CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 745	**Date: August 6, 2010**
	Change Request 6968

SUBJECT: Payment for Implantable Tissue Markers (HCPCS Code A4648) and Implantable Radiation Dosimeters (HCPCS Code A4650)

I. SUMMARY OF CHANGES: This Change Request clarifies that implantable tissue markers (HCPCS code A4648) and implantable radiation dosimeters (HCPCS code A4650) are separately billable and payable when used in conjunction with CPT codes 19499, 32553, 49411 and 55876 on a claim for physician services.

EFFECTIVE DATE: November 6, 2010
IMPLEMENTATION DATE: November 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-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

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:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 745	Date: November 6, 2010	Change Request: 6968

SUBJECT: Payment for Implantable Tissue Markers (HCPCS Code A4648) and Implantable Radiation Dosimeters (HCPCS Code A4650)

Effective Date: November 6, 2010

Implementation Date: November 6, 2010

I. GENERAL INFORMATION

A. Background:

Healthcare Procedural Coding System (HCPCS) code A4648 is defined as "Tissue marker, implantable, any type, each."

Healthcare Procedural Coding System (HCPCS) code A4650 is defined as "Implantable radiation dosimeter each."

This transmittal clarifies physician payment policy for implantable tissue markers (HCPCS code A4648) and implantable radiation dosimeters (HCPCS code A4650). Such markers or dosimeters are separately billable and payable when used in conjunction with CPT codes 19499 (unlisted procedure, breast), 32553 (placement of interstitial device(s) for radiation therapy guidance (eg., fiducial markers, dosimeter), percutaneous intra-thoracic, single or multiple), 49411(placement of interstitial device(s) for radiation therapy guidance (eg., fiducial markers, dosimeter), percutaneous intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple), and 55876 (single or multiple((the placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), prostate (via needle, any approach) on a claim for physician services.

Under the Medicare hospital outpatient prospective payment system (OPPS) and the ambulatory surgical center (ASC) payment systems, payment for HCPCS code A4648 or HCPCS code A4650 is packaged into the payment for the service in which it is used. Under the Medicare inpatient prospective payment system (IPPS) payment for HCPCS code A4648 or HCPCS code A4650 is bundled into the MS-DRG payment. Therefore, no separate payment is made by Medicare contractors for HCPCS code A4648 or HCPCS code A4650 to hospitals paid under the OPPS or IPPS. Similarly, no separate payment is made by Medicare contractors to ASCs. Hospitals that are not paid under the OPPS or IPPS are paid for HCPCS code A4648 and HCPCS code A4650 under a variety of other payment mechanisms.

B. Policy:

When billed on a physician claim, HCPCS code A4648 or HCPCS code A4650 is separately billable and payable as a supply when used in conjunction with CPT codes 19499, 32553, 49411, and 55876.

There are no changes to current payment policy for HCPCS code A4648 or HCPCS code A4650 with regard to payment to hospitals for inpatient or outpatient hospital services or with regard to payment to ASCs. Payment for HCPCS code A4648 or HCPCS code A4650 to hospitals and ASCs is not changed by this issuance.

II. BUSINESS REQUIREMENTS 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	
6968.1	Medicare contractors shall make payment for HCPCS code A4648 or HCPCS code A4650 when the implantable tissue markers or implantable radiation dosimeters are used in conjunction with either CPT codes 19499, 32553, 49411, or 55876 on a claim for physician services.	X			X						
6968.1.1	When billed on a physician claim, Medicare **c**ontractors shall deny HCPCS code A4648 or HCPCS code A4650 if either CPT code 19499, 32553, 49411or 55876 is not paid on the same claim, or in history, with the same date of service.	X			X						
6968.1.2	Medicare contractors shall use the following Claim Adjustment Reason Code when denying HCPCS code A4648 or HCPCS code A4650 on physician claims if the qualifying service is not reported on the same date of service: B15 – This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	X			X						
6968.1.3	Medicare contractors shall use the following Medicare Summary Notice (MSN) message when denying HCPCS code A4648 or HCPCS A4650 on a physician claim: 21.21 – This service was denied because Medicare only covers this service under certain circumstances.	X			X						

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	
6968.2	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	X			X						

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	
	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:

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

V. CONTACTS

Pre-Implementation Contact(s): Roberta Epps, Roberta.Epps@cms.hhs.gov

Post-Implementation Contact(s): Appropriate Project Officer or Contractor Manager

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.