CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1980	**Date: June 4, 2010**
	Change Request 6996

Transmittal 1980, dated June 4, 2010 rescinds and replaces Transmittal 1976, issued on May 28, 2010. An incorrect payment rate of $25.66 for the HCPCS, G9141 ((Influenza a (h1n1) immunization administration (includes the physician counseling the patient/family)) was inadvertently included in section I.B.5.f. and an incorrect payment rate of $25.67 for the same HCPCS in table 6 of this Change Request. The correct payment rate of $25.61 is included in this transmittal. There are no changes to the Pub. 100-02, Medicare Benefit Policy Manual portion of this CR. All other material remains the same.

SUBJECT: July 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 July 2010 OPPS update. The July 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). This Recurring Update Notification applies to chapter 4, Section 231.

July 2010 revisions to I/OCE data files, instructions, and specifications are provided in Transmittal 1969, CR 6967, July 2010 Integrated Outpatient Code Editor (I/OCE) Specifications Version 11.2.

EFFECTIVE DATE: July 1, 2010
IMPLEMENTATION DATE: July 6, 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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	4/231.11/Billing for Allogeneic Stem Cell Transplants

III. FUNDING:

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.

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: 1980	Date: June 4, 2010	Change Request: 6996

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

Transmittal 1980, dated June 4, 2010 rescinds and replaces Transmittal 1976, issued on May 28, 2010. An incorrect payment rate of $25.66 for the HCPCS, G9141 ((Influenza a (h1n1) immunization administration (includes the physician counseling the patient/family)) was inadvertently included in section I.B.5.f. and an incorrect payment rate of $25.67 for the same HCPCS in table 6 of this Change Request. The correct payment rate of $25.61 is included in this transmittal. There are no changes to the Pub. 100-02, Medicare Benefit Policy Manual portion of this CR. All other material remains the same.

Effective Date: July 1, 2010

Implementation Date: July 6, 2010

I. GENERAL INFORMATION

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

July 2010 revisions to I/OCE data files, instructions, and specifications are provided in Transmittal 1969, CR 6967, "July 2010 Integrated Outpatient Code Editor (I/OCE) Specifications Version 11.2."

Revised payment files for the 2010 Outpatient Prospective Payment System (OPPS) and Retroactive Provisions under the Affordable Care Act (Pub L.111-148), will be issued in a separate CR.

B. Policy:

1. Procedure and Device Edits for July 2010

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. Procedures for which both a Device A and a Device B are specified require that at least one each of Device A and Device B be present on the claim (i.e., there must be some combination of a Device A with a Device B in order to pass the edit). Device B can be reported with any Device A for the same procedural HCPCS code.

Device to procedure edits require that a claim that contains one of a specified set of device codes be returned to the provider if it fails to contain an appropriate procedure code. The updated lists of both types of edits can be found under "Device, Radiolabeled Product, and Procedure Edits" at http://www.cms.gov/HospitalOutpatientPPS/.

2. Category III CPT Codes

The AMA releases Category III CPT codes in January, for implementation beginning the following July, and in July, for implementation beginning the following January. Prior to CY 2006, CMS implemented new Category III CPT codes once a year in January of the following year.

As discussed in the CY 2006 OPPS final rule with comment period (70 FR 68567), CMS modified itsr process for implementing the Category III codes that the AMA releases each January for implementation in July to ensure timely collection of data pertinent to the services described by the codes; to ensure patient access to the services the codes describe; and to eliminate potential redundancy between Category III CPT codes and some of the C-codes that are payable under the OPPS and were created by CMS in response to applications for new technology services. Therefore, on July 1, 2010, CMS is implementing in the OPPS 11, Category III CPT codes that the AMA released in January 2010 for implementation in July 2010. Of the 11 Category III CPT codes, 10 are separately payable under the hospital OPPS. The Category III CPT codes, status indicators, and APCs are shown in Table 1 below. Payment rates for these services can be found in Addendum B of the July 2010 OPPS Update that is posted on the CMS Website. CPT code 0233T (skin advanced glycation endproducts (AGE) measurement by multi-wavelength fluorescent spectroscopy) will be paid under the Medicare Physician Fee Schedule, beginning July 1, 2010, when billed by OPPS providers.

