CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1536	**Date: JUNE 19, 2008**
	Change Request 6094

SUBJECT: July 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 July 2008 OPPS update. The July 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.

The July 2008 revisions to the I/OCE data files, instructions, and specifications are provided in Change Request (CR) 6080, July 2008 Integrated Outpatient Code Editor (I/OCE) Specifications Version 9.2. The attached Recurring Update Notification applies to Chapter 4, §50.7.

New / Revised Material
Effective Date: July 1, 2008
Implementation Date: July 7, 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	4/20/20.2 /Applicability of OPPS to Specific HCPCS Codes
R	4/200/200.2/Hospital Services For Patients with End Stage Renal Disease (ESRD)

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

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

regarding continued performance requirements.

IV. ATTACHMENTS:

Manual Instruction

Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1536	Date: June 20, 2008	Change Request: 6094

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

Effective Date: **July 1, 2008**

Implementation Date: July 7, 2008

I. GENERAL INFORMATION

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

The July 2008 revisions to the I/OCE data files, instructions, and specifications are provided in Change Request (CR) 6080, "July 2008 Integrated Outpatient Code Editor (I/OCE) Specifications Version 9.2."
The attached Recurring Update Notification applies to Chapter 4, §50.7.

B. Policy:

1. Applicability of OPPS to Specific HCPCS Codes

The CPT codes generally are created to describe and report physician services, but are also used by other providers/suppliers to describe and report services that they provide. Therefore, the CPT code descriptors do not necessarily reflect the facility component of a service furnished by the hospital. Some CPT code descriptors include reference to a physician performing a service. For OPPS purposes, unless indicated otherwise, the usage of the term "physician" does not restrict the reporting of the code or application of related policies to physicians only, but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In cases where there are separate codes for the technical component, professional component, and/or complete procedure, hospitals should report the code that represents the technical component for their facility services. If there is no separate technical component code for the service, hospitals should report the code that represents the complete procedure.

2. Changes to Procedure and Device Edits for July 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/.

3. Payment for Brachytherapy Sources as of July 1, 2008

The Medicare, Medicaid, and SCHIP Extension Act of 2007 requires CMS to pay for brachytherapy sources for the period of January 1 through June 30, 2008, at hospitals' charges adjusted to the costs. Therefore, we are paying for brachytherapy sources based on charges adjusted to cost through June 30, 2008, and we will pay at prospective rates as of July 1, 2008. The prospective payment rates for each source, which are listed in Addendum B to our CY 2008 final rule dated November 27, 2007, will be used for payment from July 1 through December 31, 2008. The "H" payment status indicators of brachytherapy source HCPCS codes (except C2637), which were previously paid at charges adjusted to cost, will change to payment status indicator "K" effective July 1, 2008, through December 31, 2008.

In addition, because the sources will be paid based on prospective rates as of July 1, brachytherapy sources will be eligible for outlier payments and for the rural sole community hospital (SCH) adjustment as of July 1, 2008. The HCPCS codes for separately payable brachytherapy sources, long descriptors, status indicators, and APCs for CY 2008 are listed in Table 1 below, a comprehensive list of payable brachytherapy sources. Note that 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 1- Comprehensive List of Brachytherapy Sources Payable as of July 1, 2008

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

4. Continuous Positive Airway Pressure (CPAP) Therapy

The Centers for Medicare & Medicaid Services (CMS) revised its National Coverage Determination (NCD) for Continuous Positive Airway Pressure (CPAP) Therapy for Obstructive Sleep Apnea (OSA). CMS now allows coverage of CPAP when used in adult patients diagnosed with obstructive sleep apnea (OSA) by home sleep testing (HST). This revised coverage became effective for claims with dates of service on and after March 13, 2008. Information on the criteria for coverage under this revised NCD can be found in section 240.4 of Pub 100-03 of the NCD Manual. To adequately report the home sleep study test for CPAP therapy, CMS has created the following three G-codes. Under OPPS, the G-codes have been assigned to APC 0213 (Level I Extended EEG and Sleep Studies). Payment rates for these services can be found in Addendum B of the July 2008 OPPS Update that is posted on the CMS Web site.

