



Medicare Payment Updates

April 2004

This document provides a summary of changes effective April 2004, that affect Medicare reimbursement based on provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and other payment revisions.

The Centers for Medicare and Medicaid Services (CMS) has published several program transmittals to implement changes to Medicare reimbursement based on the MMA. Changes apply to the Inpatient Prospective Payment System (PPS), Outpatient PPS, Home Health PPS, Graduate Medical Education (GME) payments, and Disproportionate Share Hospital (DSH) payments. The major changes are summarized below. The program transmittals communicating these new or changed policies and procedures are on the CMS Web site: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

Inpatient Prospective Payment System (IPPS) Rates—Program Transmittal 64

Background: Hospitals in rural and “other urban” areas received a temporary 1.6% increase to their standard operating rate for the period April 1, 2003 through September 30, 2003. This brought the rate for these areas to the same level as that for hospitals in large urban areas. The increase expired on October 1, 2003 and Congress subsequently extended it through March 31, 2004. Because the extension was agreed to after October 1, the rural and “other urban” rate for payments from November 1, 2003 through March 31 was prorated to reflect the amounts hospitals would have received had the change been implemented on October 1.

April 1 Change: The CMS transmittal implements the MMA provision making the adjustment to rural and “other urban” hospital rates permanent. The new, uniform standard rates are effective for discharges occurring from April 1, 2004 through September 30, 2004. CMS also recalculated the budget neutrality adjustments for wage indexes, reclassifications, and Diagnosis Related Group (DRG) recalibration, resulting in a slight decrease to the “large urban” rate. Below is a table showing the rates beginning with the initial equalization of the rates in federal fiscal year (FFY) 2003, beginning April 1, 2003.

IPPS Standard Rates

Geographic Location		FFY 2003 April - September	FFY 2004 October	FFY 2004 November - March	FFY 2004 April - September
Large Urban	Labor	\$3,022.31	\$3,136.39	\$3,136.39	\$3,135.49
	Non-labor	\$1,228.48	\$1,274.85	\$1,274.85	\$1,274.49
Rural / Other Urban	Labor	\$3,022.31	\$3,086.73	\$3,146.32	\$3,135.49
	Non-labor	\$1,228.48	\$1,254.67	\$1,278.89	\$1,274.49

Because of the equalization of the standard rate, the fixed loss amount for determining the cost outlier threshold has been reduced from \$31,000 to \$30,150. In addition, the capital rate has decreased from \$414.18 to \$413.48 due to revised budget neutrality factors.

IPPS Disproportionate Share Hospital Payments—Program Transmittal 64

Background: DSH payments are currently capped at 5.25% for rural hospitals and for urban hospitals with less than 100 beds. DSH payments are capped at 10% for Sole Community Hospitals (SCHs). In addition, the DSH formula for these hospitals and for rural referral centers is less generous than the formula for urban hospitals with 100 or more beds.

April 1 Change: The transmittal implements the MMA provision that raises the DSH cap to 12% for rural hospitals, for urban hospitals with less than 100 beds, and for SCHs. It also provides all hospitals with the more generous formula currently applied to urban hospitals with 100 or more beds.

Graduate Medical Education—Program Transmittal 61

Background: In FFY 2003, the Indirect Medical Education (IME) adjustment was reduced from 6.5 to 5.5. The IME adjustment continued at 5.5 for FFY 2004. The MMA provides a temporary increase in the IME adjustment factor at the levels shown in the following table.

	IME Multiplier	IME Payment Level
FFY 2003	1.35	5.50
First Half of FFY 2004	1.35	5.50
Last Half of FFY 2004	1.47	6.00
FFY 2005	1.42	5.80
FFY 2006	1.37	5.55
FFY 2007	1.32	5.35
FFY 2008 and Subsequent	1.35	5.50

April 1 Change: For patient discharges occurring on or after April 1, 2004, the multiplier used in the IME formula will increase from 1.35 to 1.47. As a result, the IME payment level will increase from 5.5 to 6.0. In addition, the transmittal provides information on other revisions to GME payments that will affect subsequent cost reports. These include:

- Direct GME payments are reduced for residents whose training continues beyond the initial residency period. Effective for cost reports beginning on or after October 1, 2003, the MMA provides an exception for geriatric programs that require a resident to complete two years of training to initially become board eligible in the geriatric specialty.
- To be paid for resident training in a non-hospital site, the hospital must incur all of the direct GME costs including teaching physician costs. This is true even if the physicians volunteer their time. The MMA creates a one-year moratorium on regulations regarding financial arrangements between hospitals and teaching physicians in family practice programs. For family practice residents training in non-hospital settings during the period January 1, 2004 through December 31, 2004, hospitals will

be able to count the residents without regard to the financial arrangements between the hospital and the teaching physicians. This will also apply to cost reports that are settled during calendar year 2004.

