CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1924	**Date: February 26, 2010**
	Change Request 6857

SUBJECT: April 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 April 2010 OPPS update. It affects Chapter 4, Sections 200.9 and 240.1 and Chapter 32, Section 140.4.1. CMS is updating information in these sections. The April 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.

EFFECTIVE DATE: April 1, 2010
IMPLEMENTATION DATE: April 5, 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	4/200.9/Billing for “Sometimes Therapy” Services that May be Paid as Non-Therapy Services for Hospital Outpatients
R	4/240.1/Editing Of Hospital Part B Inpatient Services
R	32/140.4.1/Coding Requirements for Pulmonary Rehabilitation Services Furnished On or After January 1, 2010

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:

Recurring Update Notification

Manual Instruction

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1924	Date: February 26, 2010	Change Request: 6857

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

Effective Date: April 1, 2010

Implementation Date: April 5, 2010

I. GENERAL INFORMATION

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

April 2010 revisions to I/OCE data files, instructions, and specifications are provided in Change Request (CR) 6857, "April 2010 Integrated Outpatient Code Editor (I/OCE) Specifications Version 11.1."

B. Policy:

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

2. Editing of Hospital Part B Inpatient Services

Blood and blood products are not included in the list of services that may be covered when furnished to persons who are inpatients but for whom no Medicare inpatient coverage is available and, therefore, no Part B payment may be made for them. The Medicare Claims Processing Manual, Pub.100-04, Chapter 4, Section 240.1 is revised to add revenue codes 038x (Blood and Blood Components) and 039x (Administration, Processing and Storage for Blood and Blood Components) to the table of revenue codes that are not allowed to be reported on a claim for payment of services furnished to hospital inpatients for whom there is no Medicare Part A coverage of their inpatient hospital care (12x type of bill (TOB)). The instruction is also revised to reflect that these edits are currently locally controlled by the Medicare A/B administrative contractor (MAC) or fiscal intermediary (FI) and are not imbedded in the Fiscal Intermediary Standard System. See the Medicare Benefits Policy, Manual 100-02, Chapter 6, Section 2 for the services for which payment may be made under the Part B Medicare hospital outpatient benefit for services to hospital inpatients. See the Medicare Claims Processing Manual, 100-04, Chapter 4, Section 240 for claims processing instructions for these claims.

3. Clarification to Coding Requirements for Pulmonary Rehabilitation Services Furnished On or After January 1, 2010

Section 140.4 .1 (Coding Requirements for Pulmonary Rehabilitation Services Furnished On or After January 1, 2010), Chapter 32 in the Medicare Claims Processing Manual, Pub.100-04, is being revised to reflect instructions to hospitals and practitioners' offices for reporting respiratory or pulmonary services furnished to a patient when those services do not meet the diagnosis and coverage criteria for pulmonary rehabilitation services.

4. Warfarin Testing

Effective August 3, 2009, Medicare covers pharmacogenomic testing to predict warfarin responsiveness only in the context of an approved, clinical study, in addition to the coverage criteria outlined in the Medicare National Coverage Determinations (NCD) Manual, Pub 100-03, Chapter 1, Section 90.1, and in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 32, Section 240. New Level II HCPCS code G9143 was developed to enable implementation of this new coverage policy. Pharmacogenomic testing for warfarin response is a once-in-a-lifetime test absent any reason to believe that the patient's personal genetic characteristics would change over time.

Under the hospital OPPS, HCPCS code G9143 will be assigned status indicator "A" effective in the April 2010 update, and payment for this lab test will be made under the clinical lab fee schedule (CLFS). However, because of CLFS payment requirements and the timing of creation of the new code, HCPCS code G9143 does not appear in the CY 2010 CLFS with an assigned rate and, therefore, its CY 2010 payment shall be determined by Medicare FIs and/or A/B MACs. Medicare FIs and/or A/B MACs shall determine the hospital outpatient payment rate for HCPCS code G9143 in the same manner that payment rates for unlisted laboratory CPT codes are currently determined. The reporting hospital's FI or A/B MAC shall contact the carrier or A/B MAC in the reporting hospital's jurisdiction to obtain an appropriate payment amount for HCPCS code G9143. If that carrier or A/B MAC cannot provide a payment amount for the service, then to establish a payment rate, the hospital's FI or A/B MAC should contact the carrier or A/B MAC in the jurisdiction of the reference laboratory that performed the test. If neither carrier nor A/B MAC has a payment amount for HCPCS code G9143 and the FI or A/B MAC for the reporting hospital determines that the service is covered, that FI or A/B MAC must determine the payment amount.

Further information on billing and coverage for warfarin testing can be found in CR 6715 issued December 18, 2009 (under Transmittals 111 and 1880). These transmittals can be found on the CMS Web site, specifically at http://www.cms.hhs.gov/Transmittals/downloads/R111NCD.pdf
and http://www.cms.hhs.gov/Transmittals/downloads/R1880CP.pdf .