Table 2-Home Sleep Study Tests for Continuous Positive Airway Pressure (CPAP) Therapy Services that are Effective March 13, 2008 and are Implemented July 1, 2008

HCPCS	Long Descriptor	APC	SI
G0398	Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation	0213	S
G0399	Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation	0213	S
G0400	Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels	0213	S

5. 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, we 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), we modified our 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 us in response to applications for new technology services. Therefore, on July 1, 2008, we implemented in the OPPS five Category III CPT codes that the AMA released in January 2008 for implementation in July 2008. The codes, along with their status indicators and APCs, are shown in Table 3 below. Payment rates for these services can be found in Addendum B of the July 2008 OPPS Update that is posted on the CMS Web site.

Table 3--Category III CPT Codes Implemented as of July 1, 2008

HCPCS	Long Descriptor	APC	SI
0188T	Remote real-time interactive videoconferenced critical care, evaluation and management of the critically ill or critically injured patient; first 30- 74 minutes	N/A	M
0189T	Remote real-time interactive videoconferenced critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes	N/A	M
0190T	Placement of intraocular radiation source applicator	0237	T

0191T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach	0234	T
0192T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir; external approach	0234	T

6. Cardiac Echocardiography With Contrast (C8921 - C8928)

In the April 2008 update to the OPPS (Transmittal 1487, CR 5999, issued April 8, 2008), we listed the revised short and long descriptors for the eight new C-codes for cardiac echocardiography with contrast services that were effective January 1, 2008. The codes, along with the revised short and long descriptors, were listed in Table 3. Unfortunately, the long descriptors for C8922 and C8924 were incorrect in Table 3. The correct short and long descriptors for the eight C-codes for cardiac echocardiography with contrast services were posted on the CMS HCPCS website, specifically at http://www.cms.hhs.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp#TopOfPage. Refer to the April 2008 HCPCS C-codes list dated March 25, 2008. Hospitals are advised to download this file to view the correct long descriptors for C8922 and C8924.

7. 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 July 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 July 2008 release of the OPPS PRICER. The updated payment rates effective July 1, 2008, will be included in the July 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 July 1, 2008

Six drugs have been granted OPPS pass-through status effective July 1, 2008. These drugs, their descriptors, and APC assignments are identified in Table 4 below.

Table 4- Drugs Granted Pass-Through Status Effective July 1, 2008

HCPCS	Long Descriptor	SI	APC
C9242*	Injection, fosaprepitant, 1 mg	G	9242
C9356*	Tendon, porous matrix of cross-linked collagen and glycosaminoglycan matrix (TenoGlide Tendon Protector Sheet), per square centimeter	G	9356
C9357*	Dermal substitute, granulated cross-linked collagen and glycosaminoglycan matrix (Flowable Wound Matrix), 1 cc	G	9357
C9358*	Dermal substitute, native, non-denatured collagen (SurgiMend Collagen Matrix), per 0.5 square centimeters	G	9358
J1571	Injection, hepatitis b immune globulin (Hepagam b), intramuscular, 0.5 ml	G	0946
J1573	Injection, hepatitis b immune globulin (Hepagam b), intravenous, 0.5 ml	G	1138

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

c. Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2007 through December 31, 2007

The payment rates for several HCPCS codes were incorrect in the October 2007 OPPS Pricer. The corrected payment rates are listed below and have been installed in the July 2008 OPPS Pricer, effective for services furnished on October 1, 2007, through implementation of the January 2008 update.

Table 5- Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2007 through December 31, 2007

HCPCS	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
90371	1630	Hep b ig, im	121.28	24.26
90675	9139	Rabies vaccine, im	152.82	30.56
J0637	9019	Caspofungin acetate	24.29	4.86
J1562	0804	Vivaglobulin, injection	7.01	1.40
J9015	0807	Aldesleukin/single use vial	758.15	151.63

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 below and have been installed in the July 2008 OPPS Pricer, effective for services furnished on January 1, 2008, through implementation of the April 2008 update.

Table 6- Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2008 through March 31, 2008

HCPCS	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
90675	9139	Rabies vaccine, im	150.27	30.05
J2820	0731	Sargramostim injection	25.02	5.00
J9010	9110	Alemtuzumab injection	549.29	109.86
J9015	0807	Aldesleukin/single use vial	764.56	151.47
J9226	1142	Supprelin LA implant	14694.12	2938.82

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 below and have been installed in the July 2008 OPPS Pricer, effective for services furnished on April 1, 2008, through implementation of the July 2008 update.