- The MMA extends the limit on updates for hospitals with per resident amounts (PRAs) above 140% of the national average. The Balanced Budget Refinement Act of 1999 implemented the reductions for the period October 1, 2000 through September 30, 2005. The MMA freezes the update for hospitals with a PRA over 140% of the national average for fiscal years 2004 through 2013.

Outpatient Prospective Payment System (OPPS) drug payments—Program Transmittal 112

Background: On January 6, CMS published an interim final rule implementing payment changes for a class of drugs defined as “specified covered outpatient drugs.” These are existing drugs, biologicals, or radiopharmaceutical agents for which payment was made on a pass-through basis on or before December 31, 2002. Pass-through status for these drugs has expired and they are currently paid through the Ambulatory Payment Classification (APC) rates.

Under the MMA, payments for specified covered outpatient drugs are calculated based on three categories: sole source, innovator multiple source (brand name drugs), and non-innovator multiple source (generic drugs). Payment limits for these categories are subject to varying floors and ceilings and are based on the average wholesale price (AWP). Payments were set at the following levels:

- Single source drugs: no greater than 95% of the AWP and no less than 88% of the AWP.
- Innovator multiple-source products (brand names): payment is not to exceed 68% of the AWP.
- Non-innovator multiple-source products (generics): payment is not to exceed 46% of the AWP.

The payments for these drugs went into effect on January 1. At that time, there were no Healthcare Common Procedure Coding System (HCPCS) codes that would differentiate brand name drugs from generic drugs. Therefore, for specified covered outpatient drugs furnished on or after January 1, 2004 through March 31, 2004, hospitals were instructed to report existing HCPCS codes regardless of whether a brand name or a generic drug was administered. Payments were based on the lower rate established for the generic version of the drug.

April 1 Change: The transmittal establishes new HCPCS codes and payment amounts for the brand name drugs that CMS was unable to implement in the January 1, 2004 OPPS update. Hospitals may submit an adjustment bill utilizing the new HCPCS code for brand name drugs administered from January 1, 2004 through March 31, 2004. Note that the rate for brand name drugs changes only in those cases where the rate for the generic version exceeded the 46% limit.

The following CMS table lists the specified covered drugs for which there exists both a generic and brand name form.

