Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

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(Rev. 2452, 04-26-12)
(Rev. 2531, 08-24-12)

Transmittals for Chapter 4

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(Rev. 1, 10-03-03)
A-01-93

10.1 - Background
(Rev. 1, 10-03-03)
A-01-93, A-01-15

Section 1833(t) of the Social Security Act (the Act) as amended by §4533 of the Balanced Budget Act (BBA) of 1997, authorizes CMS to implement a Medicare PPS for:

- Hospital outpatient services, including partial hospitalization services;
- Certain Part B services furnished to hospital inpatients who have no Part A coverage;
- Partial hospitalization services furnished by CMHCs;
- Hepatitis B vaccines and their administration, splints, cast, and antigens provided by HHAs that provide medical and other health services;
- Hepatitis B vaccines and their administration provided by CORFs; and
- Splints, casts, and antigens provided to hospice patients for treatment of non-terminal illness.

The Balanced Budget Refinement Act of 1999 (BBRA) contains a number of major provisions that affect the development of the OPPS. These are:

- Establish payments under OPPS in a budget neutral manner based on estimates of amounts payable in 1999 from the Part B Trust Fund and as beneficiary coinsurance under the system in effect prior to OPPS (Although the base rates were calculated using the 1999 amounts, these amounts are increased by the hospital inpatient market basket, minus one percent, to arrive at the amounts payable in the year 2000. See §10.3 for Benefits and Improvement Protection Act (BIPA) changes in market basket updates.);
- Extend the 5.8 percent reduction in operating costs and 10 percent reduction in capital costs (which had been due to sunset on December 31, 1999) through the first date the OPPS is implemented;
- Require annual updating of the OPPS payment weights, rates, payment adjustments and groups;
- Require annual consultation with an expert provider advisory panel in review and updating of payment groups;
- Establish budget neutral outlier adjustments based on the charges, adjusted to costs, for all OPPS services included on the submitted outpatient bill for services furnished before January 1, 2002, and thereafter based on the individual services billed;

- Provide transitional pass-throughs for the additional costs of new and current medical devices, drugs, and biologicals for at least two years but not more than three years;

- Provide payment under OPPS for implantable devices including durable medical equipment (DME), prosthetics and those used in diagnostic testing;

- Establish transitional payments to limit provider's losses under OPPS; the additional payments are for 3 1/2 years for CMHCs and most hospitals, and permanent for the 10 cancer hospitals; and

- Limit beneficiary coinsurance for an individual service paid under OPPS to the inpatient hospital deductible.

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), which was signed into law on December 21, 2000, made a number of revisions to the Outpatient Prospective Payment System (OPPS). These are:

- Accelerated reductions of beneficiary copayments;

- Increase in market basket update for 2001;

- Transitional corridor provision for transitional outpatient payments (TOPs) for providers that did not file 1996 cost reports; and

- Special transitional corridor treatment for children's hospitals.

The Secretary has the authority under §1883(t) of the Act to determine which services are included (with the exception of ambulance services for which a separate fee schedule is applicable starting April 1, 2002). Medicare will continue to pay for clinical diagnostic laboratory services, orthotics, prosthetics (except as noted above), and for take-home surgical dressings on their respective fee schedules. Medicare will also continue to pay for chronic dialysis using the composite rate (certain CRNA services, PPV, and influenza vaccines and their administration, orphan drugs, and ESRD drugs and supplies are not included in the composite rate), for screening mammographies based on the current payment limitation, which changes to payment under the Medicare Physician Fee Schedule (MPFS), effective January 1, 2002, and for outpatient rehabilitation services (physical therapy including speech language pathology and occupational therapy) under the MPFS. Acute dialysis, e.g., for poisoning, will be paid under OPPS. The 10 cancer centers exempt from inpatient PPS are included in this system, but are eligible for hold harmless payment under the Transitional Corridor provision.

The Outpatient Prospective Payment System (OPPS) applies to all hospital outpatient departments except for hospitals that provide Part B only services to their inpatients; Critical Access Hospitals (CAHs); Indian Health Service hospitals; hospitals located in American Samoa, Guam, and Saipan; and, effective January 1, 2002, hospitals located in the Virgin Islands. It also applies to partial hospitalization services furnished by Community Mental Health Centers (CMHCs).

Certain hospitals in Maryland that are paid under Maryland waiver provisions are also excluded from payment under OPPS but not from reporting Healthcare Common Procedure Coding System (HCPCS) and line item dates of service.

10.1.1 - Payment Status Indicators

(Rev. 1445; Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

An OPPS payment status indicator is assigned to every HCPCS code. The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. For example, services with status indicator A are paid under a fee schedule or payment system other than the OPPS. Services with status indicator N are paid under the OPPS, but their payment is packaged into payment for a separately paid service. Services with status indicator T are paid separately under OPPS but a multiple procedure payment reduction applies when two or more services with a status indicator of T are billed on the same date of service.

The full list of status indicators and their definitions is published in Addendum D1 of the OPPS/ASC proposed and final rules each year. The status indicator for each HCPCS code is shown in OPPS Addendum B.

10.2 - APC Payment Groups

(Rev. 1445; Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. (See section 10.5 for discussion of multiple procedure discounting under the OPPS).

Services within an APC are similar clinically and with respect to hospital resource use. The law requires that the median cost for the highest cost service within the APC may not be more than 2 times the median cost for the lowest cost service in the APC, and the Secretary may make exceptions in unusual cases, such as low volume items and services. This is commonly called the "2 times rule." The median costs of services change from year to year as a result of changes in hospitals' charge, changes to cost-to-charge ratios as determined from hospital cost reports, and changes in the frequency of services. Therefore, the APC assignment of a service may change from one year to the next year as is needed to avoid a violation of the 2 times rule or to improve clinical and/or resource homogeneity of APCs. This APC reconfiguration may result in significant changes in the payment rate for the APC and, therefore, for the service being billed.

10.2.1 - Composite APCs

(Rev. 2141, Issued: 01-24-11, Effective: 01-01-11, Implementation: 01-03-11)

Composite APCs provide a single payment for a comprehensive diagnostic and/or treatment service that is defined, for purposes of the APC, as a service typically reported with multiple HCPCS codes. When

HCPCS codes that meet the criteria for payment of the composite APC are billed on the same date of service, CMS makes a single payment for all of the codes as a whole, rather than paying individually for each code.

The table below identifies the composite APCs that are effective for services furnished on or after January 1, 2008. See Addendum A at www.cms.hhs.gov/HospitalOutpatientPPS/ for the national unadjusted payment rates for these composite APCs.

Composite APC	**Composite APC Title**	**Criteria for Composite Payment**
8000	Cardiac Electrophysiologic Evaluation and Ablation Composite	At least one unit of CPT code 93619 or 93620 and at least one unit of CPT code 93650, 93651 or 93652 on the same date of service.
8001	Low Dose Rate Prostate Brachytherapy Composite	One or more units of CPT codes 55875 and 77778 on the same date of service.
8002	Level I Extended Assessment and Management Composite	1) Eight or more units of HCPCS code G0378 are billed-- • On the same day as HCPCS code G0379*; or • On the same day or the day after CPT codes 99205 or 99215; and 2) There is no service with SI=T on the claim on the same date of service or 1 day earlier than HCPCS code G0378.
8003	Level II Extended Assessment and Management Composite	1) Eight or more units of HCPCS code G0378** are billed on the same date of service or the date of service after CPT codes 99284, 99285, G0384, or 99291; and 2) There is no service with SI=T on the claim on the same date of service or 1 day earlier.
0034	Mental Health Services Composite	Payment for any combination of mental health services with the same date of service exceeds the payment for APC 0173 in years prior to 2011 or APC 0176 after January 1, 2011. For the list of mental health services to which this composite applies, see the I/OCE supporting

Composite APC	Composite APC Title	Criteria for Composite Payment
		files for the pertinent period.
8004	Ultrasound Composite	Payment for any combination of designated imaging procedures within the Ultrasound imaging family on the same date of service. For the list of imaging services included in the Ultrasound imaging family, see the I/OCE specifications document for the pertinent period.
8005	Computed Tomography (CT) and Computed Tomographic Angiography (CTA) without Contrast Composite	Payment for any combination of designated imaging procedures within the CT and CTA imaging family on the same date of service. If a "without contrast" CT or CTA procedure is performed on the same date of service as a "with contrast" CT or CTA procedure, the IOCE will assign APC 8006 rather than APC 8005. For the list of imaging services included in the CT and CTA imaging family, see the I/OCE specifications document for the pertinent period.
8006	CT and CTA with Contrast Composite	
8007	Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) without Contrast Composite	Payment for any combination of designated imaging procedures within the MRI and MRA imaging family on the same date of service. If a "without contrast" MRI or MRA procedure is performed on the same date of service as a "with contrast" MRI or MRA procedure, the I/OCE will assign APC 8008 rather than APC 8007. For the list of imaging services included in the MRI and MRA imaging family, see the I/OCE specifications document for the pertinent period.
8008	MRI and MRA with Contrast Composite	

*Payment for direct admission to observation care (HCPCS code G0379) is made either under APC 604 (Level 1 Hospital Clinic Visits) or APC 8002 (Level I Extended Management and Assessment Composite) or is packaged into payment for other separately payable services. See §290.5.2 for additional information and the criteria for payment of HCPCS code G0379.

** For additional reporting requirements for observation services reported with HCPCS code G0378, see §290.5.1 of this chapter.

Future updates will be issued in a Recurring Update Notification.

10.2.2 – Cardiac Resynchronization Therapy

(Rev. 2386, Issued: 01-13-12, Effective: 01-01-12, Implementation: 01-03-12)

Effective for services furnished on or after January 1, 2012, cardiac resynchronization therapy involving an implantable cardioverter defibrillator (CRT-D) will be recognized as a single, composite service combining implantable cardioverter defibrillator procedures (described by CPT code 33249 (Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator)) and pacing electrode insertion procedures (described by CPT code 33225 (Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (including upgrade to dual chamber system))) when performed on the same date of service. When these procedures appear on the same claim but with different dates of service, or appear on the claim without the other procedure, the standard APC assignment for each service will continue to be applied.

Medicare will make a single payment for those procedures that qualify for composite service payment, as well as any packaged services furnished on the same date of service. Because CPT codes 33225 and 33249 may be treated as a composite service for payment purposes, CMS is assigning them status indicator "Q3" (Codes that may be paid through a composite APC) in Addendum B.

Hospitals will continue to use the same CPT codes to report CRT-D procedures, and the I/OCE will evaluate every claim received to determine if payment as a composite service is appropriate. Specifically, the I/OCE will determine whether payment will be made through a single, composite payment when the procedures are done on the same date of service, or through the standard APC payment methodology when they are done on different dates of service.

CMS is also implementing claims processing edits that will return to providers incorrectly coded claims on which a pacing electrode insertion procedure described by CPT code 33225 is billed without one of the following CPT codes for insertion of an implantable cardioverter defibrillator or pacemaker:

- 33206 (Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial);
- 33207 (Insertion or replacement of permanent pacemaker with transvenous electrode(s); ventricular);
- 33208 (Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular);
- 33212 (Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular);
- 33213 (Insertion or replacement of pacemaker pulse generator only; dual chamber, atrial or ventricular);

- 33214 (Upgrade of implanted pacemaker system, conversion of single chamber system to dual chamber system (includes removal of previously placed pulse generator, testing of existing lead, insertion of new lead, insertion of new pulse generator));

- 33216 (Insertion of a single transvenous electrode, permanent pacemaker or cardioverter-defibrillator);

- 33217 (Insertion of 2 transvenous electrodes, permanent pacemaker or cardioverter-defibrillator);

- 33221(Insertion of pacemaker pulse generator only; with existing multiple leads);

- 33222 (Revision or relocation of skin pocket for pacemaker);

- 33230 (Insertion of pacing cardioverter-defibrillator pulse generator only; with existing dual leads);

- 33231 (Insertion of pacing cardioverter-defibrillator pulse generator only; with existing multiple leads)

- 33233 (Removal of permanent pacemaker pulse generator);

- 33234 (Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular);

- 33235 (Removal of transvenous pacemaker electrode(s); dual lead system, atrial or ventricular);

- 33240 (Insertion of single or dual chamber pacing cardioverter-defibrillator pulse generator); or

- 33249 (Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator).