Table 1--Category III CPT Codes Implemented as of July 1, 2010

HCPCS	Long Descriptor	SI	APC
0223T	Acoustic cardiography, including automated analysis of combined acoustic and electrical intervals; single, with interpretation and report	S	0099
0224T	Multiple, including serial trended analysis and limited reprogramming of device parameter - AV or VV delays only, with interpretation and report	S	0690
0225T	Multiple, including serial trended analysis and limited reprogramming of device parameter - AV and VV delays, with interpretation and report	S	0690
0226T	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed	X	0340
0227T	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)	T	0146
0228T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; single level	T	0207
0229T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; each additional level (List separately in addition to code for primary procedure)	T	0206
0230T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; single level	T	0207
0231T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; each additional level (List separately in addition to code for primary procedure)	T	0206
0232T	Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed	X	0340
0233T	Skin advanced glycation endproducts (AGE) measurement by multi-wavelength fluorescent spectroscopy	A	NA

3. Dermal Injections for Treatment of Facial Lipodystrophy Syndrome (LDS)

Effective for claims with dates of service on and after March 23, 2010, coverage for dermal injections for the treatment of facial lipodystrophy syndrome (LDS) is considered reasonable and necessary only in HIV-infected beneficiaries who manifest depression secondary to the physical stigma of HIV treatment. CMS will cover and pay separately for the dermal filler injection procedure and the dermal filler products that are approved by the Food and Drug Administration (FDA).

CMS has created four Level II HCPCS codes to describe the dermal filler injection procedure and the dermal filler products. Specifically, CMS has created the following four HCPCS codes: C9800 (Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies), Q2026 (Injection, Radiesse, 0.1 ml), Q2027 (Injection, Sculptra, 0.1 ml), and G0429 (Dermal Filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy)). Under the hospital OPPS, CMS has assigned HCPCS code C9800 to APC 0135 with a status indicator "T". Since HCPCS code C9800 describes both the injection procedure and the dermal filler items and supplies, CMS has assigned HCPCS codes G0429, Q2026, and Q2027 to status indicator "B" to indicate that these codes are not recognized by OPPS when submitted on an outpatient hospital Part B bill type 12x or 13x.

Table 2—HCPCS Codes for Dermal Filler Injection Implemented as of July 1, 2010

HCPCS	Long Descriptor	SI	APC
C9800	Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies	T	0135
G0429	Dermal Filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy)	B	NA
Q2026	Injection, Radiesse, 0.1 ml	B	NA
Q2027	Injection, Sculptra, 0.1 ml	B	NA

4. Billing for Allogeneic Stem Cell Transplant Procedures

This CR is revising Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, Section 231.11 to clarify that charges for allogeneic stem cell acquisition services billed with revenue code 0819 (Other Organ Acquisition) should be reported on the same date of service as the allogeneic transplant procedure in order to be appropriately packaged for payment purposes.

5. 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.

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 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 July 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 third 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 program was suspended beginning January 1, 2009. Should the Part B Drug CAP program be reinstituted sometime during CY 2010, CMS would again use the Part B drug CAP rate for pass-through drugs and biologicals if they are a part of the Part B drug CAP program, as required by the statute.

In the CY 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 later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the July 2010 release of the OPPS Pricer. The updated payment rates, effective July 1, 2010, will be included in the July 2010 update of the OPPS Addendum A and Addendum B, which will be posted on the CMS Web site.

b. Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2010

Six drugs and biologicals have been granted OPPS pass-through status effective July 1, 2010. These items, along with their descriptors and APC assignments, are identified in Table 3 below.

Table 3—Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2010

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 7/1/10
C9264*	Injection, tocilizumab, 1 mg	9264	G
C9265*	Injection, romidepsin, 1 mg	9265	G
C9266*	Injection, collagenase clostridium histolyticum, 0.1 mg	9266	G
C9267*	Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO	9267	G
C9268*	Capsaicin, patch, 10cm2	9268	G
C9367*	Skin substitute, Endoform Dermal Template, per square centimeter	9367	G

NOTE: The HCPCS codes identified with an "*" indicate that these are new codes effective July 1, 2010.

c. New HCPCS Codes Effective for Certain Drugs and Biologicals

One new HCPCS code has been created for reporting drugs and biologicals in the hospital outpatient setting for July 2010. This code is listed in Table 4 below and replaces C9262. This code is effective for services furnished on or after July 1, 2010.

