the service costs that underpin OPPS payment rates. The current revenue code to cost center crosswalk that we use for setting annual hospital outpatient payments may be found on the CMS web site at: http://www.cms.hhs.gov/HospitalOutpatientPPS/03_crosswalk.asp#TopOfPage . We always invite review of this crosswalk and welcome comments. The accuracy of hospital outpatient payments for future years depends on hospitals appropriately implementing NUBC instructions and reporting appropriate revenue codes, and following all cost report instructions.

2. Payment for Radiology Services Reported with Modifier-52

CMS is revising the Medicare Claims Processing Manual, Pub 100-04, Chapter 4, §20.6.6 to remove language incorrectly stating that payment is not reduced for radiology services reported with modifier -52 (Reduced Services). As indicated in §20.6.4, modifier -52 should be appended to procedures for which anesthesia is not planned that are discontinued after the patient is prepared and taken to the room where the procedure is to be performed. These procedures are paid at 50 percent of the full OPPS payment amount.

3. Changes to Procedure and Device Edits for October 2008

Procedure to device edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code. Failure to pass these edits will result in the claim being returned to the provider. Device to procedure edits require that a claim that contains one of a specified set of device codes be returned to the provider if it fails to contain an appropriate procedure code. The updated lists of both types of edits can be found under "2008 Device and Procedure Edits" at http://www.cms.hhs.gov/HospitalOutpatientPPS/.

4. Billing for Devices

CMS is revising the Medicare Claims Processing Manual, Pub 100-04, Chapter 4, §61.1 to clarify correct HCPCS coding and charge reporting for all devices that are used to perform procedures that require the use of devices where such codes exist and are designated with a status indicator of "N" (for packaged payment) or "H" (for pass-through device payment) in the OPPS Addendum B that applies to the date of service. If there are device HCPCS codes with status indicators other than "N" or "H" that describe devices that are used to perform the procedure or that are furnished because they are necessary for the function of an implanted device, hospitals should report the charges for those other devices on an uncoded revenue code line, but should not report the HCPCS codes for those items. Typically, payment for the costs of all internal and external components required for the function of a nonpass-through device is packaged into the APC payment for the associated procedure in which the device is used. Accurate reporting of HCPCS codes and charges for these internal and external device components is necessary so that the OPPS payment for the associated procedures will be correct in future years in which the claims are used to set the APC payment rates.

5. Billing for Medical and Surgical Supplies

When medical and surgical supplies described by HCPCS codes with status indicators other than "H" or "N" are provided incident to a physician's service by a hospital outpatient department, the HCPCS codes for these items should not be reported because these items represent supplies. Claims containing charges for medical and surgical supplies used in providing hospital outpatient services are submitted to the Medicare contractor providing OPPS payment for the services in which they are used. The hospital should include charges associated with these medical and surgical supplies on claims so their costs are incorporated in ratesetting, and payment for the supplies is packaged into payment for the associated procedures under the OPPS in accordance with 42 CFR 419.2(b)(4).

For example, if the hospital staff in the emergency department initiate the intravenous administration of a drug through an infusion pump described by HCPCS code E0781 (Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient), complete the drug infusion, and discontinue use of the infusion pump before the patient leaves the hospital outpatient department, HCPCS code E0781 should not be reported because the infusion pump was used as a supply and would be paid through OPPS payment for the drug administration service. The hospital should include the charge associated with the infusion pump on the claim.

In another example, if hospital outpatient staff perform a surgical procedure on a patient in which temporary bladder catheterization is necessary and use a catheter described by HCPCS code A4338 (Indwelling catheter; Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer, or hypdrophilic, etc.), each), the hospital should not report A4338 because the catheter was used as a supply and would be paid through OPPS payment for the surgical procedure. The hospital should include the charge associated with the urinary catheter on the claim.

6. Billing for Drugs, Biologicals, and Radiopharmaceuticals

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

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

Unless otherwise specified in the long description, HCPCS 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.

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective October 1, 2008

In the CY 2008 OPPS final rule, it was stated that payments for separately payable drugs and biologicals based on average sale prices (ASPs) will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, we will incorporate changes to the payment rates in the October 2008 release of the OPPS PRICER. The updated payment rates, effective October 1, 2008, will be included in the October 2008 update of the OPPS Addendum A and Addendum B, which will be posted on the CMS Web site shortly.

b. Drugs and Biologicals with OPPS Pass-Through Status Effective October 1, 2008

Three drugs have been granted OPPS pass-through status effective October 1, 2008. These drugs, their descriptors, and APC assignments are identified in Table 1 below.