10.3 - Calculation of APC Payment Rates

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

The OPPS national unadjusted payment rates for APCs other than drugs and biologicals are calculated as the products of the scaled relative weight for the APC and the OPPS conversion factor. Hospital specific payments for these APCs are derived after application of applicable adjustment factors (e.g., multiple surgery reduction, rural sole community adjustment, etc.) and the post reclassification wage index that applies to the hospital to which payment is being made. Payment rates for separately paid drugs and biologicals are generally established based on a percentage of the average sales price of the drug or biological.

An APC's scaled relative weight is generally calculated based on the median cost (operating and capital) of all of the services included in the APC group. Median costs are developed from a database of the most currently available hospital outpatient claims using "the most recently" filed cost report data.

The following is a simplified description of the process used to calculate the OPPS payment rates for services for which the rate is based on the median cost.

- Hospital-specific, department-specific cost-to-charge ratios are used to convert billed charges to costs for each HCPCS code;

- For most APCs, single procedure bills (claims that contain only one separately paid procedure code) for all of the procedures within a particular APC are used to calculate the median costs on which APC payment weights are based to ensure that the median captures the full cost of the procedure when it is the only service furnished. The costs on the bill are summed to add the costs of any packaged services into the procedure with which the packaged services are packaged. Composite APCs are an exception to this statement since the payment for them is calculated only from multiple procedure claims that meet the criteria for composite APC payment;

- 60 percent of the total cost is wage neutralized and the set of claims for each APC is trimmed at +/- 3 standard deviations from the geometric mean;

- A median cost is calculated for each APC, using the claims for the procedures that meet the criteria for being assigned to that APC and the array of costs determined from those claims. In some cases, a subset of single procedure bills that meet specified criteria are used to calculate the median cost for the APC. For example, CMS uses only claims with correct device codes, no token charges for devices, no interrupted procedures, and without "no cost" or "full credit" devices to set the median cost for device-dependent APCs. Similarly, the median costs for composite APCs are calculated using only claims that meet the criteria for the composite APC.

- Median costs are converted to relative weights by dividing each APC's median cost by the median cost for the Level 3 Hospital Clinic Visit APC.

- Relative weights are scaled for budget neutrality.

- Scaled weights are converted to payment rates using a conversion factor which takes into account pass-through payments to be made in the coming year, changes to the wage index (see section 10.8.1), the cost of outlier payments (see section 10.7) and the annual market basket update factor.

CMS issues a proposed rule with a 60 day comment period in the summer of the year before the year in which the proposed payment rates would be applicable. There is a 60 day comment period, after which CMS issues a final rule with comment period to announce the forthcoming year's payment policies and rates. The CMS OPPS Webpage at http://www.cms.hhs.gov/HospitalOutpatientPPS/ is the best source for both rules and the supporting files.

10.4 - Packaging

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

Under the OPPS, packaged services are items and services that are considered to be an integral part of another service that is paid under the OPPS. No separate payment is made for packaged services, because the cost of these items and services is included in the APC payment for the service of which they are an

integral part. For example, routine supplies, anesthesia, recovery room use, and most drugs are considered to be an integral part of a surgical procedure so payment for these items is packaged into the APC payment for the surgical procedure.

A. Packaging for Claims Resulting in APC Payments

If a claim contains services that result in an APC payment but also contains packaged services, separate payment for the packaged services is not made since payment is included in the APC. However, charges related to the packaged services are used for outlier and Transitional Corridor Payments (TOPs) as well as for future rate setting.

Therefore, it is extremely important that hospitals report all HCPCS codes consistent with their descriptors; CPT and/or CMS instructions and correct coding principles, and all charges for all services they furnish, whether payment for the services is made separately paid or is packaged.

B. Packaging for Claims Resulting in No APC Payments

If the claim contains only services payable under cost reimbursement, such as corneal tissue, and services that would be packaged services if an APC were payable, then the packaged services are not separately payable. In addition, these charges for the packaged services are not used to calculate TOPs.

If the claim contains only services payable under a fee schedule, such as clinical diagnostic laboratory tests, and also contains services that would be packaged services if an APC were payable, the packaged services are not separately payable. In addition, the charges are not used to calculate TOPs.

If a claim contains services payable under cost reimbursement, services payable under a fee schedule, and services that would be packaged services if an APC were payable, the packaged services are not separately payable. In addition, the charges are not used to calculate TOPs payments.

C. Packaging Types Under the OPPS

1. Unconditionally packaged services are services for which separate payment is never made because the payment for the service is always packaged into the payment for other services. Unconditionally packaged services are identified in the OPPS Addendum B with status indictor of N. See the OPPS Web site at http://www.cms.hhs.gov/HospitalOutpatientPPS/ for the most recent Addendum B (HCPCS codes with status indicators). In general, the charges for unconditionally packaged services are used to calculate outlier and TOPS payments when they appear on a claim with a service that is separately paid under the OPPS because the packaged service is considered to be part of the package of services for which payment is being made through the APC payment for the separately paid service.

2. STVX-packaged services are services for which separate payment is made only if there is no service with status indicator S, T, V or X reported with the same date of service on the same claim. If a claim includes a service that is assigned status indicator S, T, V, or X reported on the same date of service as the STVX- packaged service, the payment for the STVX-packaged service is packaged into the payment for the service(s) with status indicator S, T, V or X and no separate payment is

made for the STVX-packaged service. STVX-packaged services are assigned status indicator Q1. See the OPPS Webpage at http://www.cms.hhs.gov/HospitalOutpatientPPS/ for identification of STVX-packaged codes.

3. T-packaged services are services for which separate payment is made only if there is no service with status indicator T reported with the same date of service on the same claim. When there is a claim that includes a service that is assigned status indicator T reported on the same date of service as the T-packaged service, the payment for the T-packaged service is packaged into the payment for the service(s) with status indicator T and no separate payment is made for the T-packaged service. T-packaged services are assigned status indicator Q2. See the OPPS Web site at http://www.cms.hhs.gov/HospitalOutpatientPPS/ for identification of T-packaged codes.

4. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Services mapped to composite APCs are assigned status indicator Q3. See the discussion of composite APCs in section 10.2.1.

10.4.1 - Combinations of Packaged Services of Different Types That are Furnished on the Same Date of Service

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

Where a claim contains multiple codes that are STVX-packaged codes and does not contain a procedure with status indicator S, T, V or X on the same date of service, separate payment is made for the STVX-packaged code that is assigned to the highest paid APC and payment for the other STVX-packaged codes on the claim is packaged into the payment for the highest paid STVX-packaged code.

Where a claim contains multiple codes that are T-packaged codes and does not contain a procedure with status indicator T on the same date of service, separate payment is made for the T-packaged code assigned to the highest paid APC and payment for the other T-packaged codes on the claim is packaged into the payment for the highest paid T-packaged code.

Where a claim contains a combination of STVX-packaged and T-packaged codes on the same date of service and does not contain a procedure with status indicator S, T, V or X on the same date, separate payment is made for the STVX-packaged or T-packaged code with the highest payment rate and payment for the other STVX-packaged and T-packaged codes is packaged into the payment for the highest paid STVX-packaged or T-packaged procedure.

Where a claim contains a combination of STVX-packaged and T-packaged codes and codes that could be paid through composite APCs, payment for the STVX-packaged and/or T-packaged services is packaged into separate payment for the composite APC.

10.5 - Discounting

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

- Fifty percent of the full OPPS amount is paid if a procedure for which anesthesia is planned is discontinued after the patient is prepared and taken to the room where the procedure is to be performed but before anesthesia is provided.

- Fifty percent of the full OPPS amount is paid if a procedure for which anesthesia is not planned is discontinued after the patient is prepared and taken to the room where the procedure is to be performed.

- Multiple surgical procedures furnished during the same operative session are discounted.

    - The full amount is paid for the surgical procedure with the highest weight;

    - Fifty percent is paid for any other surgical procedure(s) performed at the same time;

    - Similar discounting occurs now under the physician fee schedule and the payment system for ASCs;

- When multiple surgical procedures are performed during the same operative session, beneficiary coinsurance is discounted in proportion to the APC payment.

10.6 - Payment Adjustments

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

Payments are adjusted to reflect geographic differences in labor-related costs. In addition, beginning January 1, 2006, rural sole community hospitals (SCHs) receive a 7.1 percent increase in payments for most services, with certain exceptions, including separately paid drugs and biologicals. This adjustment is authorized under section 1833(t)(13)(B) of the Act, and implemented in accordance with section 419.43(g) of the regulations. The adjustment is automatically applied in Pricer.

The Secretary may also establish other adjustments or special adjustments for certain classes of hospitals.

10.6.1 - Payment Adjustment for Certain Rural Hospitals

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

Beginning January 1, 2006, rural sole community hospitals (SCHs), including essential access community hospitals (EACHs), receive a 7.1 percent increase in payments for most services, with certain exceptions. Services which are excepted from the increase in payments include, but are not limited to, separately paid drugs and biologicals and items paid at charges adjusted to cost. This adjustment is authorized under Section 1833(t)(13)(B) of the Act, and implemented in accordance with Section 419.43(g) of the regulations. The adjustment is automatically applied in Pricer.

10.6.2 - Payment Adjustment for Failure to Meet the Hospital Outpatient Quality Reporting Requirements

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

Effective for services furnished on or after January 1, 2009, Section 1833(t)(17)(A) of the Act requires that "Subsection (d) hospitals" that have failed to meet the specified hospital outpatient quality reporting requirements for the relevant calendar year will receive payment under the OPPS that reflects a 2 percentage point reduction of the annual OPPS update factor. See www.qualitynet.org for information on complying with the reporting requirements and standards that must be met to receive the full update.

10.6.2.1 - Hospitals to Which the Payment Reduction Applies

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

The reduction applies only to hospitals that are identified as "Subsection (d) hospitals." "Subsection (d) hospitals" have the same definition for hospitals paid under the OPPS as for hospitals paid under the IPPS. Specifically, "Subsection (d) hospitals" are defined under Section 1886(d)(1)(B) of the Act as hospitals that are located in the 50 states or the District of Columbia other than those categories of hospitals or hospital units that are specifically excluded from the IPPS, including psychiatric, rehabilitation, long-term care, children's and cancer hospitals or hospital units. In other words, the provision does not apply to hospitals and hospital units excluded from the IPPS or to hospitals located in Maryland, Puerto Rico or the U.S. territories. Hospitals that are not required to submit quality data (i.e., those that are not Subsection (d) hospitals) will receive the full OPPS update. Similarly, the reduced update will not apply to Subpart (d) hospitals that are not paid under the OPPS (e.g., Indian Health Service hospitals).

10.6.2.2 - Services to which the Payment Reduction Applies

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

The reduction to the annual update factor for failure to meet the quality reporting requirements applies to most, but not all, services paid under the OPPS. The reduction of payments does not apply to services paid under the OPPS if the payment amounts are not calculated using the conversion factor to which the annual update factor applies (e.g., drugs and biologicals paid based on the average sales price (ASP) methodology, new technology services paid at a fixed amount, and services paid at charges adjusted to cost). The reduction also does not apply to hospital outpatient services paid through other fee schedules or other mechanisms. Examples of these exceptions are services paid under the physician fee schedule (e.g., physical therapy and diagnostic and screening mammography), services paid at reasonable cost (e.g., influenza and pneumococcal vaccines), and services paid under other fee schedules (e.g., clinical laboratory services and durable medical equipment).

The specific services to which this policy applies can be identified by OPPS status indicator. CMS will identify the status indicators of the HCPCS codes to which the reduction applies each year in the change request that announces changes to the OPPS for the forthcoming calendar year. Also, the status indicators for the services (identified by HCPCS codes) to which the reduction applies can be found in the OPPS final rule for the year of interest under "Hospital Outpatient Regulations and Notices" at www.cms.hhs.gov/HospitalOutpatientPPS/. The services excluded from the payment reduction may change each year if the method of calculating payment under the OPPS changes.