Table 7- Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2008 through June 30, 2008

HCPCS	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J2323	9126	Natalizumab injection	7.51	1.49
J2778	9233	Ranibizumab inj	406.18	80.47
J3488	0951	Reclast injection	216.61	42.91

f. 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.

g. 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.

h. Changes to Payment for Therapeutic Radiopharmaceuticals for July 2008

The Medicare, Medicaid, and State Children's Health Insurance Program Extension Act of 2007, Pub. L. No. 110-173, amended the Medicare statute and provided a continuation of payment for therapeutic radiopharmaceuticals based on individual hospital charges adjusted to cost from January 1 through June 30, 2008. Therefore, in accordance with the statute, finalized CY 2008 prospective payment rates for therapeutic radiopharmaceuticals were not implemented in the OPPS during this time period. However, the statute expires on June 30, 2008, and, as such, our finalized payment prospective payment rates go into effect on July 1, 2008. Therefore, payment for separately payable therapeutic radiopharmaceuticals under the OPPS will be made on a prospective basis, with payment rates based upon mean costs from hospital claims data as set forth in the CY 2008 OPPS/ASC final rule (72 FR 66772), beginning on July 1, 2008.

Table 8-Therapeutic Radiopharmaceuticals that are Separately Payable Effective July 1, 2008

HCPCS	Long Descriptor	SI	APC
A9517	Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie	K	1064
A9530	Iodine I-131 sodium iodide solution, therapeutic, per millicurie	K	1150
A9543	Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries	K	1643
A9545	Iodine I-131 tositumomab, therapeutic, per treatment dose	K	1645
A9563	Sodium phosphate P-32, therapeutic, per millicurie	K	1675
A9564	Chromic phosphate P-32 suspension, therapeutic, per millicurie	K	1676
A9600	Strontium Sr-89 chloride, therapeutic, per millicurie	K	0701
A9605	Samarium Sm-153 lexidronamm, therapeutic, per 50 millicuries	K	0702

i. Changes to Nuclear Medicine Procedure to Radiopharmaceutical Edits for July 2008

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 captured appropriate diagnostic radiopharmaceutical costs for future ratesetting purposes, we implemented 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.

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.

Since our change to the edit list was adopted for the April update, we have received several descriptions of clinical scenarios where a therapeutic radiopharmaceutical or a brachytherapy source is provided to a patient by a hospital and a nuclear medicine procedure follows, without administration of a diagnostic radiopharmaceutical. Members of the public bringing these situations to our attention state that situations where these radiolabeled products would be used without a diagnostic radiopharmaceutical 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 July 2008 update we have included the HCPCS codes for all diagnostic radiopharmaceuticals, therapeutic radiopharmaceuticals, and brachytherapy sources as radiolabeled products that may be reported on a claim with nuclear medicine procedures to satisfy the edit requirements. We expect that the majority of nuclear medicine procedures will be performed with diagnostic radiopharmaceuticals, and that it will be only in uncommon circumstances that hospitals would report nuclear medicine procedures with therapeutic radiopharmaceuticals or brachytherapy sources. We will be monitoring claims to ensure that this is the case.

Therefore, beginning in July 2008, claims for nuclear imaging procedures reported with any of the HCPCS codes for diagnostic radiopharmaceuticals, therapeutic radiopharmaceuticals, or brachytherapy sources will not be returned to the provider as long as the nuclear medicine procedure and radiolabeled product are included on the same claim.

Hospitals are to only report HCPCS codes for products they administer and should not be reporting a token charge for a radiolabeled product on the edit list solely for the purpose of bypassing edits present in the I/OCE.

The complete list of updated edits can be found at http://www.cms.hhs.gov/HospitalOutpatientPPS/02_device_procedure.asp#TopOfPage.

8. Hospital Services for Patients with End Stage Renal Disease

CMS is revising the Medicare Claims Processing Manual, Pub. 100-04, Chapter 4, §200.2 to expand the circumstances under which payment may be made to a hospital for unscheduled outpatient dialysis provided to an ESRD patient. The first circumstance listed is "dialysis performed following or in connection with a vascular access procedure". We are expanding this to include any dialysis related procedure such as vascular access procedures or blood transfusions.