Table 1-Drugs Granted Pass-Through Status Effective October 1, 2008

HCPCS Code	Long Descriptor	SI	APC
J9225	Histrelin implant (Vantas), 50 mg	G	1711
C9243*	Injection, bendamustine hcl, 1 mg	G	9243
C9359*	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Putty, Integra OS Osteoconductive Scaffold Putty), per 0.5cc	G	9359

NOTE: Those HCPCS codes identified with a "*" indicate that they are new codes effective October 1, 2008.

c. New HCPCS Codes for Drugs and Biologicals

There is one new drug HCPCS code for October 2008. HCPCS code C9244 (Injection, regadenoson, 0.4 mg) is assigned status indicator "K" and is assigned to APC 9244 effective October 1, 2008.

d. Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2008 through March 31, 2008

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

Table 2- Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2008 through March 31, 2008

HCPCS Code	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J7324	0877	Orthovisc inj per dose	$169.10	$33.82
J9015	0807	Aldesleukin/single use vial	$757.34	$151.47
J9303	9235	Panitumumab injection	$82.86	$16.42

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

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

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

HCPCS Code	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment

HCPCS Code	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J7324	0877	Orthovisc inj per dose	$174.63	$34.93
J9303	9235	Panitumumab injection	$82.83	$16.29
Q4096	1213	VWF complex, not Humate-P	$0.65	$0.13

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

The payment rate for one HCPCS code was incorrect in the July 2008 OPPS Pricer. The corrected payment rate is listed in Table 4 below and has been installed in the October 2008 OPPS Pricer, effective for services furnished on July 1, 2008 through implementation of the October 2008 update.

Table 4- Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2008 through September 30, 2008

HCPCS Code	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J7324	0877	Orthovisc inj per dose	$175.85	$35.17

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

Hospitals are not to bill separately for drug and biological HCPCS codes, with the exception of drugs and 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 drugs and biologicals during surgical procedures as implantable devices, hospitals may include the charges for these items in their charge for the procedure, report the charge on an uncoded revenue center line, or report the charge under a device HCPCS code (if one exists) so these costs would appropriately contribute to the future median setting for the associated surgical procedure.

h. Correct Reporting of Units for Drugs

Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor. For example, if the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be 1. As another example, if the description for the drug code is 50 mg, but 200 mg of the drug was administered to the patient, the units billed should be 4. Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, 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. Correct Reporting of Outpatient Diagnostic Nuclear Medicine Procedures When a Radiolabeled Product is Provided in the Inpatient Setting

Effective January 1, 2008, under the OPPS, payment for diagnostic radiopharmaceuticals is packaged into payment for their associated nuclear medicine procedures. In order to ensure that we capture appropriate diagnostic radiopharmaceutical costs for future ratesetting purposes, we implemented nuclear medicine procedure-to-radiopharmaceutical edits in the I/OCE effective January 2008 that required a diagnostic radiopharmaceutical to be present on the same claim as a nuclear medicine procedure for payment under the OPPS to be made.

As is the standard process for edit lists under the OPPS, we review the appropriateness of the edits and consider modifying the edits quarterly as issues are brought to our attention. In April 2008, in response to several descriptions of specific clinical scenarios provided to us by members of the public, we added HCPCS code A9517 (Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie) to our list of radiopharmaceuticals that would be accepted for a nuclear medicine procedure claim to process. In addition, in July 2008, in response to additional comments and clinical scenarios provided to us by members of the public, we expanded our list of radiolabeled products that are accepted for nuclear medicine procedure claims to process to include all therapeutic radiopharmaceuticals and brachytherapy sources, in additional to all diagnostic radiopharmaceuticals.

Since these changes to the edit list were adopted for the July update, we have received additional reports of a clinical scenario where a radiolabeled product is provided to a patient by a hospital during an inpatient stay, and a nuclear medicine procedure follows after the patient has been discharged from the inpatient setting (typically days or weeks after the provision of the radiolabeled product). No additional radiolabeled product is administered to the patient for purposes of the nuclear medicine procedure. Payment for the radiolabeled product is bundled into payment for the inpatient admission, so the hospital is unable to report a HCPCS code for a radiolabeled product on the OPPS claim for the nuclear medicine procedure in order to meet the edit requirements.