10.6.2.3 - Contractor Responsibilities

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

CMS claims processing software will automatically reduce payment to "Subsection (d) hospitals" when those hospitals that fail to meet the quality reporting requirements bill for services to which the reduced update applies. However, contractors must update the Outpatient Provider Specific File (OPSF) quality reporting field when CMS furnishes the list of hospitals to which the payment reduction applies. The FISS auto-populates the Hospital Quality Indicator field of the OPSF field with a "1" for all hospitals. Once CMS has issued the list of hospitals failing to meet the requirements, Medicare contractors must remove the '1' in the Hospital Quality Indicator field for each Subsection (d) hospital that fails to meet the quality reporting requirements. Contractors make no changes to the '1" indicator for hospitals that are not Subsection (d) hospitals providing OPPS services or for hospitals that are Subsection (d) hospitals providing OPPS services that are not listed as failing the requirements.

CMS sends Medicare contractors the file of hospitals to which the reduction applies for a given calendar year by a Joint Signature Memorandum/Technical Direction Letter as soon as the list is available. This will be sent as soon as possible, expected to be on or about December 1 of each year preceding the calendar year to which the payment reduction applies. Should a Subsection (d) hospital later be determined to have met the criteria after dissemination of this list, CMS will change the hospital's status. CMS will notify Medicare contractors of the change in status and contractors must update the OPSF as needed and must mass adjust paid claims.

For new hospitals, Medicare contractors must provide information to the Quality Contractor to be specified by CMS as soon as possible so that the Quality Contractor can enter the provider information into the Program Resource System and follow through with ensuring provider participation with the requirements for quality data reporting, if applicable. CMS will notify Medicare contractors of how to contact the Quality Contractor each year in the annual OPPS update change request. This allows the Quality Contractor the opportunity to contact new facilities as early as possible in the calendar year to inform them of the hospital outpatient quality reporting requirements. As soon as possible, Medicare contractors must provide the following information on newly participating hospitals to the Quality Contractor to be specified by CMS:

- State code;
- Provider name;
- Provider ID numbe;
- Medicare accept dat;e
- Contact name (if available); and
- Telephone number.

10.6.2.4 - Application of the Payment Reduction Factor in Calculation of the Reduced Payment and Reduced Copayment

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

For services to which the payment adjustment applies, CMS calculates a payment reduction factor that is used in the OPPS Pricer to adjust the payments for hospitals that fail to meet the reporting requirements. **CMS calculates this factor by dividing the OPPS conversion factor that incorporates the reduced update factor by the OPPS conversion factor that incorporates the full update factor for the applicable calendar year.** This ratio is applied to the full national unadjusted payment amount for a service subject to the payment reduction in order to calculate the reduced payment amount. Similarly, this ratio is applied to the full national unadjusted copayment for an applicable service to calculate the reduced

copayment that may be collected from the beneficiary by the hospital. The payment reduction factor will be included in the annual OPPS update change request and may also be found in the applicable OPPS final rule, which can be found at www.cms.hhs.gov/HospitalOutpatientPPS/ under "Hospital Outpatient Regulations and Notices".

10.6.3 - Payment Adjustment for Certain Cancer Hospitals

(Rev. 2453, Issued: 04-26-12, Effective: 01-01-12, Implementation: 05-29 -12)

Section 3138 of the Affordable Care Act requires CMS to conduct a study to determine if, under the OPPS, outpatient costs incurred by 11 specified cancer hospitals exceed the costs incurred by other hospitals furnishing services under the OPPS. In addition, Section 3138 of the Affordable Care Act provides that if the specified cancer hospitals' costs are determined to be greater than the costs of other hospitals furnishing services under the OPPS, CMS shall provide a payment adjustment to the 11 specified cancer hospitals that will appropriately reflect these higher outpatient costs. We determined that outpatient costs incurred by the 11 specified cancer hospitals were greater than the costs incurred by other OPPS hospitals. Therefore, consistent with Section 3138 of the Affordable Care Act, we adopted a policy to provide additional payments to each of the 11 cancer hospitals so that each cancer hospital's final payment to cost ratio (PCR) for services provided in a given calendar year is equal to the weighted average PCR (which we refer to as the "target PCR") for other hospitals paid under the OPPS. The target PCR is set in advance of the calendar year and is calculated using the most recent submitted or settled cost report data that are available at the time of final rulemaking for the calendar year.

The cancer hospital payment adjustment will be made through interim monthly payments with the final payment adjustment amount calculated based on the provider's settled cost report. The calculation for the monthly cancer hospital payment adjustment amount is described as follows:

Step 1 – Compute the cancer hospital target payment amount for each month by first multiplying the total charges for covered services for all OPPS services on claims paid during the month and adjust the total charges to cost by multiplying them by the outpatient cost-to-charge ratio and then multiplying this amount by the target PCR for the calendar year.

Step 2 – Add together the total Medicare program payments, unreduced coinsurance and deductible applied for all APCs, as well as all outlier payments (including reconciled outlier payments and the time value of money) and transitional pass-through payments for drugs, biological and/or devices for those same claims paid during the month as those used in Step 1. If the result is greater than the result of Step 1, go to Step 4. No additional payment is due this month.

Step 3 – Subtract the result of Step 2 from the result of Step 1 and pay .85 times this amount.

Step 4 – When the result of step 2 is greater than the result of Step 1 for the final month of a provider's cost report period, do nothing more. When the result of Step 2 is greater than the result of Step 1 for any other month, store all Step 1 and Step 2 totals and include these totals with the totals for the next month's additional payment calculation.

10.6.3.1 - Payment Adjustment for Certain Cancer Hospitals for CY 2012

(Rev. 2453, Issued: 04-26-12, Effective: 01-01-12, Implementation: 05-29 -12)

The target PCR that should be used in the calculation of the interim monthly payments associated with the cancer hospital adjustment, as described above in section 10.6.3, and at final cost report settlement is 0.91 for hospital outpatient services furnished on or after January 1, 2012 through December 31, 2012.

10.7 - Outliers

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

10.7.1 - Outlier Adjustments

(Rev. 2061, Issued: 10-01-10, Effective: 10-01-10, Implementation: 10-04-10)

The OPPS incorporates an outlier adjustment to ensure that outpatient services with variable and potentially significant costs do not pose excessive financial risk to providers. Section 419.43(f) of the Code of Federal Regulations excludes drugs, biologicals and items and services paid at charges adjusted to cost from outlier payments. The OPPS determines eligibility for outliers using either a "multiple" threshold, which is the product of a multiplier and the APC payment rate, or a combination of a multiple and fixed-dollar threshold. A service or group of services becomes eligible for outlier payments when the cost of the service or group of services estimated using the hospital's most recent overall cost-to-charge ratio (CCR) separately exceeds each relevant threshold. For community mental health centers (CMHCs), CMS determines whether billed partial hospitalization services are eligible for outlier payments using a multiple threshold specific to CMHCs. The outlier payment is a percentage of the difference between the cost estimate and the multiple threshold. The CMS OPPS Web site at www.cms.hhs.gov/HospitalOutpatientPPS/ under "Annual Policy Files" includes a table depicting the specific hospital and CMHC outlier thresholds and the payment percentages in place for each year of the OPPS.

Beginning in CY 2000, CMS determined outlier payments on a claim basis. CMS determined a claim's eligibility to receive outlier payments using a multiple threshold. A claim was eligible for outlier payments when the total estimate of charges reduced to cost for the entire claim exceeded a multiple of the total claim APC payment amount. As provided in Section 1833(t)(5)(D), CMS used each hospital's overall CCR rather than a CCR for each department within the hospital. CMS continues to use an overall hospital CCR specific to ancillary cost centers to estimate costs from charges for outlier payments.

In CY 2002, CMS adopted a policy of calculating outlier payments based on each individual OPPS (line-item) service. CMS continued using a multiple threshold, modified to be a multiple of each service's APC payment rather than the total claim APC payment amount, and an overall hospital CCR to estimate costs from charges. For CY 2004, CMS established separate multiple outlier thresholds for hospitals and CMHCs.

Beginning in CY 2005, for hospitals only, CMS implemented the use of a fixed-dollar threshold to better target outlier payments to complex and costly services that pose hospitals with significant financial risk. The current hospital outlier policy is calculated on a service basis using both fixed-dollar and multiple thresholds to determine outlier eligibility.

The current outlier payment is determined by:

- Calculating the cost related to an OPPS line-item service, including a pro rata portion of the total cost of packaged services on the claim and adding payment for any device with pass- through status to payment for

the associated procedure, by multiplying the total charges for OPPS services by each hospital's overall CCR (see §10.11.8 of this chapter); and

- Determining whether the total cost for a service exceeds 1.75 times the OPPS payment and separately exceeds the fixed-dollar threshold determined each year; and

- If total cost for the service exceeds both thresholds, the outlier payment is 50 percent of the amount by which the cost exceeds 1.75 times the OPPS payment.

The total cost of all packaged items and services, including the cost of uncoded revenue code lines with a revenue code status indicator of "N", that appear on a claim is allocated across all separately paid OPPS services that appear on the same claim. The proportional amount of total packaged cost allocated to each separately paid OPPS service is based on the percent of the APC payment rate for that service out of the total APC payment for all separately paid OPPS services on the claim.

To illustrate, assume the total cost of all packaged services and revenue codes on the claim is $100, and the three APC payment amounts paid for OPPS services on the claim are $200, $300, and $500 (total APC payments of $1000). The first OPPS service or line-item is allocated $20 or 20 percent of the total cost of packaged services, because the APC payment for that service/line-item represents 20 percent ($200/$1000) of total APC payments on the claim. The second OPPS service is allocated $30 or 30 percent of the total cost of packaged services, and the third OPPS service is allocated $50 or 50 percent of the total cost of packaged services.

If a claim has more than one surgical service line with a status indicator (SI) of S or T and any lines with an SI of S or T have less than $1.01 as charges, charges for all S and/or T lines are summed and the charges are then divided across S and/or T lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation.

If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, CMS estimates a single cost for the composite APC from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim.

In accordance with Section 1833(t)(5)(A)(i) of the Act, if a claim includes a device receiving pass-through payment, the payment for the pass-through device is added to the payment for the associated procedure, less any offset, in determining the associated procedure's eligibility for outlier payment, and the outlier payment amount. The estimated cost of the device, which is equal to payment, also is added to the estimated cost of the procedure to ensure that cost and payment both contain the procedure and device costs when determining the procedure's eligibility for an outlier payment.

Future updates will be issued in a Recurring Update Notification.

10.7.2 - Outlier Reconciliation

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

10.7.2.1 - Identifying Hospitals and CMHCs Subject to Outlier Reconciliation
(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

A. General

Under §419.43(d)(6)(i), for hospital outpatient services furnished during cost reporting periods beginning on or after January 1, 2009, OPPS high cost outlier payments may be reconciled upon cost report settlement to account for differences between the overall ancillary CCR used to pay the claim at its original submission by the provider, and the CCR determined at final settlement of the cost reporting period during which the service was furnished. Hospitals and CMHCs that Medicare contractors identify using the criteria listed below are subject to the OPPS outlier reconciliation policies described in this section. OPPS outlier payments are reconciled if the CMS Central Office and Regional Office confirm that reconciliation is appropriate. Services with an APC payment paid at charges adjusted to cost are not subject to reconciliation policies.

Subject to the approval of the CMS Central Office and Regional Office, a hospital's outpatient outlier claims are reconciled at the time of cost report final settlement if they meet the following criteria:

1. The actual overall ancillary CCR is found to be plus or minus 10 percentage points or more from the CCR used during that time period to make OPPS outlier payments, and

2. Total OPPS outlier payments in that cost reporting period exceed $500,000.

Subject to the approval of the CMS Central Office and Regional Office, a CMHC's outlier claims are reconciled at the time of cost report final settlement if they meet the following criteria:

1. The actual overall CCR is found to be plus or minus 10 percentage points or more from the CCR used during that time period to make OPPS outlier payments, and

2. Any CMHC OPPS outlier payments are made in that cost reporting period.

To determine if a hospital or CMHC meets the criteria above, the Medicare contractor shall incorporate all the adjustments from the cost report, run the cost report, calculate the revised CCR, and compute the actual overall ancillary CCR prior to issuing a Notice of Program Reimbursement (NPR). If the criteria for OPPS outlier reconciliation are not met, the cost report shall be finalized. If the criteria for reconciliation are met, Medicare contractors shall follow the instructions below in §10.7.2.4 of this chapter. The NPR cannot be issued nor can the cost report be finalized until OPPS outlier reconciliation is complete. These hospital and CMHC cost reports will remain open until their claims have been processed for OPPS outlier reconciliation.

