Program Memorandum Intermediaries

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal A-02-120 **Date: NOVEMBER 22, 2002**

CHANGE REQUEST 2185

SUBJECT: Change in Requirements for Medicare Payment for Low Osmolar Contrast Material (LOCM) Under the Outpatient Prospective Payment System (OPPS)

The purpose of this Program Memorandum (PM) is to remove the requirements that currently apply to payment for LOCM for hospitals that are subject to the OPPS. For hospitals that are subject to the OPPS, this PM supersedes instructions in §§443.C.3f and 443.C.3g of the Medicare Hospital Manual and §§3631.C.3f and 3631.C.3g of the Medicare Intermediary Manual that differentiate payment between high osmolar contrast material and LOCM and restrict payment for LOCM to only those patients having specific diagnoses. Those instructions continue to be applicable to non-OPPS hospitals.

Change in LOCM Requirements

Under the OPPS, separate payment is not made for ionic and non-ionic contrast material. Medicare payment for ionic and non-ionic contrast media, including LOCM, is packaged into the ambulatory payment classification (APC) payment for the diagnostic procedure. Under the OPPS, there is no longer a payment difference between LOCM and other contrast materials; therefore, we are removing the requirements imposed under §§443.C.3f and 443.C.3g of the Medicare Hospital Manual and §§3631.C.3f and 3631.C.3g of the Medicare Intermediary Manual for LOCM furnished on or after January 1, 2003. Effective January 1, 2003, for hospitals subject to the OPPS, do not edit to prohibit payment for LOCM if specific diagnoses are not reflected on the claim.

Billing for LOCM

For LOCM furnished on or after January 1, 2003, hospitals that are subject to the OPPS should either include the charge for LOCM in the charge for the diagnostic procedure or, if billing for LOCM as a separate charge, bill using revenue code 255, *Drugs Incident to Radiology* or revenue code 254, *Drugs Incident to Other Diagnostic Services,* as appropriate.

Instruct your OPPS hospitals that until they receive further notice, they must not use LOCM HCPCS codes A4644, A4645, or A4646 when billing for LOCM furnished on or after January 1, 2003. Return to the provider claims submitted with the LOCM HCPCS codes A4644, A4645, or A4646 for services furnished on or after January 1, 2003.

Non-OPPS hospitals must follow the billing instructions in §§443.C.3f and 443.C.3g of the Medicare Hospital Manual and §§3631.C.3f and 3631.C.3g of the Medicare Intermediary Manual. These instructions continue to be applicable to non-OPPS hospitals.

The *effective date* for this PM is January 1, 2003.

The *implementation date* for this PM is April 1, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after November 30, 2003.

If you have any questions, contact your regional office.