Similar to other clinical scenarios we have previously addressed through changes to our edit list, members of the public bringing this situation to our attention have indicated that situations where these radiolabeled products would be provided to a hospital inpatient, with follow-up diagnostic imaging performed in the hospital outpatient setting days or weeks later, would be rare, but are sufficiently common that hospitals require a methodology to appropriately bill and be paid for the associated nuclear medicine procedures. As a result of these requests, for the October 2008 update we have created 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. This HCPCS code is assigned status indicator “N” because no separate payment is made for the code under the OPPS. The effective date of the code is January 1, 2008, the date the procedure-to-radiopharmaceutical edits were initially implemented. Because the Medicare claims processing system requires that there be a charge for each HCPCS code reported on the claim, hospitals should always report a token charge of less than $1.01 for HCPCS code C9898. The date of service reported on the claim for HCPCS code C9898 should be the same as the date of service for the nuclear medicine procedure HCPCS code, which should always accompany the reporting of HCPCS code C9898.

With the specific exception described above for HCPCS code C9898, 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.

We expect that the majority of hospital outpatient claims for diagnostic nuclear medicine procedures will include reporting of a diagnostic radiopharmaceutical because both the radiopharmaceutical and the nuclear medicine procedure are provided in the hospital outpatient department, and that it will be only in uncommon circumstances that hospitals will provide a radiolabeled product during a hospital inpatient stay, followed by a diagnostic nuclear medicine procedure after the patient has been discharged. We will be monitoring claims to ensure that this is the case.

Therefore, beginning in October 2008, claims for diagnostic nuclear medicine procedures in which the radiolabeled product that provides the radioactivity for the study was furnished during a hospital inpatient stay will not be returned to the provider as long as the nuclear medicine procedure and HCPCS code C9898 are included on the same claim, with a token charge for HCPCS code C9898. HCPCS code C9898 should never be reported on a claim without a diagnostic nuclear medicine procedure that is subject to the nuclear medicine procedure-to-radiolabeled product edits. Hospitals may submit claims reporting HCPCS code C9898 for dates of service beginning January 1, 2008.

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

j. Payment for Therapeutic Radiopharmaceuticals

The Medicare Improvement for Patients and Providers Act of 2008 requires CMS to pay for therapeutic radiopharmaceuticals for the period of July 1, 2008 through December 31, 2009, at hospitals' charges adjusted to the costs. Therefore, the prospective payment rates for the HCPCS codes listed in Table 5 below, which were listed in Addendum B to our CY 2008 final rule dated November 27, 2007, will not be used for payment during the period from July 1 through December 31, 2008, as we indicated in Transmittal 1536 (dated June 19, 2008.) Instead, the status indicators of therapeutic radiopharmaceutical HCPCS codes which were previously paid at charges adjusted to cost will remain "H" effective July 1, 2008 through December 31, 2009, to indicate payment will be made for therapeutic radiopharmaceuticals at hospitals' charges adjusted to their costs.

Table 5 – Therapeutic Radiopharmaceuticals Paid At Charges Adjusted to Cost From July 1, 2008 through December 31, 2009

HCPCS Code	Long Descriptor	SI
A9517	Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie	H
A9530	Iodine I-131 sodium iodide solution, therapeutic, per millicurie	H
A9543	Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries	H
A9545	Iodine I-131 tositumomab, therapeutic, per treatment dose	H
A9563	Sodium phosphate P-32, therapeutic, per millicurie	H
A9564	Chromic phosphate P-32 suspension, therapeutic, per millicurie	H
A9600	Strontium Sr-89 chloride, therapeutic, per millicurie	H
A9605	Samarium Sm-153 lexidronamm, therapeutic, per 50 millicuries	H