As stated above, if a cost report is reopened after final settlement and as a result of this reopening there is a change to the CCR (which could trigger or affect OPPS outlier reconciliation and outlier payments), Medicare contractors shall notify the CMS Central and Regional Offices for further instructions. Notification to the CMS Central Office shall be sent to the address and email address provided in §10.11.3.1.

Any cost report that has been final settled that meets the qualifications for OPPS outlier reconciliation shall be reopened. Medicare contractors shall notify the CMS Central Office and Regional Office that the OPPS outlier payments need to be reconciled, using the procedures included in §10.7.2.4. After CMS' approval of the reconciliation, the Medicare contractor shall issue a reporting notice to the provider.

B. Hospitals and CMHCs Already Flagged for Outlier Reconciliation

Medicare contractors shall have until April 25, 2011 to submit via email to outliersopps@cms.hhs.gov a list of providers that were flagged for outlier reconciliation prior to April 1, 2011 (**NOTE**: Do not send this list prior to April 1, 2011 as this list shall include all providers flagged for outlier reconciliation prior to April 1, 2011). In this list, Medicare contractors shall include the provider number, provider name, cost reporting begin date, cost reporting end date, status of cost report (was the Notice of Program Reimbursement (NPR) issued), date of NPR, total outlier payments in the cost reporting period, the CCR or weighted CCR from the time the claims were paid during the cost reporting period being reconciled and the final settled CCR. The CMS Central Office will then review this list and grant formal approval via email for Medicare contractors to reprice and reconcile the claims of those hospitals with open cost reports. Upon receiving approval for reconciliation from the CMS Central Office, Medicare contractors shall follow the procedures in §10.7.2.4 and complete the reconciliation process by October 1, 2011. If a Medicare contractor cannot complete the reconciliation process by October 1, 2011, the Medicare contractor shall contact the CMS Central Office for further guidance. **NOTE**: Those Medicare contractors that do not have any providers flagged for outlier reconciliation prior to April 1, 2011 shall also send an email to the address above indicating that they have no providers flagged for outlier reconciliation prior to April 1, 2011.

10.7.2.2 - Reconciling Outlier Payments for Hospitals and CMHCs

(Rev. 1760, Issued: 06-23-09; Effective Date: 07-01-09; Implementation Date: 07-06-09)

For hospital outpatient services furnished during cost reporting periods beginning on or after January 1, 2009, all hospitals and CMHCs are subject to the OPPS outlier reconciliation policies set forth in this section. If a hospital or CMHC meets the criteria in §10.7.2.1, the Medicare contractors shall notify the central office and regional office at the address and email address provided in §10.11.3.1. Further instructions for Medicare contractors on reconciliation and the time value of money are provided below in §§10.7.2.3 and 10.7.2.4 of this chapter. The following examples demonstrate how to apply the criteria for reconciliation:

EXAMPLE A:

Cost reporting period: 01/01/2009-12/31/2009

Overall ancillary CCR used to pay original claims submitted during cost reporting period: 0.40

(In this example, this CCR is from the tentatively settled 2007 cost report.)

Final settled overall ancillary CCR from 01/01/2009 – 12/31/2009 cost report: 0.50

Total OPPS outlier payout in 01/01/2009-12/31/2009 cost reporting period: $600,000

Because the CCR of 0.40 used at the time the claim was originally paid changed to 0.50 at the time of final settlement, and the provider received greater than $500,000 in OPPS outlier payments during that cost reporting period, the criteria are met for reconciliation, and therefore, the Medicare contractor notifies the central office and the regional office. The provider's OPPS outlier payments for this cost reporting period are reconciled using the correct CCR of 0.50.

In the event that multiple overall ancillary CCRs are used in a given cost reporting period to calculate outlier payments, Medicare contractors should calculate a weighted average of the CCRs in that cost reporting period. Example B below shows how to weight the CCRs. The Medicare contractor shall then compare the weighted CCR to the CCR determined at the time of final settlement of the cost reporting period to determine if OPPS outlier reconciliation is required. Total OPPS outlier payments for the entire cost reporting period must exceed $500,000 in order to trigger reconciliation.

EXAMPLE B:

Cost reporting period: 01/01/2009-12/31/2009

Overall ancillary CCR used to pay original claims submitted during cost reporting period:

- 0.40 from 01/01/2009 to 03/31/2009 (This CCR could be from the tentatively settled 2006 cost report.)

- 0.50 from 04/01/2009 to 12/31/2009 (This CCR could be from the tentatively settled 2007 cost report.)

Final settled operating CCR from 01/01/2009 – 12/31/2009 cost report: 0.35

Total OPPS outlier payout in 01/01/2009 -12/31/2009 cost reporting period: $600,000

Weighted average CCR: 0.476

CCR	Days	Weight	Weighted CCR
0.40	90	0.247 (90 Days / 365 Days)	(a) 0.099 = (0.40 * 0.247)
0.50	275	0.753 (275 Days / 365 Days)	(b) 0.377 = (0.50 * 0.753)
TOTAL	365		(a)+(b) = 0.476

The hospital meets the criteria for OPPS outlier reconciliation in this cost reporting period because the weighted average CCR at the time the claim was originally paid changes from 0.476 to 0.35 (which is greater than 10 percentage points) at the time of final settlement, and the provider received an OPPS outlier payment greater than $500,000 for the entire cost reporting period.

Even if a hospital or CMHC does not meet the criteria for reconciliation in §10.7.2.1, subject to approval of the central and regional offices, the Medicare contractor has the discretion to request that a hospital or CMHC's OPPS outlier payments in a cost reporting period be reconciled if the hospital's most recent cost and charge data indicate that the OPPS outlier payments to the hospital were significantly inaccurate. The Medicare contractor sends notification to the regional office and central office via the address and email address provided in §10.11.3.1. Upon approval of the central and regional office that a hospital or CMHC's outpatient outlier claims need to be reconciled, Medicare contractors should follow the instructions in §10.7.2.4.

10.7.2.3 - Time Value of Money

(Rev. 2242, Issued: 06-17-11, Effective: 07-01-11, Implementation: 07-01-11)

Effective for hospital outpatient services furnished in the first cost reporting period on or after January 1, 2009, at the time of any reconciliation under §10.7.2.2, OPPS outlier payment may be adjusted to account for the time value of money of any adjustments to OPPS outlier payments as a result of reconciliation. As described in 42 CFR 419.43(d)(6)(ii), the time value of money is applied from the midpoint of the hospital or CMHC's cost reporting period being settled to the date on which the CMS Central Office receives notification from the Medicare contractor that reconciliation should be performed.

If a hospital or CMHC's OPPS outlier payments have met the criteria for reconciliation, CMS will calculate the aggregate adjustment using the instructions below concerning reprocessing claims and determine the additional amount attributable to the time value of money of that adjustment. The index that is used to calculate the time value of money is the monthly rate of return that the Medicare trust fund earns. This index can be found at http://www.ssa.gov/OACT/ProgData/newIssueRates.html.

The following formula is used to calculate the rate of the time value of money:

(Rate from Web site as of the midpoint of the cost report being settled / 365) * # of days from that midpoint until date of reconciliation. **NOTE**: The time value of money can be a positive or negative amount depending if the provider is owed money by CMS or if the provider owes money to CMS.

For purposes of calculating the time value of money, the "date of reconciliation" is the day on which the CMS Central Office receives notification. This "date of reconciliation" is based solely on the date CMS Central Office receives notification and not on the date that reconciliation is approved by the CMS Central and Regional Offices. This date is either the postmark from the written notification sent to the CMS Central Office via mail by the Medicare contractor, or the date an email was received from the Medicare contractor by the CMS Central Office, whichever is first.

The following is an example of the procedures for reconciliation and computation of the adjustment to account for the time value of money:

EXAMPLE:

Cost reporting period: 01/01/2009 – 12/31/2009

Midpoint of cost reporting period: 07/01/2009

Date of reconciliation: 12/31/2010

Number of days from midpoint until date of reconciliation: 548

Rate from Social Security Web site: 4.625%

Overall ancillary CCR used to pay actual original claims in cost reporting period: 0.40 (This CCR could be from the tentatively settled 2006 or 2007 cost report.)

Final settled operating CCR from 01/01/2009 – 12/31/2009 cost report: 0.50
Total OPPS outlier payout in 01/01/2009 – 12/31/2009 cost reporting period: $600,000

Because the CCR fluctuated from 0.40 at the time the claims were originally paid to 0.50 at the time of final settlement and the provider has an OPPS outlier payout greater than $500,000, the criteria have been met to trigger reconciliation. The Medicare contractor notifies the CMS Central and Regional Offices.

The Medicare contractor reprices the claims in accordance with the process in §10.7.2.4 below. The repricing indicates the revised outlier payments are $700,000.

Using the values above, the rate that is used for the time value of money is determined:

(4.625 / 365) * 548 = 6.9438%

Based on the claims reconciled, the provider is owed $100,000 ($700,000 - $600,000) for the reconciled amount and $6,943.80 for the time value of money.

10.7.2.4 - Procedures for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

The following is a step-by-step explanation of the procedures that Medicare contractors are to follow if a hospital (or CMHC) is eligible for outlier reconciliation:

1) The Medicare contractor sends notification to the CMS Central Office (not the hospital or CMHC), via the street address and email address provided in §10.11.3.1 and to the CMS Regional Office that a hospital or CMHC has met the criteria for OPPS outlier reconciliation. Medicare contractors shall include in their notification the provider number, provider name, cost reporting begin date, cost reporting end date, total outlier payments in the cost reporting period, the CCR or weighted average CCR from the time the claims were paid during the cost reporting period eligible for reconciliation and the final settled CCR.

2) If the Medicare contractor receives approval from the CMS Central Office and Regional Office that OPPS outlier reconciliation is appropriate, the Medicare contractor follows steps 3-14 below.
NOTE: Hospital and CMHC cost reports will remain open until their claims have been processed for OPPS outlier reconciliation.

3) The Medicare contractor shall notify the hospital or CMHC and copy the CMS Regional Office and Central Office in writing and via email (through the address provided in §10.11.3.1) that the hospital or CMHC's OPPS outlier claims are to be reconciled.

4) Prior to running claims in the FISS Lump Sum Utility*, Medicare contractors shall update the applicable provider record in the Outpatient Provider Specific File (OPSF) by entering the final settled CCR from the cost report in Outpatient Cost to Charge Ratio field. No other elements in the OPSF shall be updated for the applicable provider records in the PSF that span the cost reporting period being reconciled aside from the CCR.

   *__NOTE__: The FISS Lump Sum Utility is a Medicare contractor tool that, depending on the elements that are input, will produce an extract that will calculate the difference between the original PPS payment amounts and revised PPS payment amounts into a Microsoft Access generated report. The Lump Sum Utility calculates the original and revised payments offline and will not affect the original claim payment amounts as displayed in various CMS systems (such as NCH).

5) Medicare contractors shall ensure that, prior to running claims through the FISS Lump Sum Utility, all pending claims (e.g., appeal adjustments) are finalized for the applicable provider.

6) Medicare contractors shall only run claims in the Lump Sum Utility that meet the following criteria:

   - TOB 12X, 13X, 34X, 75X, 76X or any TOB with a condition code 07
   - Claim has a line item date of service of January 1, 2009 or later that also contains a Pay Method Flag of '0'
   - Previous claim is in a paid status (P location) within FISS
   - Cancel date is 'blank'

7) The Medicare contractor reconciles the claims through the OPPS Pricer software and not through any editing or grouping software.