Status	HCPCS (Generic)	APC (Generic)	Description (Generic)	Payment Rate (Generic)	HCPCS (Brand)	APC (Brand)	Description (Brand)	Payment Rate (Brand)
K	A9505	1603	Thallos chloride TL 201/mci	\$18.29	C9400	9400	Thallos chloride, brand	\$19.89
K	A9517	1064	Th I131 so iodide cap millic	\$5.48	C9402	9402	Th I131 so iodide cap, brand	\$5.48
K	A9528	1064	Dx I131 so iodide cap millic	\$5.48	C9403	9403	Dx I131 so iodide cap, brand	\$5.48
K	A9529	1065	Dx I131 so iodide sol millic	\$6.49	C9404	9404	Dx I131 so iodide sol, brand	\$6.49
K	A9530	1065	Th I131 so iodide sol millic	\$6.49	C9405	9405	Th I131 so iodide sol, brand	\$6.49
K	C1775	1775	FDG, per dose (4-40 mCi/ml)	\$324.48	C9408	9408	FDG,brand, per dose	\$324.48
K	J1190	0726	Dexrazoxane HCl injection	\$112.48	C9410	9410	Dexrazoxane HCl inj, brand	\$112.48
K	J2430	0730	Pamidronate disodium/30 MG	\$128.74	C9411	9411	Pamidronate disodium, brand	\$174.32
K	J7310	0913	Ganciclovir long act implant	\$86.54	C9412	9412	Ganciclovir implant, brand	\$86.54
K	J7317	7316	Sodium hyaluronate injection	\$67.16	C9413	9413	Sodium hyaluronate inj, brand	\$99.29
K	J8560	0802	Etoposide oral 50 MG	\$21.91	C9414	9414	Etoposide oral, brand	\$27.37
K	J9000	0847	Doxorubic hcl 10 MG v1 chemo	\$4.69	C9415	9415	Doxorubic hcl chemo, brand	\$6.61
K	J9031	0809	Bcg live intravesical vac	\$77.54	C9416	9416	Bcg live intravesical, brand	\$103.75
K	J9040	0857	Bleomycin sulfate injection	\$88.32	C9417	9417	Bleomycin sulfate inj, brand	\$130.56
K	J9060	0813	Cisplatin 10 MG injection	\$7.73	C9418	9418	Cisplatin inj, brand	\$11.42
K	J9065	0858	Inj cladribine per 1 MG	\$24.84	C9419	9419	Inj cladribine, brand	\$36.72
K	J9070	0815	Cyclophosphamide 100 MG inj	\$2.77	C9420	9420	Cyclophosphamide inj, brand	\$4.10
K	J9093	0816	Cyclophosphamide lyophilized	\$2.36	C9421	9421	Cyclophosphamide lyo, brand	\$3.50
K	J9100	0817	Cytarabine hcl 100 MG inj	\$1.55	C9422	9422	Cytarabine hcl inj, brand	\$2.28
K	J9130	0819	Dacarbazine 100 mg inj	\$5.31	C9423	9423	Decarbazine inj, brand	\$5.31
K	J9150	0820	Daunorubicin	\$35.94	C9424	9424	Daunorubicin, brand	\$53.14
K	J9181	0824	Etoposide 10 MG inj	\$0.83	C9425	9425	Etoposide inj, brand	\$1.22
K	J9200	0827	Floxuridine injection	\$66.24	C9426	9426	Floxuridine inj, brand	\$97.92
K	J9208	0831	Ifosfomide injection	\$72.81	C9427	9427	Ifosfomide inj, brand	\$106.04
K	J9209	0732	Mesna injection	\$17.66	C9428	9428	Mesna injection, brand	\$26.11
K	J9211	0832	Idarubicin hcl injection	\$178.21	C9429	9429	Idarubicin hcl inj, brand	\$178.21
K	J9218	0861	Leuprolide acetate injection	\$14.48	C9430	9430	Leuprolide acetate inj, brand	\$21.41
K	J9265	0863	Paclitaxel injection	\$79.04	C9431	9431	Paclitaxel inj, brand	\$112.14
K	J9280	0862	Mitomycin 5 MG inj	\$30.91	C9432	9432	Mitomycin inj, brand	\$45.70
K	J9340	0851	Thiotepa injection	\$45.31	C9433	9433	Thiotepa inj, brand	\$59.93
K	Q3002	1619	Gallium ga 67	\$11.22	C9434	9434	Gallium ga 67, brand	\$11.22
K	J7502	0888	Cyclosporine oral 100 mg	\$2.41	C9438	9438	Cyclosporine oral, brand	\$2.56

OPPS Revised Payment Rates—Program Transmittal 113

This transmittal corrects errors in the APC rates that were effective January 1, 2004. The errors affect one surgical procedure (status indicator “T”), 27 non-pass through drugs (status indicator “K”), and one pass-through drug (status indicator “G”). CMS instructed fiscal intermediaries to adjust payments for claims with dates of service between January 1 and March 31 that are affected by the revised rates. The following CMS table reports the initial rate that was paid for these APCs beginning January 1, 2004 and the corrected rate that will be implemented April 1.