7. Payment for Brachytherapy Sources

The Medicare Improvement for Patients and Providers Act of 2008 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 (with the exception of C2637, which is non-payable, as noted in the table below). Therefore, the prospective payment rates for each source, which are listed in Addendum B to our CY 2008 final rule dated November 27, 2007, will not be used for payment during the period from July 1 through December 31, 2008, as we indicated in Transmittal 1536 (dated June 19, 2008.) Instead, the

status indicators of brachytherapy source HCPCS codes (except C2637) which were previously paid at charges adjusted to cost will remain "H" effective July 1, 2008 through December 31, 2008, for payment of brachytherapy sources at hospitals' charges adjusted to their costs. In addition, because of their cost-based payment methodology through CY 2009, brachytherapy sources will not be eligible for outlier payments or for the rural sole community hospital (SCH) adjustment during that time period. CMS will provide new instructions at a later date for brachytherapy source payment effective January 1, 2010. The codes for separately paid brachytherapy sources, long descriptors, status indicators, and APCs for CY 2008 are listed in Table 6, 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 6- Comprehensive List of Brachytherapy Sources Payable as of July 1, 2008

HCPCS Code	Long Descriptor	SI	APC
A9527	Iodine I-125, sodium iodide solution, therapeutic, per millicurie	H	2632
C1716	Brachytherapy source, non-stranded, Gold-198, per source	H	1716
C1717	Brachytherapy source, non-stranded, High Dose Rate Iridium-192, per source	H	1717
C1719	Brachytherapy source, non-stranded, Non-High Dose Rate Iridium-192, per source	H	1719
C2616	Brachytherapy source, non-stranded, Yttrium-90, per source	H	2616
C2634	Brachytherapy source, non-stranded, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source	H	2634
C2635	Brachytherapy source, non-stranded, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source	H	2635
C2636	Brachytherapy linear source, non-stranded, Palladium-103, per 1MM	H	2636
C2637	Brachytherapy source, non-stranded, Ytterbium-169, per source	B	
C2638	Brachytherapy source, stranded, Iodine-125, per source	H	2638
C2639	Brachytherapy source, non-stranded, Iodine-125, per source	H	2639
C2640	Brachytherapy source, stranded, Palladium-103, per source	H	2640
C2641	Brachytherapy source, non-stranded, Palladium-103, per source	H	2641
C2642	Brachytherapy source, stranded, Cesium-131, per source	H	2642
C2643	Brachytherapy source, non-stranded, Cesium-131, per source	H	2643
C2698	Brachytherapy source, stranded, not otherwise specified, per source	H	2698
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source	H	2699

8. Mental Health codes on Partial Hospitalization (PH/PHP) Claims

If a hospital-based PHP bills with Condition Code 41 for mental health codes that are not on the PHP code list (List B) housed in the IOCE, the IOCE will return the claim to the provider (edit 80) with the claim message, "Mental Health (MH) code not approved for partial hospitalization program". Examples of current mental health codes that are not used in PHP processing are 90804, 90805, 90810, 90811, 96110, and 96111. These codes may be billed by the hospital but cannot be counted toward the 3 minimum services required to qualify for partial hospitalization.

9. 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, FI/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	
6196.1	Medicare contractors shall install the October 2008 OPPS Pricer.	X		X		X	X				COBC
6196.2	HCPCS codes: C9243, C9244, C9359 and C9898 are included in the October 2008 I/OCE update. However, these codes are not on the 2008 HCPCS file. Medicare contractors shall manually add these codes to their systems. Status and payment indicators for these codes will be listed in the October 2008 update of the OPPS Addendum A and Addendum B on the CMS Web site.	X		X		X	X			X	COBC
6196.3	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service that fall on or after January 1, 2008, but prior to April 1, 2008; 2) Contain HCPCS code(s) listed in Table 2; and 3) Were originally processed prior to the installation of the October 2008 OPPS Pricer.	X		X		X					COBC
6196.4	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service that fall on or after April 1, 2008, but prior to July 1, 2008; 2) Contain HCPCS code(s) listed in Table 3; and 3) Were originally processed prior to the installation of the October 2008 OPPS Pricer.	X		X		X					COBC
6196.5	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service that fall on or after July 1, 2008, but prior to October 1, 2008;	X		X		X					COBC

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	2) Contain HCPCS code listed in Table 4; and 3) Were originally processed prior to the installation of the October 2008 OPPS Pricer.										

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	
6196.6	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:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
CR 6186	"October 2008 Integrated Outpatient Code Editor (I/OCE) Specifications Version 9.3."