Table 4— New HCPCS Codes Effective for Certain Drugs and Biologicals Effective July 1, 2010

HCPCS Code	Long Descriptor	APC	Status Indicator Effective

			7/1/10
Q2025	Fludarabine phosphate, oral, 1 mg	9262	G

d. Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2010 through June 30, 2010

The payment rates for three HCPCS codes were incorrect in the April 2010 OPPS Pricer. The corrected payment rates are listed in Table 5 below and have been incorporated into the reissued Pricer, effective for services furnished on April 1, 2010, through implementation of the July 2010 update. Affected claims that were already processed/paid prior to the reissued Pricer have been reprocessed (or are in the process of being reprocessed).

Table 5—Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2010 through June 30, 2010

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9258	G	9258	Telavancin injection	$2.12	$0.42
C9262	G	9262	Fludarabine phosphate, oral	$8.18	$1.61
J1540	K	0923	Gamma globulin 9 CC inj	$141.64	$28.33

e. Adjustment to Status Indicator for HCPCS Code 90670 Effective April 1, 2010

Effective April 1, 2010, the status indicator for HCPCS code 90670 (Pneumococcal conjugate vaccine, 13 valent, for intramuscular use) will change from SI=E (not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=K (paid under OPPS; separate APC payment). For the remainder of CY 2010, HCPCS code 90670 will be separately paid and the price will be updated on a quarterly basis.

f. Category I H1N1 Vaccine CPT Codes

As stated in the October 2009 Update of the hospital OPPS that was published in Transmittal 1803, Change Request 6626, dated August 28, 2009, CMS created two Level II HCPCS codes to describe the H1N1 vaccine itself and the H1N1 vaccine administration. Specifically, G9141 ((Influenza a (h1n1) immunization administration (includes the physician counseling the patient/family)) and G9142 ((Influenza a (h1n1) vaccine, any route of administration)) were made effective September 1, 2009. Under the OPPS, HCPCS code G9142 is assigned to status indicator "E" indicating that payment is not made by Medicare when this code is submitted on an outpatient bill type because the H1N1 vaccine is supplied at no cost to providers. However, payment will be made to a provider for the administration of the H1N1 vaccine when reported under HCPCS code G9141, even if the vaccine is supplied at no cost to the provider. HCPCS code G9141 is assigned to APC 0350 (Administration of Flu and PPV Vaccine) with a status indicator of "S" and a payment rate of $25.61 for CY 2010. Beneficiary copayment and deductible do not apply to HCPCS code G9141 (for both OPPS and non OPPS providers). Providers should report one unit of HCPCS code G9141 for each administration of the H1N1 vaccine.

In January 2010, the CPT Editorial Panel, through the AMA Website, released four new H1N1 vaccine CPT codes for implementation on July 1, 2010. The four new H1N1 vaccine codes are: 90664, 90666, 90667, and 90668 (see Table 6 for the code descriptors). CMS notes that CPT code 90663 was made effective September 28, 2009 and was assigned to status indicator "E" under the OPPS since its effective date. Because two existing H1N1 G-codes appropriately describe the vaccine itself and the

administration, Medicare will only recognize the G-codes. Under the hospital OPPS, providers must report the H1N1 vaccine itself by reporting G9142 and G9141 for the H1N1 vaccine administration. Table 6 provides a list of H1N1 vaccine and H1N1 vaccine administration HCPCS codes, status indicators, APCs, and payment rates as of July 1, 2010 under the hospital OPPS.

Table 6—H1N1 Vaccine and H1N1 Vaccine Administration HCPCS Codes as of July 1, 2010

	HCPCS	Long Descriptor	SI	APC	Payment Rate
H1N1 Vaccine HCPCS Codes	G9142	Influenza a (h1n1) vaccine, any route of administration	E	NA	NA
	90663	Influenza virus vaccine, pandemic formulation, H1N1	E	NA	NA
	90664	Influenza Influenza virus vaccine, pandemic formulation, live, for intranasal use	E	NA	NA
	90666	Influenza virus vaccine, pandemic formulation, split virus, preservative free, for intramuscular use	E	NA	NA
	90667	Influenza virus vaccine, pandemic formulation, split virus, adjuvanted, for intramuscular use	E	NA	NA
	90668	Influenza virus vaccine, pandemic formulation, split virus, for intramuscular use	E	NA	NA
H1N1 Vaccine Administration HCPCS Codes	G9141	Influenza a (h1n1) immunization administration (includes the physician counseling the patient/family)	S	0350	$25.61
	90470	H1N1 immunization administration (intramuscular, intranasal), including counseling when performed	E	NA	NA

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. Units should be reported in multiples of the units included in the HCPCS descriptor. Providers and hospitals should not bill the units based on the way the implantable biological is packaged, stored, or stocked. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the implantable biological. Therefore, before submitting Medicare claims for biologicals that are used as implantable devices, it is extremely important to review the complete long descriptors for the applicable HCPCS codes. In circumstances where the implanted biological has pass-through status, 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. 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, 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.