Table 1—Warfarin Testing

HCPCS	Long Descriptor	APC	SI
G9143	Warfarin responsiveness testing by genetic technique using any method, any number of specimen(s)	NA	A

5. Human Immunodeficiency Virus (HIV) Screening Tests

The Centers for Medicare and Medicaid Services (CMS) has determined that screening for HIV infection, which is recommended with a grade of A by the U.S. Preventive Services Task Force (USPSTF) for certain individuals, is reasonable and necessary for early detection of HIV and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B. Therefore, effective December 8, 2009, Medicare covers HIV screening tests for beneficiaries that are at increased risk for HIV infection per the USPSTF guidelines and beneficiaries that are pregnant whose diagnosis of pregnancy is known, during the third trimester, and at labor.

Three new Level II HCPCS G-codes were created to implement this new coverage decision. The three HCPCS G-codes, specifically G0432, G0433, and G0435, describe both standard and FDA-approved rapid HIV screening tests. Under the hospital OPPS, HCPCS G-codes G0432, G0433, and G0435 will be assigned status indicator "A" effective in the April 2010 update, and payment for these tests will be made under the clinical lab fee schedule (CLFS). However, because of CLFS payment requirements and the timing of creation of the new codes, HCPCS codes G0432, G0433, and G0435 do not appear in the CY 2010 CLFS with assigned rates and, therefore, payment for them must be determined by Medicare FIs and/or A/B MACs. Medicare FIs and/or A/B MACs shall determine the hospital outpatient payment rates for HCPCS codes G0432, G0433, and G0435 in the same manner that the payment rates for unlisted laboratory CPT codes are currently determined. The reporting hospital's FI or A/B MAC shall contact the carrier or A/B MAC in the reporting hospital's jurisdiction to obtain an appropriate payment amount for HCPCS codes G0432, G0433, and G0435. If that carrier or A/B MAC cannot provide a payment amount for the service, then to establish a payment rate, the hospital's FI or A/B MAC should contact the carrier or A/B MAC in the jurisdiction of the reference laboratory that performed the test. If neither carrier nor A/B MAC has a payment amount for the HCPCS G-code and the FI or A/B MAC for the reporting hospital determines that the service is covered, that FI or A/B MAC must determine the payment amount. Further information on coverage for HIV screening tests under this new coverage decision can be found in a separate CR which will be released shortly.

Table 2—HIV Testing

HCPCS	Long Descriptor	APC	SI
G0432	Infectious agent antigen detection by enzyme immunoassay (EIA) technique, qualitative or semi-quantitative, multiple-step method, HIV-1 or HIV-2, screening	NA	A
G0433	Infectious agent antigen detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening	NA	A
G0435	Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2, screening	NA	A

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 April 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 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 and pharmacy overhead costs of these pass-through items. We note that for the second 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, we would again use the Part B drug CAP rate for pass-through drugs and biologicals if they are a part of the Part B drug CAP program, as required by the statute.

In the CY 2010 OPPS/ASC final rule with comment period, we stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, we will incorporate changes to the payment rates in the April 2010 release of the OPPS Pricer. The updated payment rates, effective April 1, 2010 will be included in the April 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 April 1, 2010

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

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

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 4/1/10
C9258*	Injection, telavancin, 10 mg	9258	G
C9259*	Injection, pralatrexate, 1 mg	9259	G
C9260*	Injection, ofatumumab, 10 mg	9260	G
C9261*	Injection, ustekinumab, 1 mg	9261	G
C9262*	Fludarabine phosphate, oral, 1 mg	9262	G
C9263*	Injection, ecallantide, 1 mg	9263	G

NOTE: The HCPCS codes identified with an "*" are new codes effective April 1, 2010.

c. Updated Payment Rate for HCPCS Code J9031 Effective January 1, 2009 through March 31, 2009

The payment rate for one HCPCS code was incorrect in the January 2009 OPPS Pricer. The corrected payment rate is listed in Table 4 below and has been installed in the April 2010 OPPS Pricer, effective for services furnished on January 1, 2009, through implementation of the April 2009 update.

Table 4—Updated Payment Rate for HCPCS Code J9031 Effective January 1, 2009 through March 31, 2009

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J9031	K	0809	Bcg live intravesical vac	$118.96	$23.79

d. Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2009 through December 31, 2009

The payment rates for several HCPCS codes were incorrect in the October 2009 OPPS Pricer. The corrected payment rates are listed in Table 5 below and have been installed in the April 2010 OPPS Pricer effective for services furnished on October 1, 2009, through implementation of the January 2010 update.

Table 5—Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2009 through December 31, 2009

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
90371	K	1630	Hep b ig, im	$113.78	$22.76
J1458	K	9224	Galsulfase injection	$333.49	$66.70
J2278	K	1694	Ziconotide injection	$6.38	$1.28
J2323	K	9126	Natalizumab injection	$7.97	$1.59

e. 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.

f. 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.

g. 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 we 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. We believe that this situation is extremely rare and we expect that the majority of hospitals will not encounter this situation.