Section B: For all other recommendations and supporting information, use this space:

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), Carriers, and Regional Home Health Intermediaries (RHHIs)*:

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 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

20.6.6 - Modifiers for Radiology Services

(Rev.1599, Issued: 09-19-08, Effective: 10-01-08, Implementation: 10-06-08)

Modifiers -52 (Reduced Services), -59, -76, and -77, and the Level II modifiers apply to radiology services.

When a radiology procedure is reduced, the correct reporting is to code to the extent of the procedure performed. If no *HCPCS* code exists for *the service that* has been *completed,* report the intended *HCPCS* code with modifier -52 appended.

EXAMPLE: *CPT c*ode 71020 (Radiologic examination, chest, two views, frontal and lateral) is ordered. Only one *frontal* view is performed. *CPT c*ode 71010 (Radiologic examination, chest: single view, frontal) is reported. *The service is not reported as CPT c*ode 71020-52.

61.1 - Requirement that Hospitals Report Device Codes on Claims on Which They Report Specified Procedures

(Rev.1599, Issued: 09-19-08, Effective: 10-01-08, Implementation: 10-06-08)

Effective January 1, 2005, hospitals paid under the OPPS (bill types 12X and 13X) that report procedure codes that require the use of devices must also report the applicable HCPCS codes and charges for all devices that are used to perform the procedures where such codes exist *and are designated with a status indicator of "N" (for packaged payment) or "H" (for pass-through device payment) in the OPPS Addendum B that applies to the date of service. If there are device HCPCS codes with status indicators other than "N" or "H" that describe devices that are used to perform the procedure or that are furnished because they are necessary for the function of an implanted device, hospitals should report the charges for those other devices on an uncoded revenue code line, but should not report the HCPCS codes for those items. Typically, payment for the costs of all internal and external components required for the function of a nonpass-through device is packaged into the APC payment for the associated procedure in which the device is used. Accurate reporting of HCPCS codes and charges for these internal and external device components* is necessary so that the OPPS payment for the *associated* procedures will be correct in future years in which the claims are used to *set* the APC payment *rates.*

200.8 - Billing for Nuclear Medicine Procedures

(Rev.1599, Issued: 09-19-08, Effective: 10-01-08, Implementation: 10-06-08)

Beginning January 1, 2008, the I/OCE requires claims with separately payable nuclear medicine procedures to include a radiolabeled product (i.e., diagnostic radiopharmaceutical, therapeutic radiopharmaceutical, or brachytherapy source). Hospitals are required to submit the HCPCS code for the radiolabeled product on the same claim as the HCPCS code for the nuclear medicine procedure. Hospitals are also instructed to submit the claim so that the services on the claim each reflect the date the particular service was provided. Therefore, if the nuclear medicine procedure is provided on a different date of service from the radiolabeled product, the claim will contain more than one date of service. More information regarding these edits is available on the OPPS Web site at http://www.cms.hhs.gov/HospitalOutpatientPPS/.

There are rare situations where a hospital provides a radiolabeled product to an inpatient, and then the patient is discharged and later returns to the outpatient department for a nuclear medicine imaging procedure but does not require additional radiolabeled product. In these situations, hospitals are to include HCPCS code C9898 (Radiolabeled product provided during a hospital inpatient stay) with a token charge (of less than $1.01) on the same claim as the nuclear medicine procedure in order to receive payment for the nuclear medicine procedure. HCPCS code C9898 should only be reported under the circumstances described above and the date of service for C9898 should be the same as the date of service for the diagnostic nuclear medicine procedure.

Future updates to this section will be communicated in a Recurring Update Notification.

Medicare Claims Processing Manual
Chapter 17 - Drugs and Biologicals

80.2 - Oral Anti-Emetic Drugs Used as Full Replacement for Intravenous Anti-Emetic Drugs as Part of a Cancer Chemotherapeutic Regimen
(Rev.1599, Issued: 09-19-08, Effective: 10-01-08, Implementation: 10-06-08)

See the Medicare Benefits Policy Manual, Chapter 15, for detailed coverage requirements.

Effective for dates of service on or after January 1, 1998, FIs and carriers pay for oral anti-emetic drugs when used as full therapeutic replacement for intravenous dosage forms as part of a cancer chemotherapeutic regimen when the drug(s) is administered or prescribed by a physician for use immediately before, at, or within 48 hours after the time of administration of the chemotherapeutic agent.