8) Upon completing steps 3 through 7 above, the Medicare contractor shall run the claims through the Lump Sum Utility. The Lump Sum Utility will produce an extract, according to the elements in Table 1 below. **NOTE**: The extract must be importable by Microsoft Access or a similar software program (Microsoft Excel).

9) Medicare contractors shall upload the extract into Microsoft Access or a similar software program to generate a report that contains elements in Table 1. Medicare contractors shall ensure this report is retained with the cost report settlement work papers.

10) For hospitals paid under the OPPS, the Lump Sum Utility will calculate the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17). If the difference between the original and revised outlier amount is positive, then a credit amount (addition) shall be issued to the provider. If the difference between the original and revised outlier amount is negative, then a debit amount (deduction) shall be issued to the provider.

11) Medicare contractors shall determine the applicable time value of money amount by using the calculation methodology in §10.7.2.3. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is a negative amount then the time value of money is also a negative amount. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is a positive amount then the time value of money is also a positive amount. Similar to step 10, if the time value of money is positive, then a credit amount (addition) shall be issued to the provider. If the time value of money is negative, then a debit amount (deduction) shall be issued to the provider. **NOTE**: The time value of money is applied to the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17).

12) For cost reporting periods beginning before May 1, 2010, under cost report 2552-96, the Medicare contractor shall record the original outlier amount from Worksheet E, Part B, line 1.02 (prior to the inclusion of line 54 of Worksheet E, Part B), the outlier reconciliation adjustment amount (the difference between the original and revised outlier amount (calculated by the Lump Sum Utility), the total time value of money, the rate used to calculate the time value of money and the sum of lines 51 and 53 on lines 50-54, of Worksheet E, Part B of the cost report (**NOTE**: the amounts recorded on lines 50, 51, 53 and 54 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (Worksheet E, Part B, line 54) shall be included on Worksheet E, Part B, line 1.02. For complete instructions on how to fill out these lines see §3630.2 of the Provider Reimbursement Manual, Part II.

    For cost reporting periods beginning on or after May 1, 2010, under cost report 2552-10, the Medicare contractor shall record the original outlier amount from Worksheet E, Part B, line 4 (prior to the inclusion of line 94 of Worksheet E, Part B), the outlier reconciliation adjustment amount (the difference between the original and revised outlier amount (calculated by the Lump Sum Utility), the total time value of money, the rate used to calculate the time value of money and the sum of lines 91 and 93 on lines 90-94, of Worksheet E, Part B of the cost report (**NOTE**: the amounts recorded on lines 90, 91, 93 and 94 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (Worksheet E, Part B, line 94) shall be included on Worksheet E, Part B, line 1.02.

13) The Medicare contractor shall finalize the cost report, issue a NPR and make the necessary adjustment from or to the provider.

14) After determining the total outlier reconciliation amount and issuing a NPR, Medicare contractors shall restore the CCR(s) elements to their original values (that is, the CCRs used to pay the claims) in the applicable provider records in the PSF to ensure an accurate history is maintained. Specifically, for hospitals paid under the OPPS, Medicare contractors shall enter the original CCR in PSF field 25 -Operating Cost to Charge Ratio.

Medicare contractors shall contact the CMS Central Office via the address and email address provided in §10.11.3.1 with any questions regarding this process.

Table 1: Data Elements for FISS Extract

List of Data Elements for FISS Extract

Provider #
Health Insurance Claim (HIC) Number
Document Control Number (DCN)
Type of Bill
Original Paid Date
Statement From Date
Statement To Date
Original Reimbursement Amount (claims page 10)
Revised Reimbursement Amount (claim page 10)
Difference between these amounts
Original Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Revised Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Difference between these amounts
Original Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Revised Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Difference between these amounts
Original Outlier Amount (Value Code 17)
Revised Outlier Amount (Value Code 17)
Difference between these amounts
Original DSH Amount (Value Code 18)
Revised DSH Amount (Value Code 18)
Difference between these amounts
Original IME Amount (Value Code 19)
Revised IME Amount (Value Code 19)
Difference between these amounts
Original New Tech Add-on (Value Code 77)
Revised New Tech Add-on (Value Code 77)
Difference between these amounts
Original Device Reductions (Value Code D4)
Revised Device Reductions (Value Code D4)
Difference between these amounts
Original Hospital Portion (claim page 14)
Revised Hospital Portion (claim page 14)
Difference between these amounts
Original Federal Portion (claim page 14)
Revised Federal Portion (claim page 14)
Difference between these amounts
Original C TOT PAY (claim page 14)
Revised C TOT PAY (claim page 14)
Difference between these amounts
Original C FSP (claim page 14)
Revised C FSP (claim page 14)
Difference between these amounts
Original C OUTLIER (claim page 14)
Revised C OUTLIER (claim page 14)
Difference between these amounts
Original C DSH ADJ (claim page 14)

Revised C DSH ADJ (claim page 14)
Difference between these amounts
Original C IME ADJ (claim page 14)
Revised C IME ADJ (claim page 14)
Difference between these amounts
Original Pricer Amount
Revised Pricer Amount
Difference between these amounts
Original PPS Payment (claim page 14)
Revised PPS Payment (claim page 14)
Difference between these amounts
Original PPS Return Code (claim page 14)
Revised PPS Return Code (claim page 14)
DRG
MSP Indicator (Value Codes 12-16 & 41-43 – indicator indicating the claim is MSP; 'Y' = MSP, 'blank' = no MSP
Reason Code
HMO-IME Indicator
Filler

10.8 - Geographic Adjustments

(Rev. 1, 10-03-03)
A-01-93

Adjustments for differences in wages across geographical areas are made using inpatient hospital PPS wage index (post-reclassification, post-floor).

It is estimated that 60 percent of the group payment represents labor-related costs and are subject to the geographic adjustment.

10.8.1 - Wage Index Changes

(Rev. 1, 10-03-03)
A-02-026 §XIII, A-01-144

Refer to the CMS Web site http://www.cms.gov/medicare/hopsmain.htm for wage index change information.

10.9 - Updates

(Rev. 132, 03-30-04)

Section 1833(t) of the Social Security Act (the Act) as amended by §4533 of the Balanced Budget Act (BBA) of 1997, authorizes CMS to implement a Medicare prospective payment system for hospital outpatient services, including partial hospitalization services; Certain Part B services furnished to hospital inpatients who have no Part A coverage; Partial hospitalization services furnished by CMHCs; Hepatitis B vaccines and their administration, splints, cast, and antigens provided by HHAs that provide medical and

other health services; Hepatitis B vaccines and their administration provided by CORFs; and Splints, casts, and antigens provided to hospice patients for treatment of non-terminal illness.

By statute, CMS is required to review and revise the APC groups, relative payment rates, wage adjustments, outlier payments and other adjustments required under the OPPS on an annual basis. These annual updates are made final through the publication of proposed and final rules in the Federal Register. The annual update Federal Register rules can be accessed on the OPPS Web site at: http://www.cms.hhs.gov/providers/hopps/

In addition to the annual update at the beginning of each calendar year, we also update the OPPS on a quarterly basis to account for mid-year changes such as adding new pass-through drugs and/or devices, adding new treatments and procedures to the new technology APCs, removing procedures from the inpatient list, and recognizing new HCPCS codes that may be added during the year. The quarterly updates are issued as Recurring Update Notifications. The quarterly Recurring Update Notifications can be found in Pub. 100-21, Recurring Update Notification, which can be accessed at the following Web site: http://www.cms.hhs.gov/manuals/cmsindex.asp

10.10 - Biweekly Interim Payments for Certain Hospital Outpatient Items and Services That Are Paid on a Cost Basis, and Direct Medical Education Payments, Not Included in the Hospital Outpatient Prospective Payment System (OPPS)

(Rev. 1, 10-03-03)
A-01-32

For hospitals subject to the OPPS, payment for certain items that are not paid under the OPPS, but which are reimbursable in addition to OPPS, are made through biweekly interim payments subject to retrospective adjustment based on a settled cost report. These payments include:

- Direct medical education payments;
- Costs of nursing and allied health programs;
- Costs associated with interns and residents not in an approved teaching program as described in 42 CFR 415.202;
- Teaching physicians costs attributable to Part B services for hospitals that elect cost-based reimbursement for teaching physicians under 42 CFR 415.160;
- CRNA services;
- For hospitals that meet the requirements under 42 CFR 412.113(c), the reasonable costs of anesthesia services furnished to hospital outpatients by qualified nonphysician anesthetists (i.e., certified registered nurse anesthetists and anesthesiologists' assistants) employed by the hospital or obtained under arrangements;
- Bad debts for uncollectible deductibles and coinsurance;

- Organ acquisition costs paid under Part B.

For hospitals that are paid under the OPPS, interim payments for these items attributable to both hospital outpatients, as well as inpatients whose services are paid under Part B of the Medicare program are made on a biweekly basis. The FI determines the amount of the biweekly payment by estimating a hospital's reimbursement amount for these items for the cost reporting period by using:

- Medicare principles of cost reimbursement for cost-based items; and

- Medicare rules for determining payment for graduate medical education for direct medical education, and dividing the total annual estimated amount for these items into 26 equal biweekly payments.

The estimated annual amount is based on the most current data available. Biweekly interim payments are reviewed and, if necessary, adjusted at least twice during the reporting period, with final settlement based on a submitted cost report.

Because hospitals subject to the OPPS have not received payment for these items attributable to services furnished on or after August 1, 2000, the date the OPPS was implemented, the first payment to each hospital included all the payments due to the hospital retroactive to August 1, 2000. Thereafter, FIs continue to make payment on a biweekly basis. Each payment is made two weeks after the end of a biweekly period of services. The FI was required to make retroactive payments and begin making biweekly interim payments to all hospitals that are due these payments no later than 60 days after March 8, 2001.

These biweekly payments may be combined with the inpatient biweekly payments that the FI makes under §2405.2 of the Medicare Provider Reimbursement Manual (CMS Pub.15-I). However, if a single payment is made, for purposes of final cost report settlement, they must maintain records to separately identify the amount of the hospital's combined payment that is paid out of the Part A or Part B trust fund.

10.11 - Calculation of Overall Cost-to-Charge Ratios (CCRs) for Hospitals Paid Under the Outpatient Prospective Payment System (OPPS) and Community Mental Health Centers (CMHCs) Paid Under the Hospital OPPS

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

10.11.1 - Requirement to Calculate CCRs for Hospitals Paid under OPPS and for CMHCs

(Rev. 2296, Issued: 09-02-11, Effective: 10-01-11, Implementation: 10-03-11)

Medicare contractors must calculate overall cost-to-charge ratios for hospitals paid under OPPS and for CMHCs using the provider's most recent full year cost reporting period, whether tentatively settled or final settled, in accordance with the instructions in §§10.11.7, 10.11.7.1, 10.11.8, 10.11.8.1 or 10.11.9 as applicable. The contractor must calculate a provider overall CCR whenever a more recent full year cost report becomes available. If a CCR is calculated based on the tentatively settled cost report, the contractor must calculate another overall CCR when the cost report is final or when a cost report for a subsequent cost reporting period is tentatively settled, whichever occurs first. If a CCR is based on a final settled cost report,

the contractor must calculate the CCR when a cost report for a subsequent cost reporting period is tentatively settled.

10.11.2 - Circumstances in Which CCRs are Used
(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

The contractors must apply CCRs prospectively to calculate outlier payments (for hospitals paid under OPPS and CMHCs), Transitional Outpatient Payment System (TOPS) payments (for hospitals paid under OPPS), device pass-through payments (for hospitals paid under OPPS), and items and services paid at charges adjusted to cost (for hospitals paid under OPPS).

10.11.3 - Selection of the CCR to be Used
(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

Contractors will use the CCR calculated for the most recent period of time, whether based on a tentatively settled cost report or a final settled cost report. For example, if the CCR being used is the tentatively settled CCR for FY 2008, and a tentatively settled CCR for FY 2009 is determined before the final settled CCR for FY 2008, then the contractor uses the CCR based on the tentatively settled 2009 cost report.