As discussed in Pub.100-04, Medicare Claims Processing Manual, chapter 17, section 40, CMS encourages hospitals to use drugs efficiently and in a clinically appropriate manner. However, CMS also recognizes that hospitals may discard some drug and biological product when administering from a single use vial or package. In that circumstance, Medicare pays for the amount of drug or biological discarded *as well as* the *dose* administered, up to the amount of the drug or biological as indicated on the vial or package label. Multi-use vials are not subject to payment for discarded amounts of drug or biological.

i. Reporting of Outpatient Diagnostic Nuclear Medicine Procedures

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 expects that the majority of hospitals will not encounter this situation.

6. Information regarding the Core-Based Statistical Area (CBSA) and Wage Indexes in effect for CY 2010

Sections 3137(a) and 10317 of Pub. L 111-148 (Affordable Care Act) revised the wage indexes that are in effect for FY 2010. As a result of these changes, instructions were issued to contractors in a separate CR regarding the revised wage indices in effect for FY 2010. The OPPS adopts the post reclassification fiscal year wage index in effect for the inpatient prospective payment system (IPPS) on a calendar year basis. Therefore, CMS adopted the reclassified wage indices that began for IPPS payment on April 1, 2010, for hospital outpatient payment under the OPPS beginning July 1 to align the mid-year change in post-reclassification wages for some CBSAs with the OPPS calendar year payment period. The OPPS also adopts section 508 geographic reclassifications on a fiscal year basis. The Affordable Care Act extended section 508 reclassification wage indexes through September 30, 2010. Similar to CMS' treatment of section 508 reclassifications as previously extended under 124 of Pub. L. 110- 275 (MIPPA), hospitals with section 508 reclassifications will revert to their home area wage index, with out- migration adjustment if applicable, from October 1, 2010, to December 31, 2010. As CMS did for CY 2009, CMS is also beginning reclassification wage indexes for certain special exception hospitals on January 1 and extending them through December 31, 2010. Note that the wage indices included in the July 1, 2010 OPPS Pricer reflect the revised post-reclassification wage index values implemented for the IPPS on April 1, 2010. Contractors shall maintain the current CBSA value assigned to all OPPS hospitals, including those with non section 508 wage index reclassifications that have been approved by the Medicare Geographic Classification Review Board (MGCRB).

7. 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	
6996.1	Medicare contractors shall install the July 2010 OPPS Pricer.	X		X		X	X				COBC
6996.2	Medicare contactors shall manually add the following HCPCS codes to their systems: • All HCPCS listed in tables 1, 2, 3, 4, and • HCPCS 90664-90668 (listed in table 6 of this CR), and • HCPCS G0428 (listed in CR6967)	X		X		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	
	Note: These HCPCS codes will be included with the July 2010 IOCE update. They are currently not on the 2010 HCPCS file; however, they will be listed on the CMS Web site at http://www.cms.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp#TopOfPage. Status and payment indicators for these HCPCS codes will be listed in the July 2010 update of the OPPS Addendum A and Addendum B on the CMS Web site.										
6996.3	Medicare contractors shall maintain the current CBSA value assigned to all OPPS hospitals, including those with (MGCRB) reclassifications that are not section 508 or special exception reclassifications.	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	
6996.4	A provider education article related to this instruction will be available at http://www.cms.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:
	None

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

Refer to Transmittal 1969, CR 6967 "July 2010 Integrated Outpatient Code Editor (I/OCE) Specifications Version 11.2" for supporting information.

V. CONTACTS

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

Post-Implementation Contact(s): Appropriate 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.

231.11 - Billing for Allogeneic Stem Cell Transplants

(*Rev. 1980, Issued: 06-04-10, Effective: 07-01-10, Implementation: 07-06-10*)

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. *Recurring update notifications describing changes to and billing instructions for various payment policies implemented in the OPPS are issues annually.*

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*, and should be reported on the same date of service as the transplant procedure in order to be appropriately packaged for payment purposes*.

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.