The allowable period of covered therapy includes day one, the date of service of the chemotherapy drug (beginning of the time of treatment), plus a period not to exceed two additional calendar days, or a maximum period up to 48 hours. Some drugs are limited to 24 hours; some to 48 hours. The hour limit is included in the narrative description of the HCPCS code.

The oral three drug combination is aprepitant, a 5-HT_3 antagonist, e.g. granisetron, ondansetron, or dolasetron, and dexamethasone, a cortico-steroid.

The oral anti-emetic drug(s) should be prescribed only on a per chemotherapy treatment basis. For example, only enough of the oral anti-emetic(s) for one 24- or 48-hour dosage regimen (depending upon the drug) should be prescribed/supplied for each incidence of chemotherapy treatment. The three drug combination protocol requires the first dose to be administered before, during, or immediately after the anti-cancer chemotherapy administration. The second day is defined as “within 24 hours” and the third day is defined as “within 48 hours” of the chemotherapy administration. These drugs may be supplied by the physician in the office, by an inpatient or outpatient provider (e.g., hospital, CAH, SNF), or through a supplier (e.g., a pharmacy).

The physician must indicate on the prescription that the beneficiary is receiving the oral anti-emetic drug(s) as full therapeutic replacement for an intravenous anti-emetic drug as part of a cancer chemotherapeutic regimen. Where the drug is provided by a facility, the beneficiary’s medical record maintained by the facility must be documented to reflect that the beneficiary is receiving the oral anti-emetic drug(s) as full therapeutic replacement for an intravenous anti-emetic drug as part of a cancer chemotherapeutic regimen.

Payment for these drugs is made under Part B. Beginning 1/1/05, the payment allowance limit for these Part B drugs (the term "drugs" includes biologicals) will be based on the Average Sales Price (ASP) plus 6%. Hospital outpatient department providers may either:

(1) Bill the entire Tri-Pak to the FI (three days of aprepitant, 57 units of J8501), or (2) Bill the first day's drug to their local FI or A/B MAC, and give a prescription for the second and third days' supply of aprepitant.

If billed to the FI, all three drugs in the combination oral anti-emetic must be on the same claim. Providers subject to the hospital outpatient PPS will be paid on the basis of an APC. If the hospital outpatient department dispenses the aprepitant for days two and three to the beneficiary and bills the DME MAC for the take home drugs, the hospital's billing department should review all instructions for billing oral anti-emetics. Follow this link to reach the LCD for oral anti-emetics:

http://www.cms.hhs.gov/mcd/viewlcd.asp?lcd_id=5058&lcd_version=27&show=all

In the case of IV Emend provided on day 1, payment for days 2 and 3 would not be made under Part B.

Payment allowances for these drugs dispensed in physician offices will be based on the lower of the submitted charge or the ASP file price. These drugs continue to be priced based on the date of service. The drug payment allowance limit pricing file is distributed to contractors by CMS on a quarterly basis.

The HCPCS codes shown in section 80.2.1 are used.

The CWF edits claims with these codes to assure that the beneficiary is receiving the oral anti-emetic(s) as part of a cancer chemotherapeutic regimen by requiring a diagnosis of cancer.

Most drugs furnished as an outpatient hospital service are packaged under OPPS. However, chemotherapeutic agents and the supportive and adjunctive drugs used with them are paid separately.

Effective for dates of service on or after April 4, 2005, coverage for the use of the oral anti-emetic 3-drug combination of aprepitant (Emend®), a 5-HT_3 antagonist, and dexamethasone is considered reasonable and necessary for only those patients who are receiving one or more of the following anti-cancer chemotherapeutic agents:

- Carmustine
- Cisplatin

- Cyclophosphamide
- Dacarbazine
- Mechlorethamine
- Streptozocin
- Doxorubicin
- Epirubicin

90.2 - Drugs, Biologicals, and Radiopharmaceuticals

(Rev.1599, Issued: 09-19-08, Effective: 10-01-08, Implementation: 10-06-08)

A. General Billing and Coding for Hospital Outpatient Drugs, Biologicals, and Radiopharmaceuticals

Hospitals should 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 code are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used in the care of the patient.

Payment for drugs, biologicals and radiopharmaceuticals under the OPPS is inclusive of both the acquisition cost and the associated pharmacy overhead or nuclear medicine handling cost. Hospitals should include these costs in their line-item charges for drugs, biologicals, and radiopharmaceuticals.