10.11.3.1 - CMS Specification of Alternative CCR
(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

Effective January 1, 2009, the central office may direct Medicare contractors to use an alternative CCR if CMS believes this will result in a more accurate CCR. Also, if the Medicare contractor finds evidence that indicates that using data from the latest settled or tentatively settled cost report would not result in the most accurate CCR, then the Medicare contractor shall notify the CMS central office and CMS regional office to seek approval to use a CCR-based on alternative data. For example, CCRs may be revised more often if a change in a hospital or CMHC's operations occurs which materially affects a hospital or CMHC's costs and charges. The central and regional offices must approve the Medicare contractor's request before the Medicare contractor may use a CCR-based on alternative data. Revised CCRs are applied prospectively to all OPPS claims processed after the update. Medicare contractors shall send notification to the central office via the following address and e-mail address:

CMS
C/O Division of Outpatient Care – OPPS Outlier Team
7500 Security Blvd.
Mail Stop C4-05-17
Baltimore, MD 21244
outliersOPPS@cms.hhs.gov

10.11.3.2 - Hospital or CMHC Request for Use of a Different CCR
(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

Effective January 1, 2009, CMS (or the Medicare contractor) may specify an alternative CCR if it believes that the CCR being applied is inaccurate. In addition, a hospital or CMHC has the opportunity to request

that a different CCR be applied for outlier payment calculation in the event it believes the CCR being applied is inaccurate. The hospital or CMHC is required to present substantial evidence supporting its request. Such evidence should include documentation regarding its costs and charges that demonstrate its claim that an alternative ratio is more accurate. After the Medicare contractor has evaluated the evidence presented by the hospital or CMHC, the Medicare contractor notifies the CMS central office and CMS regional office of any such request. The CMS central and regional offices approve or deny any request by the hospital (or CMHC) or Medicare contractor for use of a different CCR. Medicare contractors shall send requests to the CMS central office using the address and e-mail address provided above.

10.11.3.3 - Notification to Hospitals Paid Under the OPPS of a Change in the CCR

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

The Medicare contractor shall notify a hospital or CMHC whenever it makes a change to its CCR. When a CCR is changed as a result of a tentative settlement or a final settlement of the cost report, the change to the CCR can be included in the notice that is issued to each provider after a tentative or final settlement is completed. Medicare contractors can also issue separate notification to a hospital about a change to its CCR(s).

10.11.4 - Use of CCRs in Mergers, Acquisitions, Other Ownership Changes, or Errors Related to CCRs

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

The contractors use the CCR for the surviving provider in cases of provider merger, acquisition or other such changes.

Effective for hospitals experiencing a change of ownership after January 1, 2007, that have not accepted assignment of an existing hospital's provider agreement in accordance with 42 CFR 489.18, and do not yet have a Medicare cost report, the contractor may use the default Statewide CCR to determine cost-based payments until the hospital has submitted its first Medicare cost report. See §10.11.10 for the location of the Statewide CCRs and the upper limit above which the contractor must use the Statewide CCR. For purposes of identifying a CCR for payment, Medicare contractors may apply a Statewide average to hospitals receiving a new provider number, such as hospitals converting from non-IPPS to IPPS status. Also, for purposes of identifying a CCR for payment, hospitals receiving a new provider number may request use of a different CCR based on substantial evidence. Use of an alternative CCR is subject to the approval of the CMS central and regional offices as discussed in §10.11.3.2. For hospitals experiencing a change of ownership prior to January 1, 2007, the contractor should use the prior hospital's CCR.

In instances where errors related to CCRs and/or outlier payments are discovered, the Medicare contractor shall contact the CMS central office to seek further guidance. Medicare contractors may contact the CMS central office via the address and e-mail address listed in §10.11.3.1 of this chapter.

If a cost report is reopened after final settlement and as a result of this reopening, there is a change to the CCR, Medicare contractors should contact the CMS regional and central office for further instructions. Medicare contractors may contact the CMS central office via the address and email address listed in §10.11.3.1.

10.11.5 - New Providers and Providers with Cost Report Periods Less Than a Full Year
(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

The contractors must calculate a hospital CCR using the most recent full-year cost report if a hospital or CMHC has a short period cost report.

The contractors must use the Statewide CCR for all inclusive rate hospitals paid under OPPS, or when a new provider does not have a full year's cost report and has no cost report history.

See §10.11.10 for the location of the Statewide CCRs.

10.11.6 - Substitution of Statewide CCRs for Extreme OPPS Hospital Specific CCRs
(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

The contractors must use the applicable Statewide average urban or rural hospital default ratio if the CCR calculated for a hospital paid under OPPS is greater than the upper limit CCR in the file of overall OPPS hospital CCR limits on the CMS Web site.

In addition to the circumstances listed in §§10.11.6, 10.11.5, and 10.11.4 of this chapter, a Medicare contractor also should use a Statewide average CCR if it is unable to determine an accurate overall ancillary CCR for a hospital for whom accurate data with which to calculate an operating CCR is not available. Further, the policies of §§10.11.3.1 and 10.11.3.2 can be applied as an alternative to the Statewide average.

See §10.11.10 for the location of the Statewide CCRs and the upper limit above which the contractor must use the Statewide CCR.

10.11.7 - Methodology for Calculation of Hospital Overall CCR for Hospitals That Do Not Have Nursing and Paramedical Education Programs for Cost Reporting Periods Beginning Before May 1, 2010, Under Cost Report Form 2552-96
(Rev. 2296, Issued: 09-02-11, Effective: 10-01-11, Implementation: 10-03-11)

10.11.7.1 - Methodology for Calculation of Hospital Overall CCR for Hospitals That Do Not Have Nursing and Paramedical Education Programs for Cost Reporting Periods Beginning On or After May 1, 2010, Under Cost Report 2552-10
(Rev. 2296, Issued: 09-02-11, Effective: 10-01-11, Implementation: 10-03-11)

In calculating the hospital's costs or charges, do not include departmental CCRs and charges for services that are not paid under the OPPS such as physical, occupational and speech language therapies, clinical diagnostic laboratory services, ambulance, rural health clinic services, non-implantable DME, etc. See §10.11.10 for the location of the list of exact cost centers that shall be included in the calculation of the overall CCR.

Step 1 – Determining Overall Costs:

Calculate costs for each cost center by multiplying the departmental CCR for each cost center (and subscripts thereof) that reflect services subject to the OPPS from Form CMS 2552-10, Worksheet C, Part I, Column 9 by the Medicare outpatient charges for that cost center (and subscripts thereof) from Worksheet D, Part V, Columns 2, 3, and 4,. Sum the costs calculated for each cost center to arrive at Medicare outpatient cost of services subject to OPPS.

Step 2 – Determining Overall Charges: Calculate charges by summing the Medicare outpatient charges from Form CMS 2552-10, Worksheet D, Part V, Columns 2, 3, and 4, (and for each cost center (and subscripts thereof) that reflect services subject to the OPPS.

Step 3 – Calculating the Overall CCR: Divide the costs from Step 1 by the charges from Step 2 to calculate the hospital's Medicare outpatient CCR.

10.11.8 - Methodology for Calculation of Hospital Overall CCR for Hospitals That Have Nursing and Paramedical Education Programs for Cost Reporting Periods Beginning Before May 1, 2010, Under Cost Report Form 2552-96

(Rev. 2296, Issued: 09-02-11, Effective: 10-01-11, Implementation: 10-03-11)

10.11.8.1 - Methodology for Calculation of Hospital Overall CCR for Hospitals That Have Nursing and Paramedical Education Programs for Cost Reporting Periods Beginning On or After May 1, 2010, Under Cost Report 2552-10

(Rev. 2296, Issued: 09-02-11, Effective: 10-01-11, Implementation: 10-03-11)

Do not include departmental CCRs and charges for services not subject to the OPPS (such as physical, occupational and speech language therapies, clinical diagnostic laboratory services, ambulance, rural health clinic services, non-implantable DME, etc.) in calculating the hospital's costs or charges. See §10.11.10 for the location of the list of the exact cost centers that should be included in the overall CCR.

Step 1 -- Determining costs for each department:

From Worksheet B, Part 1 – Column 26, deduct the nursing and paramedical education costs found on the applicable line in Columns -20, and 23 of Worksheet B, Part I to calculate a cost for each cost center.

Exception: The costs for 9200 are not calculated on this worksheet. For cost center 9200, Observation Beds (Non-Distinct Part), use the cost reported on Worksheet D-1, Part IV, line 89, and deduct the nursing and paramedical education costs found on Worksheet D-1, Part IV, line 93 and subscripts, column 5. See Step 3 below.

Step 2 – Determining charges for each department: From worksheet C, Part 1 – Column 8 (sum of columns 6 and 7), identify ―total charges.

Step 3 – Determining the CCRs for each department without nursing and paramedical education costs: For each line, divide the costs from Step1 by the charges from Step 2 to acquire CCRs for each line, without inclusion of nursing and paramedical education costs. Exception: For cost center 9200, Observation Beds (Non-Distinct Part), use the cost reported on Worksheet D-1, Part IV, line 89, and deduct the nursing and paramedical education costs found on Worksheet D-1, Part IV, line 93 and subscripts, column 5.

Step 4 – Determining Overall Costs: Multiply the CCR in step 3 by the Medicare outpatient charges for that cost center (and subscripts thereof) from Worksheet D Part V, Columns 2, 3, and 4,. Sum the costs calculated for each cost center to arrive at Medicare outpatient cost of services subject to OPPS.

Step 5 – Determining Overall Charges: Calculate charges by summing the Medicare outpatient charges from Form CMS 2552-10, Worksheet D, Part V, Columns 2, 3, and 4, for each cost center (and subscripts thereof) that reflect service subject to the OPPS.

Step 6 – Calculating the Overall CCR: Divide the costs from Step 4 by the charges from step 5 to calculate the hospital‘s Medicare outpatient CCR..

10.11.9 - Methodology for Calculation of CCR for CMHCs

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

Calculate the CMHC’s CCR using the provider’s most recent full year cost report, Form CMS 2088-92, and Medicare cost and charges from Worksheet C, Page 2. Divide costs from line 39.01, Column 3 by charges from line 39.02, Column 3 to calculate the CCR.

If the CCR is above 1.0 enter the appropriate Statewide average urban or rural hospital default ratio that is in the OPSF for the CMHC. There is no lower limit for CMHC CCRs. Use the CCR you calculate and do not substitute the Statewide average urban or rural hospital default ratio in cases where the CCR is below 1.0.

Note that CCR reporting requirements in §10.11 apply to both hospitals paid under OPPS and to CMHCs.

10.11.10 - Location of Statewide CCRs, Tolerances for Use of Statewide CCRs in Lieu of Calculated CCRs and Cost Centers to be Used in the Calculation of CCRs

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

The file of OPPS hospital upper limit CCRs and the file of Statewide CCRs are located on the CMS Web site at www.cms.hhs.gov/HospitalOutpatientPPS/ under “Annual Policy Files.” A spreadsheet listing the Statewide CCRs also can be found in the file containing the preamble tables that appears in the most recent OPPS/ASC final rule. The contractors must always use the most recent Statewide CCR.

The file of standard and nonstandard cost centers to be used in the calculation of hospital outpatient CCRs is also found on the CMS Web site at www.cms.hhs.gov/HospitalOutpatientPPS/ under “Revenue Code to Cost Center Crosswalk.”

10.11.11 - Reporting of CCRs for Hospitals Paid Under OPPS and for CMHCs

(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

The contractors shall report the OPPS hospital overall or CMHC CCR they calculate, or the Statewide CCR they select, for each provider to the Outpatient Provider Specific File (OPSF; see §50.1 of this chapter) within 30 days after the date of the calculation or selection of the Statewide CCR for the provider. If a cost report reopening results in adjustments that would change the CCR that is currently in effect, the contractor shall calculate and enter the CCR in the OPSF within 30 days of the date that the reopening is finalized. In

such an instance, contractors must create an additional record in the OPSF for the provider. The contractor entries in the OPSF shall include the effective date of the CCR being entered. Entries in the OPSF shall not replace a pre-existing entry for the provider. The only instances a Medicare contractor retroactively changes a field in the PSF is to update the CCR when using the FISS Lump Sum Utility for outlier reconciliation or otherwise specified by the CMS Regional Office or Central Office.

