MLN Matters®
Information for Medicare Fee-for-Service Health Care Professionals

News Flash – Get your NEW How to Use the National Correct Coding Initiative (NCCI) Tools booklet from the MLN and learn how to navigate the CMS NCCI website. This new MLN product explains how to look up Medicare code pair edits and Medically Unlikely Edits (MUEs). NCCI tools can help providers avoid coding and billing errors and subsequent payment denials. If you want to become familiar with the "National Correct Coding Initiative Policy Manual for Medicare Services" and the tools on the NCCI website, this is your best resource! Go to *http://www.cms.gov/MLNProducts/MPUB/list.asp* and enter 'How to' to find this and other MLN 'How to' series publications.

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Related Change Request (CR) #: 6968

Related CR Release Date: August 6, 2010

Effective Date: November 6, 2010

Related CR Transmittal #: R745OTN

Implementation Date: November 6, 2010

Payment for Implantable Tissue Markers (Healthcare Common Procedure Coding System (HCPCS) Code A4648) and Implantable Radiation Dosimeters (HCPCS Code A4650)

Note: This article was revised on August 18, 2010, to correct an error in the "What You Need to Know" section on page 1. The HCPCS code of A450 was corrected to show A4650. All other information remains the same.

Provider Types Affected

This article is for physicians who bill Medicare carriers or Part A/B Medicare Administrative Contractors (A/B MAC) for providing services for implantable tissue markers or implantable radiation dosimeters to Medicare beneficiaries.

What You Need to Know

CR 6968, from which this article is taken, clarifies that the Healthcare Common Procedure Coding System (HCPCS) codes for implantable tissue markers (HCPCS A4648 – Tissue marker, implantable, any type, each) and for implantable radiation dosimeters (HCPCS code A4650 -- Implantable radiation dosimeter each) are separately billable, and payable, for physicians when used with Current Procedural Terminology (CPT) codes 19499, 32553, 49411, and 55876.

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See the Background section, below, for details. You should make sure that your billing staffs are aware of this coding requirement.

Background

Under the Medicare hospital outpatient prospective payment system (OPPS) and the ambulatory surgical center (ASC) payment system, carriers and A/B MACS do not pay hospitals or ASCs separately for HCPCS codes A4648 (Tissue marker, implantable, any type, each) or A4650 (Implantable radiation dosimeter each); rather, payment for these codes is packaged into the payment for the service in which they are used. Similarly, under the Medicare inpatient prospective payment system (IPPS), payment for these services is bundled into the MS-DRG payment.

NOTE: 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.

CR 6968, from which this article is taken, clarifies that these two HCPCS codes, however, are separately billable, and payable, when billed by physicians and when used with one of the following four CPT codes:

1. 19499 (unlisted procedure, breast);
2. 32553 (placement of interstitial device(s) for radiation therapy guidance (eg., fiducial markers, dosimeter)), percutaneous intra-thoracic, single or multiple);
3. 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
4. 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.

Therefore, effective for dates of service on or after November 6, 2010, your carrier or A/B MAC will pay physicians for these HCPCS codes when the implantable tissue markers or implantable radiation dosimeters are used in conjunction with one of these four CPT codes, but will deny payment if one of the above CPT codes is not paid on the same claim (or in history) with the same date of service.

When denying your claim for these codes if the qualifying service is not reported on the same date of service, they will use Claim Adjustment Reason Code B15 (This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.).

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Please note that CR 6968 makes no changes in current payment policies for HCPCS code A4648 or HCPCS code A4650 for inpatient or outpatient hospital services, or to ASCs.

Additional Information

You can find the official instruction, CR6968, issued to your carrier or A/B MAC by visiting *http://www.cms.gov/Transmittals/downloads/R745OTN.pdf* on the Centers for Medicare & Medicaid Services (CMS) website.

If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.

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