Under the OPPS, if commercially available products are being mixed together to facilitate their concurrent administration, the hospital should report the quantity of each product (reported by HCPCS code) used in the care of the patient. Alternatively, if the hospital is compounding drugs that are not a mixture of commercially available products, but are a different product that has no applicable HCPCS code, then the hospital should report an appropriate unlisted drug code (J9999 or J3490). In these situations, 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 FDA on or after January 1, 2004, for which a specific HCPCS code has not been assigned.

The HCPCS code list of retired codes and new HCPCS codes reported under the hospital OPPS is published quarterly via Recurring Update Notifications. The latest payment rates associated with each APC and HCPCS code may be found in the most current Addendum A and Addendum B, respectively, that can be found under the CMS quarterly

provider updates on the CMS Web site at:
http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp

B. Pass-Through Drugs, Biologicals, and Radiopharmaceuticals

Payment for drugs, biologicals, and radiopharmaceuticals may be made under the pass-through provision which provides additional payments for drugs, biologicals, and radiopharmaceuticals that meet certain requirements relating to newness and relative costs. According to section 1833(t) of the Social Security Act, transitional pass-through payments can be made for at least 2 years, but no more than 3 years. For the process and information required to apply for transitional pass-through payment status for drugs, biologicals, and radiopharmaceuticals, go to the main OPPS Web page, currently at http://www.cms.hhs.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage to see the latest instructions. (**NOTE:** Due to the continuing development of the new cms.hhs.gov Web site, this link may change.) Payment rates for pass-through drugs, biologicals, and radiopharmaceuticals are updated quarterly. The all-inclusive list of billable drugs, biologicals, and radiopharmaceuticals for pass-through payment is included in the current quarterly Addendum B. The most current Addendum B can be found under the CMS quarterly provider updates on the CMS Web site at: http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp.

C. Non Pass-Through Drugs and Biologicals

Under the OPPS, drugs and biologicals that are not granted pass-through status receive either packaged payment or separate payment. Payment for drugs and biologicals with estimated per day costs equal to or below the applicable drug packaging threshold is packaged into the payment for the associated procedure, commonly a drug administration procedure. Drugs and biologicals with per day costs above the applicable drug packaging threshold are paid separately through their own APCs.

D. Radiopharmaceuticals

1. General

Beginning in CY 2008, the OPPS divides radiopharmaceuticals into two groups for payment purposes: diagnostic and therapeutic. Diagnostic radiopharmaceuticals function effectively as products that enable the provision of an independent service, specifically, a diagnostic nuclear medicine scan. Therapeutic radiopharmaceuticals are themselves the primary therapeutic modality.

Beginning January 1, 2008, the I/OCE requires claims with separately payable nuclear medicine procedures to include a radiolabeled product (i.e., diagnostic radiopharmaceutical, therapeutic radiopharmaceutical, or brachytherapy source). Hospitals are required to submit the HCPCS code for the radiolabeled product on the same claim as the HCPCS code for the nuclear medicine procedure. Hospitals are also

instructed to submit the claim so that the services on the claim each reflect the date the particular service was provided. Therefore, if the nuclear medicine procedure is provided on a different date of service from the radiolabeled product, the claim will contain more than one date of service. More information regarding these edits is available on the OPPS Web site at http://www.cms.hhs.gov/HospitalOutpatientPPS/.

There are rare situations where a hospital provides a radiolabeled product to an inpatient, and then the patient is discharged and later returns to the outpatient department for a nuclear medicine imaging procedure but does not require additional radiolabeled product. In these situations, hospitals are to include HCPCS code C9898 (Radiolabeled product provided during a hospital inpatient stay) with a token charge (of less than $1.01) on the same claim as the nuclear medicine procedure in order to receive payment for the nuclear medicine procedure. HCPCS code C9898 should only be reported under the circumstances described above, and the date of service for C9898 should be the same as the date of service for the diagnostic nuclear medicine procedure.

2. Diagnostic Radiopharmaceuticals

Beginning in CY 2008, payment for non pass-through diagnostic radiopharmaceuticals is packaged into the payment for the associated nuclear medicine procedure.

3. Therapeutic Radiopharmaceuticals

The OPPS will continue to pay for non pass-through therapeutic radiopharmaceuticals at charges adjusted to cost From January 1, 2008 through *December 31, 2009*.