10.12 – Payment Window for Outpatient Services Treated as Inpatient Services

(Rev. 2483, Issued: 06-08-12, Effective: 07-01-12, Implementation: 07-02-12)

The policy for the payment window for outpatient services treated as inpatient services is discussed in §40.3, of Chapter 3 of the Medicare Claims Processing Manual. The policy requires payment for certain outpatient services provided to a beneficiary on the date of an inpatient admission or during the 3 calendar days (or 1 calendar day for a non-IPPS hospital) prior to the date of an inpatient admission to be bundled (i.e., included) with the payment for the beneficiary‘s inpatient admission if those outpatient services are provided by the admitting hospital or an entity that is wholly owned or wholly operated by the admitting hospital. The policy applies to all diagnostic outpatient services and non-diagnostic services (i.e., therapeutic) that are related to the inpatient stay. Ambulance and maintenance renal dialysis services are not subject to the payment window.

All diagnostic services provided to a Medicare beneficiary by a hospital (or an entity wholly owned or wholly operated by the hospital) on the date of the beneficiary’s inpatient admission or during the 3 calendar days (or, in the case of a non-subsection (d) hospital, 1 calendar day) immediately preceding the date of admission are required to be included on the bill for the inpatient stay.

Outpatient non-diagnostic services that are related to an inpatient admission must be bundled with the billing for the inpatient stay. An outpatient service is related to the admission if it is clinically associated with the reason for a patient’s inpatient admission. In accordance with section 102 of Pub. L. 111-192, for services furnished on or after June 25, 2010, all outpatient non-diagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the date of a beneficiary’s inpatient admission are deemed related to the admission, and thus, must be billed with the inpatient stay. Also, outpatient non-diagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the first, second, and third calendar days for a subsection (d) hospital paid under the IPPS (first calendar day for non-subsection (d) hospitals) preceding the date of a beneficiary‘s inpatient admission are deemed related to the admission, and thus, must be billed with the inpatient stay, unless the hospital attests to specific non-diagnostic services as being unrelated to the hospital claim (that is, the preadmission non-diagnostic services are clinically distinct or independent from the reason for the beneficiary‘s admission). Outpatient non-diagnostic services provided during the payment window that are unrelated to the admission, and are covered by Part B, may be separately billed to Part B. The June 25, 2010, effective date of section 102 of Pub. L. 111-192 applies to outpatient services provided on or after June 25, 2010.

In the event that there is no Part A coverage for the inpatient stay, there is no inpatient service into which outpatient services (i.e., services provided to a beneficiary on the date of an inpatient admission or during the 3 calendar days (or 1 calendar day for a non-IPPS hospital) prior to the date of an inpatient admission)

must be bundled. Therefore services provided to the beneficiary prior to the point of admission (i.e., the admission order) may be separately billed to Part B as the outpatient services that they were.

A hospital may attest to specific non-diagnostic services as being unrelated to the hospital claim (that is, the preadmission non-diagnostic services are clinically distinct or independent from the reason for the beneficiary's admission) by adding a condition code 51 (definition "51 - Attestation of Unrelated Outpatient Non-diagnostic Services") to the separately billed outpatient non-diagnostic services claim. Providers may submit outpatient claims with condition code 51 starting April 1, 2011, for outpatient claims that have a date of service on or after June 25, 2010. Outpatient claims with a date of service on or after June 25, 2010, that did not contain condition code 51 received prior to April, 1, 2011, will need to be adjusted by the provider if they were rejected by FISS or CWF.

As stated in §180.7, "inpatient-only" procedures that are provided to a patient in the outpatient setting during the 3 calendar days (or 1 calendar day for a non-subsection (d) hospital) preceding the date of the inpatient admission that would otherwise be deemed related to the admission are not paid for by CMS. Providers should bill for these services on a no-pay claim (Type of Bill (TOB) 110). If there are covered services/procedures provided during the same outpatient encounter as the non-covered inpatient-only procedure (see the two exceptions listed in §180.7), providers are then required to submit two claims:

- One claim with covered service(s)/procedure(s) on a TOB 11X (with the exception of 110), and,
- The other claim with the non-covered service(s)/procedure(s) on a TOB 110 (no-pay claim).

NOTE: Both the covered and non-covered claim must have a matching Statement Covers Period.

20 - Reporting Hospital Outpatient Services Using Healthcare Common Procedure Coding System (HCPCS)

(Rev. 1, 10-03-03)
A3-3626.4, HO-442.6

20.1 - General

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

Reporting of HCPCS codes is required of acute care hospitals including those paid under alternate payment systems, e.g., Maryland, long-term care hospitals. HCPCS codes are also required of rehabilitation hospitals, psychiatric hospitals, hospital-based RHCs, hospital-based FQHCs, and CAHs reimbursed under Method II (HCPCS required to be billed for fee reimbursed services). This also includes all-inclusive rate hospitals.

HCPCS includes the American Medical Association's "Current Procedural Terminology," 4th Edition, (CPT-4) for physician services and CMS developed codes for certain nonphysician services. All of the CPT-4 is contained within HCPCS, and is identified as Level I CPT codes consist of five numeric characters. The CMS developed codes are known as Level II. Level II codes are five-character codes that begin with an alpha character that is followed by either numeric or alpha characters.

Hospital-based and independent ESRD facilities must use HCPCS to bill for blood and blood products, and to bill for drugs and clinical laboratory services paid outside the composite rate. In addition, the hospital is required to report modifiers as applicable and as described in §20.6.

The CAHs are required to report HCPCS only for Part B services not paid to them on a reasonable cost basis, e.g., screening mammographies and bone mass measurements.

The HCPCS codes are required for all outpatient hospital services unless specifically excepted in manual instructions. This means that codes are required on surgery, radiology, other diagnostic procedures, clinical diagnostic laboratory, durable medical equipment, orthotic-prosthetic devices, take-home surgical dressings, therapies, preventative services, immunosuppressive drugs, other covered drugs, and most other services.

When medical and surgical supplies (other than prosthetic and orthotic devices as described in the Medicare Claims Processing Manual, Chapter 20, §10.1) described by HCPCS codes with status indicators other than "H" or "N" are provided incident to a physician's service by a hospital outpatient department, the HCPCS codes for these items should not be reported because these items represent supplies. Claims containing charges for medical and surgical supplies used in providing hospital outpatient services are submitted to the Medicare contractor providing OPPS payment for the services in which they are used. The hospital should include charges associated with these medical and surgical supplies on claims so their costs are incorporated in ratesetting, and payment for the supplies is packaged into payment for the associated procedures under the OPPS in accordance with 42 CFR 419.2(b)(4).

For example, if the hospital staff in the emergency department initiate the intravenous administration of a drug through an infusion pump described by HCPCS code E0781 (Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient), complete the drug infusion, and discontinue use of the infusion pump before the patient leaves the hospital outpatient department, HCPCS code E0781 should not be reported because the infusion pump was used as a supply and would be paid through OPPS payment for the drug administration service. The hospital should include the charge associated with the infusion pump on the claim.

In another example, if hospital outpatient staff perform a surgical procedure on a patient in which temporary bladder catheterization is necessary and use a catheter described by HCPCS code A4338 (Indwelling catheter; Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each), the hospital should not report A4338 because the catheter was used as a supply and would be paid through OPPS payment for the surgical procedure. The hospital should include the charge associated with the urinary catheter on the claim.

When hospital outpatient staff provide a prosthetic or orthotic device, and the HCPCS code that describes that device includes the fitting, adjustment, or other services necessary for the patient's use of the item, the hospital should not bill a visit or procedure HCPCS code to report the charges associated with the fitting, adjustment, or other related services. Instead, the HCPCS code for the device already includes the fitting, adjustment or other similar services. For example, if the hospital outpatient staff provides the orthotic device described by HCPCS code L1830 (KO, immobilizer, canvas longitudinal, prefabricated, includes fitting and adjustment), the hospital should only bill HCPCS code L1830 and should not bill a visit or procedure HCPCS code to describe the fitting and adjustment.

Claims with required HCPCS coding missing will be returned to the hospital for correction.

Future updates will be issued in a Recurring Update Notification.

20.1.1 – Elimination of 90-day Grace Period for HCPCS (Level I and Level II)
(Rev. 89, 02-06-04)

The CMS had permitted a 90-day grace period for the use of discontinued codes for dates of service January through March 31 that were submitted to Medicare contractors by April 1 of the current year.

The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets must be date of service compliant. Since HCPCS is a medical code set, effective January 1, 2005, CMS will no longer provide a 90-day grace period for discontinued HCPCS. The elimination of the grace period applies to the annual HCPCS update and to any mid-year coding changes. Any codes discontinued mid-year will no longer have a 90-day grace period.

The FIs must eliminate the 90-day grace period from their system effective with the January 1, 2005 HCPCS update. FIs will no longer accept discontinued HCPCS codes for dates of service January 1 through March 31 submitted prior to April 1. Hospitals can purchase the American Medical Association's CPT-4 coding book that is published each October that contains new, revised, and discontinued CPT-4 codes for the upcoming year. CMS posts on its Web site the annual alpha-numeric HCPCS file for the upcoming year at the end of each October. Hospitals are encouraged to access CMS Web site to see the new, revised, and discontinued alpha-numeric codes for the upcoming year. The CMS web site to view the annual HCPCS update is http://www.cms.hhs.gov/providers/pufdownload/anhcpcdl.asp

The FIs must continue to return to the provider (RTP) claims containing deleted codes.

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.

20.3 - Line Item Dates of Service
(Rev. 1, 10-03-03)

Where HCPCS is required a line item date of service is also required. (FL 45 on Form CMS-1450).

The FI will return claims to hospitals where a line item date of service is not entered for each HCPCS code reported or if the line item dates of service reported are outside of the statement-covers period.

20.4 - Reporting of Service Units
(Rev. 1, 10-03-03)

The definition of service units (FL 46 on the Form CMS-1450) where HCPCS code reporting is required is the number of times the service or procedure being reported was performed.

EXAMPLES:

If the following codes are performed once on a specific date of service, the entry in the service units field is as follows:

HCPCS Code	**Service Units**
90849 - Multiple-family group psychotherapy	Units $\geq$ 1
92265 - Needle oculoelectromyography, one or more extraocular muscles, one or both eyes, with interpretation and report	Units $\geq$ 1
95004 - Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, specify number of tests.	Units = no. of tests performed
95861 - Needle electromyography two extremities with or without related paraspinal areas	Units $\geq$ 1
	6 Units $\geq$ 83 min. to < 98 min. 7 Units $\geq$ 98 min. to < 113 min. 8 Units $\geq$ 113 min. to < 128 min.

The pattern remains the same for treatment times in excess of two hours. Hospitals should not bill for services performed for less than eight minutes. The expectation (based on the work values for these codes) is that a provider's time for each unit will average 15 minutes in length. If hospitals have a practice of billing less than 15 minutes for a unit, their FI will highlight these situations for review.

The above schedule of times is intended to provide assistance in rounding time into 15-minute increments. It does not imply that any minute until the eighth should be excluded from the total count as the timing of active treatment counted includes time.

The beginning and ending time of the treatment should be recorded in the patient's medical record along with the note describing the treatment. (The total length of the treatment to the minute could be recorded

instead.) If more than one CPT code is billed during a calendar day, then the total number of units that can be billed is constrained by the total treatment time. For example, if 24 minutes of code 97112 and 23 minutes of code 97110 were furnished, then the total treatment time was 47 minutes; so only 3 units can be billed for the treatment. The correct coding is two units of code 97112 and one unit of code 97110, assigning more units to the service that took more time.

20.5 - Clarification of HCPCS Code to Revenue Code Reporting

(Rev. 1487, Issued: 04-08-08, Effective: 04-01-08, Implementation: 04-07-08)

Generally, CMS does not instruct hospitals on the assignment of HCPCS codes to revenue codes for services provided under OPPS since hospitals' assignment of cost vary. Where explicit instructions are not provided, providers should report their charges under the revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report.