9. Coverage of Outpatient Therapeutic Services Incident to a Physician's Service Furnished on or After August 1, 2000

CMS is revising the Medicare Benefit Policy Manual, Pub 100-02, Chapter 6, §20.5.1 to remove language stating that services furnished in provider-based departments of hospitals must be rendered under the direct supervision of a physician "who is treating the patient." While this "treating the patient" language has been a part of the manual for several years, recent revisions made to §20.5.1 in Transmittal 82, CR 5946 (February 8, 2008) have caused confusion related to the context and application of this phrase in relation to the requirements of the Code of Federal Regulations.

10. 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	
6094.1	Medicare contractors shall install the July 2008 OPPS Pricer.	X		X		X	X				COBC
6094.2	HCPCS codes: C9242, C9356, C9357, C9358, G0398, G0399, G0400, 0188T, 0189T, 0190T, 0191T, and 0192T are included in the July 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 July 2008 update of the OPPS Addendum A and Addendum B on the CMS Web site.	X		X		X	X				COBC
6094.3	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service that fall on or after October 1, 2007, but prior to January 1, 2008; 2) Contain HCPCS code listed in Table 5; and 3) Were originally processed prior to the installation of the July 2008 OPPS Pricer.	X		X		X					COBC
6094.4	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 listed in Table 6; and 3) Were originally processed prior to the installation of the July 2008 OPPS Pricer.	X		X		X					COBC
6094.5	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 listed in Table 7; and 3) Were originally processed prior to the installation of the July 2008 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	
6094.6	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 6080	July 2008 Integrated Outpatient Code Editor (I/OCE) Specifications Version 9.2

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

V. CONTACTS

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

Post-Implementation Contact(s): Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs)* use only one of the following statements:

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),*** **use the following statement:**

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.

20.2 - Applicability of OPPS to Specific HCPCS Codes

(Rev. 1536, Issued: 06-19-08; Effective: 07-01-08; Implementation: 07-07-08)

The CPT codes generally are created to describe and report physician services, but are also used by other providers/suppliers to describe and report services that they provide. Therefore, the CPT code descriptors do not necessarily reflect the facility component of a service furnished by the hospital. Some CPT code descriptors include reference to a physician performing a service. For OPPS purposes, unless indicated otherwise, the usage of the term "physician" does not restrict the reporting of the code or application of related policies to physicians only, but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In cases where there are separate codes for the technical component, professional component, and/or complete procedure, hospitals should report the code that represents the technical component for their facility services. If there is no separate technical component code for the service, hospitals should report the code that represents the complete procedure. Tables describing the treatment of HCPCS codes for OPPS are published in the Federal Register annually.

200.2 - Hospital Services For Patients with End Stage Renal Disease (ESRD)

(Rev. 1536, Issued: 06-19-08; Effective: 07-01-08; Implementation: 07-07-08)

Effective with claims with dates of service on or after August 1, 2000, hospital-based ESRD facilities must submit ESRD dialysis and those items and services directly related to dialysis (e.g., drugs, supplies) on a separate claim from services not related to ESRD. Items and services not related to the dialysis must be billed by the hospital using the hospital bill type. ESRD related services use the ESRD bill type. This requirement is necessary to properly pay the unrelated ESRD services under OPPS.

Generally, Medicare does not allow payment under the OPPS for routine dialysis treatments furnished to End Stage Renal Disease (ESRD) patients in the outpatient department of a hospital that does not have a certified dialysis facility. However, in certain medical situations in which the ESRD patient cannot obtain her or his regularly scheduled dialysis treatment at a certified ESRD facility, the OPPS rule for 2003 allows payment for non-routine dialysis treatments furnished to ESRD patients in the outpatient department of a hospital that does not have a certified dialysis facility. Payment is limited to unscheduled dialysis for ESRD patients in the following circumstances:

- Dialysis performed following or in connection with a *dialysis-related procedure such as* vascular access procedure *or blood transfusions;*

- Dialysis performed following treatment for an unrelated medical emergency; e.g., if a patient goes to the emergency room for chest pains and misses a regularly scheduled dialysis treatment that cannot be rescheduled, CMS allows the hospital to provide and bill Medicare for the dialysis treatment; or

- Emergency dialysis for ESRD patients who would otherwise have to be admitted as inpatients in order for the hospital to receive payment.

In these situations, non-ESRD certified hospital outpatient facilities are to bill Medicare using a new Healthcare Common Procedure Coding System (HCPCS) code, G0257 - Unscheduled or emergency treatment for dialysis for ESRD patient in the outpatient department of a hospital that does not have a certified ESRD facility.