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	
6857.1	Medicare contractors shall install the April 2010 OPPS Pricer.	X		X		X	X				COBC
6857.2	Medicare contactors shall manually add HCPCS codes: C9258, C9259, C9260, C9261, C9262, C9263, G0432, G0433 and G0435 to their systems. These HCPCS codes will be included with the April 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.hhs.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp#TopOfPage. Status and payment indicators for these HCPCS codes will be listed in the April 2010 update of the OPPS Addendum A and Addendum B on the CMS Web site.	X		X		X	X			X	COBC
6857.3	Medicare contractors shall add revenue codes 038x and 039x to the table of revenue codes that are not allowed on 12x type of bill (TOB). See the Medicare Claims Processing Manual, Pub.100-04, Chapter 4, Section 240."	X		X		X					COBC
6857.4	Medicare FIs and/or A/B MACs shall determine CY 2010 payment rates for G9143, G0432, G0433, and G0435 because these HCPCS codes do not appear in the CY 2010 CLFS with assigned rates.	X		X		X					COBC
6857.4.1	Medicare FIs and/or A/B MACs shall determine the hospital outpatient payment rates for HCPCS codes G9143, G0432, G0433, and G0435 in the same manner that payment rates for unlisted laboratory CPT codes are currently determined as per CR5544, issued March 21, 2007.	X		X		X					COBC
6857.4.1.1	The reporting hospital's FI or A/B MAC shall contact the carrier or A/B MAC in the reporting hospital's jurisdiction to obtain an appropriate payment amount for HCPCS codes G9143, G0432, G0433, and G0435.	X		X		X					COBC
6857.4.1.2	If that carrier or A/B MAC cannot provide a payment amount for the service, then to establish a payment rate,	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	
	the FI or A/B MAC should contact the carrier or A/B MAC in the jurisdiction of the reference laboratory that performed the test.										
6857.4.1.3	If neither carrier nor A/B MAC has a payment amount for HCPCS G-code and the FI or A/B MAC for the reporting hospital determines that the service is covered, that FI or A/B MAC must determine the payment amount.	X		X		X					COBC
6857.5	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service that fall on or after January 1, 2009, but prior to April 1, 2009; 2) Contain HCPCS code listed in Table 4; and 3) Were originally processed prior to the installation of the April 2010 OPPS Pricer.	X		X		X					COBC
6857.6	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service that fall on or after October 1, 2009, but prior to January 1, 2010; 2) Contain HCPCS code listed in Table 5; and 3) Were originally processed prior to the installation of the April 2010 OPPS Pricer.	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	
6857.7	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"	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	
	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.										

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:

Please refer to CR 6857 "April 2010 Integrated Outpatient Code Editor (I/OCE) Specifications Version 11.1" 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 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

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

(Rev.1924, Issued: 02-26-10, Effective: 04-01-10, Implementation: 04-05-10)

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 *OPPS*.

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 (ie., aerodynamic testing and acoustic testing)
97597	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg., 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 (eg., 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 (eg., 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 (eg., 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

240.1 – Editing Of Hospital Part B Inpatient Services

(Rev.1924, Issued: 02-26-10, Effective: 04-01-10, Implementation: 04-05-10)

Medicare pays under Part B for physician services and for non-physician medical and other health services listed in Section 240 above when furnished by a participating hospital to an inpatient of the hospital when patients are not eligible or entitled to Part A benefits or the patient has exhausted their Part A benefits.

The contractor shall set revenue code edits to prevent payment on Type of Bill 12x for claims containing the revenue codes listed in the table below.

010x	011x	012x	013x	014x	015x	016x	017x
018x	019x	020x	021x	022x	023x	0250	0251
0252	0253	0256	0257	0258	0259	0261	0269
0270	0273	0277	0279	029x	0339	036x	0370
0374	041x	045x	0472	0479	049x	050x	051x
052x	053x	0541	0542	0543	0544	0546	0547
0548	0549	055x	057x	058x	059x	060x	0630
0631	0632	0633	0637	064x	065x	066x	067x
068x	072x	0762	078x	079x	093x	0940	0941
0943	0944	0945	0946	0947	0949	095x	0960
0961	0962	0969	097x	098x	099x	100x	210x
310x	*038x*	*039x*					

When denying lines containing the above revenue codes on TOB 12x, the *A/B MAC* or FI shall use MSN message 21.21– This service was denied because Medicare only covers this service under certain circumstances.

The *A/B MAC* or FI shall place reason code M28 on the remittance advice when denying services reported under the specified revenue codes.

Medicare Claims Processing Manual

Chapter 32 – Billing Requirements for Special Services

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

(Rev.1924, Issued: 02-26-10, Effective: 04-01-10, Implementation: 04-05-10)

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.

If medically necessary, separately reportable respiratory or pulmonary services are furnished to a patient in a hospital or practitioner's office and those services do not meet the diagnosis and coverage criteria for pulmonary rehabilitation services, then those services should not be reported using HCPCS code G0424 but should be reported using the appropriate CPT or HCPCS codes.