Status	HCPCS	APC	Initial Rate	Corrected Rate
T		0384 GI Procedures with Stents	\$1,993.66	\$1,580.26
K	A9502	0705 Technetium TC99M tetrofosmin	\$665.28	\$110.88
K	A9508	1045 Iobenguane sulfate I-131, per 0.5 mCiI	\$165.82	\$1,056.00
K	A9511	1095 Technetium TC 99m depreotide	\$704.00	\$37.87
K	A9605	0702 Samarium sm153 lexidronamm	\$493.89	\$944.84
K	C1091	1091 IN111 oxyquinoline,per 0.5mCi	\$224.52	\$396.00
K	C9008	9008 Baclofen Refill Kit-500 mcg	\$73.92	\$10.82
K	C9105	9105 Hep B imm glob, per 1 ml	\$65.58	\$125.45
K	J0288	0735 Ampho b cholesteryl sulfate	\$20.86	\$15.20
K	J0289	0736 Amphotericin b liposome inj	\$20.86	\$33.16
K	J1563	0905 Immune globulin, 1 g	\$37.95	\$72.60
K	J1564	9021 Immune globulin 10 mg	\$0.41	\$0.79
K	J1745	7043 Infliximab injection	\$31.81	\$60.86
K	J7190	0925 Factor viii	\$0.42	\$0.81
K	J7192	0927 Factor viii recombinant	\$0.61	\$1.17
K	J7193	0931 Factor IX non-recombinant	\$0.51	\$1.04
K	J7194	0928 Factor ix complex	\$0.18	\$0.37
K	J7198	0929 Anti-inhibitor	\$0.69	\$1.32
K	J7517	9015 Mycophenolate mofetil oral	\$1.36	\$2.60
K	Q0166	0765 Granisetron HCl 1 mg oral	\$171.78	\$41.40
K	Q0180	0763 Dolasetron mesylate oral	\$152.38	\$67.09
K	Q2006	7025 Digoxin immune fab (ovine)	\$1.79	\$352.00
K	Q2022	1618 VonWillebrandFactrCmplxp	\$0.46	\$0.95
K	Q3005	1622 Technetium tc99m mertiatide	\$1,650.00	\$33.00
K	Q3007	1624 Sodium phosphate p32	\$66.44	\$100.70
K	Q3011	1628 Chromic phosphate p32	\$81.27	\$155.47
K	Q3012	1089 Cyanocobalamin cobalt co57	\$47.38	\$90.64
K	Q3025	9022 IM inj interferon beta 1-a	\$13.36	\$78.93
G	J9395	9120 Injection, Fulvestrant	\$78.36	\$156.72

OPPS April 2004 Update—Program Transmittal 132

This transmittal designates the drugs in the following table as eligible for pass-through payment, effective April 1.

Status	HCPCS	APC	Rate
G	C9124	9124 Injection, daptomycin, per 1 mg	\$0.31
G	C9125	9125 Injection, risperidone, per 12.5 mg	\$131.86
G	J2783	0738 Injection, rasburicase, 0.5 mg	\$105.54

The transmittal adds the services shown in the following table to the procedures that are assigned for payment in new technology service APCs effective April 1.

Status	HCPCS	APC	Rate
S	C9712	1506 Insert pH capsule, GERD	\$450.00
S	C9713	1525 Non-contact laser vap prosta	\$3,750.00
S	C9714	1523 Breast inters rad tx, immed	\$2,750.00
S	C9715	1524 Breast inters rad tx, delay	\$3,250.00

Two HCPCS codes were incorrectly assigned status indicator “N” in the APC rates effective January 1, 2004; as a result, they were treated as packaged services with no separate payment rates. CMS has determined that an APC payment should be made for these procedures (see table below). Hospitals may submit an adjustment bill for payment for these codes for services furnished from January 1 through March 31.

Status	HCPCS	APC	Rate
K	A9526	0737 Ammonia N-13, per dose	\$162.63
K	Q4078	0737 Ammonia N-13, per dose	\$162.63

CMS has also indicated that payments for HCPCS code C9207, Injection, Bortezomib, per 3.5 mg (“Velcade”) should have been made beginning October 1, 2003. Instead, they were incorrectly made effective as of January 1, 2004. Hospitals that billed this code for services furnished from October 1, 2003 through December 31, 2003, may resubmit the claims.

The transmittal provides billing instructions for intensity modulated radiation therapy (IMRT) services and for brachytherapy. It also specifies that outlier payments are not generally calculated for APCs with status indicator “K” (APCs covering non-pass through drugs and biologicals) and provides a list of APCs that are exceptions to this rule for which outlier payments may be made.

Home Health Prospective Payment System—Program Transmittal 59

The transmittal implements changes that will affect the Home Health PPS as a result of MMA provisions. These include:

- The Home Health PPS update will be the marketbasket percentage increase minus 0.8% for the last three quarters of calendar year (CY) 2004 (April 1, 2004 – December 31, 2004), CY 2005, and CY 2006. Therefore, the adjusted payment amount per 60-day episode ending on or after April 1, 2004 and before December 31, 2004 is \$2,213.37 (based on a marketbasket of 3.3%, reduced by 0.8%).
- CMS is required to change the annual Home Health PPS update from a federal fiscal year basis to a calendar year basis. This will be implemented by applying the next update on January 1, 2005 instead of October 1, 2004.
- A one-year 5% add-on payment will be applied to Home Health PPS services furnished to beneficiaries living in rural areas. This adjustment expires on April 1, 2005.