20.6 - Use of Modifiers

(Rev. 1487, Issued: 04-08-08, Effective: 04-01-08, Implementation: 04-07-08)

The Integrated Outpatient Code Editor (I/OCE) accepts all valid CPT and HCPCS modifiers on OPPS claims. Definitions for the following modifiers may be found in the CPT and HCPCS guides:

Level I (CPT) Modifiers

-25, -27, -50, -52, -58, -59, -73, -74, -76, -77, -78, -79, -91

Level II (HCPCS) Modifiers

-CA, -E1, -E2, -E3, -E4, -FA, -FB, -FC, -F1, -F2, -F3, -F4, -F5, -F6, -F7, -F8, -F9, -GA, -GG, -GH, -GY, -GZ, -LC, -LD, -LT, -QL, -QM, -RC, -RT, -TA, -T1, -T2, -T3, -T4, -T5, -T6, -T7, -T8, -T9

As indicated in §20.6.2, modifier -50, while it may be used with diagnostic and radiology procedures as well as with surgical procedures, should be used to report bilateral procedures that are performed at the same operative session as a single line item. Modifiers RT and LT are not used when modifier -50 applies. A bilateral procedure is reported on one line using modifier -50. Modifier -50 applies to any bilateral procedure performed on both sides at the same session.

NOTE: Use of modifiers applies to services/procedures performed on the same calendar day.

Other valid modifiers that are used under other payment methods are still valid and should continue to be reported, e.g., those that are used to report outpatient rehabilitation and ambulance services. Modifiers may be applied to surgical, radiology, and other diagnostic procedures. Providers must use any applicable modifier where appropriate.

Providers do not use a modifier if the narrative definition of a code indicates multiple occurrences.

EXAMPLES:

The code definition indicates two to four lesions. The code indicates multiple extremities.

Providers do not use a modifier if the narrative definition of a code indicates that the procedure applies to different body parts.

EXAMPLES:

Code 11600 (Excision malignant lesion, trunks, arms, or legs; lesion diameter 0.5 cm. or less)

Code 11640 (Excision malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 0.5 cm. or less)

Modifiers -GN, -GO, and -GP must be used to identify the therapist performing speech language therapy, occupational therapy, and physical therapy respectively.

Modifier -50 (bilateral) applies to diagnostic, radiological, and surgical procedures.

Modifier -52 applies to radiological procedures.

Modifiers -73, and -74 apply only to certain diagnostic and surgical procedures that require anesthesia.

Following are some general guidelines for using modifiers. They are in the form of questions to be considered. If the answer to any of the following questions is yes, it is appropriate to use the applicable modifier.

1. Will the modifier add more information regarding the anatomic site of the procedure?

EXAMPLE: Cataract surgery on the right or left eye.

2. Will the modifier help to eliminate the appearance of duplicate billing?

EXAMPLES: Use modifier 77 to report the same procedure performed more than once on the same date of service but at different encounters.

Use modifier 25 to report significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.

Use modifier 58 to report staged or related procedure or service by the same physician during the postoperative period.

Use modifier 78 to report a return to the operating room for a related procedure during the postoperative period.

Use modifier 79 to report an unrelated procedure or service by the same physician during the postoperative period.

3. Would a modifier help to eliminate the appearance of unbundling?

EXAMPLE: CPT codes 90765 (Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour) and 36000 (Introduction of needle or intra catheter, vein): If procedure 36000 was performed for a reason other than as part of the IV infusion, modifier -59 would be appropriate.

20.6.1 - Where to Report Modifiers on the UB-92 (Form CMS-1450) and ANSI X12N Formats

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Modifiers are reported on the hardcopy CMS-1450 and the HIPAA X12N 837 corresponding to the HCPCS code. There is space for four modifiers on the hardcopy form.

The dash that is often seen preceding a modifier should never be reported.

When it is appropriate to use a modifier, the most specific modifier should be used first. That is, when modifiers E1 through E4, FA through F9, LC, LD, RC, and TA through T9 apply, they should be used before modifiers LT, RT, or -59.

NOTE: Information regarding the claim form locators that correspond with these fields and a table to crosswalk the CMS-1450 form locators to the 837 transaction is found in Chapter 25.

20.6.2 - Use of Modifiers -50, -LT, and -RT

(Rev. 1, 10-03-03)

Modifier -50 is used to report bilateral procedures that are performed at the same operative session as a single line item. Do not use modifiers RT and LT when modifier -50 applies. Do not submit two line items to report a bilateral procedure using modifier -50.

Modifier -50 applies to any bilateral procedure performed on both sides at the same operative session.

The bilateral modifier -50 is restricted to operative sessions only.

Modifier -50 may not be used:

- To report surgical procedures identified by their terminology as “bilateral,” or
- To report surgical procedures identified by their terminology as “unilateral or bilateral”.

The unit entry to use when modifier -50 is reported is one.

20.6.3 - Modifiers -LT and -RT

(Rev. 1, 10-03-03)

Modifiers -LT or -RT apply to codes, which identify procedures, which can be performed on paired organs, e.g., ears, eyes, nostrils, kidneys, lungs, and ovaries.

Modifiers -LT and -RT should be used whenever a procedure is performed on only one side. Hospitals use the appropriate -RT or -LT modifier to identify which of the paired organs was operated upon.

These modifiers are required whenever they are appropriate.

20.6.4 - Use of Modifiers for Discontinued Services

(Rev. 2386, Issued: 01-13-12, Effective: 01-01-12, Implementation: 01-03-12)

A. General

Modifiers provide a way for hospitals to report and be paid for expenses incurred in preparing a patient for a procedure and scheduling a room for performing the procedure where the service is subsequently discontinued. This instruction is applicable to both outpatient hospital departments and to ambulatory surgical centers.

Modifier -73 is used by the facility to indicate that a procedure requiring anesthesia was terminated due to extenuating circumstances or to circumstances that threatened the well being of the patient after the patient had been prepared for the procedure (including procedural pre-medication when provided), and been taken to the room where the procedure was to be performed, but prior to administration of anesthesia. For purposes of billing for services furnished in the hospital outpatient department, anesthesia is defined to include local, regional block(s), moderate sedation/analgesia ("conscious sedation"), deep sedation/analgesia, or general anesthesia. This modifier code was created so that the costs incurred by the hospital to prepare the patient for the procedure and the resources expended in the procedure room and recovery room (if needed) could be recognized for payment even though the procedure was discontinued.

Modifier -74 is used by the facility to indicate that a procedure requiring anesthesia was terminated after the induction of anesthesia or after the procedure was started (e.g., incision made, intubation started, scope inserted) due to extenuating circumstances or circumstances that threatened the well being of the patient. This modifier may also be used to indicate that a planned surgical or diagnostic procedure was discontinued, partially reduced or cancelled at the physician's discretion after the administration of anesthesia. For purposes of billing for services furnished in the hospital outpatient department, anesthesia is defined to include local, regional block(s), moderate sedation/analgesia ("conscious sedation"), deep sedation/analgesia, and general anesthesia. This modifier code was created so that the costs incurred by the hospital to initiate the procedure (preparation of the patient, procedure room, recovery room) could be recognized for payment even though the procedure was discontinued prior to completion.

Coinciding with the addition of the modifiers -73 and -74, modifiers -52 and -53 were revised. Modifier -52 is used to indicate partial reduction, cancellation, or discontinuation of services for which anesthesia is not planned. The modifier provides a means for reporting reduced services without disturbing the identification of the basic service. Modifier -53 is used to indicate discontinuation of physician services and is not approved for use for outpatient hospital services.

The elective cancellation of a procedure should not be reported.

Modifiers -73 and -74 are only used to indicate discontinued procedures for which anesthesia is planned or provided.

B. Effect on Payment

Procedures that are discontinued after the patient has been prepared for the procedure and taken to the procedure room but before anesthesia is provided will be paid at 50 percent of the full OPPS payment amount. Modifier -73 is used for these procedures.

Procedures that are discontinued, partially reduced or cancelled after the procedure has been initiated and/or the patient has received anesthesia will be paid at the full OPPS payment amount. Modifier -74 is used for these procedures.

Procedures for which anesthesia is not planned that are discontinued, partially reduced or cancelled after the patient is prepared and taken to the room where the procedure is to be performed will be paid at 50 percent of the full OPPS payment amount. Modifier -52 is used for these procedures.

C. Termination Where Multiple Procedures Planned

When one or more of the procedures planned is completed, the completed procedures are reported as usual. The other(s) that were planned, and not started, are not reported. When none of the procedures that were planned are completed, and the patient has been prepared and taken to the procedure room, the first procedure that was planned, but not completed is reported with modifier -73. If the first procedure has been started (scope inserted, intubation started, incision made, etc.) and/or the patient has received anesthesia, modifier -74 is used. The other procedures are not reported.

If the first procedure is terminated prior to the induction of anesthesia and before the patient is wheeled into the procedure room, the procedure should not be reported. The patient has to be taken to the room where the procedure is to be performed in order to report modifier -73 or -74.

20.6.5 - Modifiers for Repeat Procedures

(Rev. 1, 10-03-03)

Two repeat procedure modifiers are applicable for hospital use:

- Modifier -76 is used to indicate that the same physician repeated a procedure or service in a separate operative session on the same day.

- Modifier -77 is used to indicate that another physician repeated a procedure or service in a separate operative session on the same day.

If there is a question regarding who the ordering physician was and whether or not the same physician ordered the second procedure, the code selected is based on whether or not the physician performing the procedure is the same.

The procedure must be the same procedure. It is listed once and then listed again with the appropriate modifier.

20.6.6 - Modifiers for Radiology Services
(Rev. 1599, Issued: 09-19-08, Effective: 10-01-08, Implementation: 10-06-08)

Modifiers -52 (Reduced Services), -59, -76, and -77, and the Level II modifiers apply to radiology services.

When a radiology procedure is reduced, the correct reporting is to code to the extent of the procedure performed. If no HCPCS code exists for the service that has been completed, report the intended HCPCS code with modifier -52 appended.

EXAMPLE: CPT code 71020 (Radiologic examination, chest, two views, frontal and lateral) is ordered. Only one frontal view is performed. CPT code 71010 (Radiologic examination, chest: single view, frontal) is reported. The service is not reported as CPT code 71020-52.

20.6.7 - CA Modifier
(Rev. 1, 10-03-03)

Definition:

Procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission.

20.6.8 - HCPCS Level II Modifiers
(Rev. 1, 10-03-03)

Generally, these codes are required to add specificity to the reporting of procedures performed on eyelids, fingers, toes, and arteries.

They may be appended to CPT codes.

If more than one level II modifier applies, the HCPCS code is repeated on another line with the appropriate level II modifier:

EXAMPLE: Code 26010 (drainage of finger abscess; simple) done on the left thumb and second finger would be coded:

26010FA
26010F1

The Level II modifiers apply whether Medicare is the primary or secondary payer.

20.6.9 - Use of HCPCS Modifier -FB
(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

Effective January 1, 2007, the definition of modifier –FB is "**Item Provided Without Cost to Provider, Supplier or Practitioner, or Credit Received for Replacement Device (Examples, but not Limited to: Covered Under Warranty, Replaced Due to Defect, Free Samples)**". See the Medicare Claims

Processing Manual, Pub 100-04, Chapter 4, §61.3 for instructions regarding charges for items billed with the –FB modifier.

The OPPS hospitals must report modifier –FB on the same line as the procedure code (not the device code) for a service that requires a device for which neither the hospital, nor the beneficiary, is liable to the manufacturer. Hospitals must report modifier –FB on the same line as the procedure code for a service that requires a device when the manufacturer gives credit for a device being replaced with a more costly device.

20.6.10 - Use of HCPCS Modifier -FC

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

Effective January 1, 2008, the definition of modifier -FC is "**Partial credit received for replaced device.**" See the Medicare Claims Processing Manual, Pub 100-04, Chapter 4, §61.3 for instructions regarding charges for items billed with modifier –FC.
OPPS hospitals must report modifier –FC for cases in which the hospital receives a partial credit of 50 percent or more of the cost of a new replacement device under warranty, recall, or field action. The hospital must append modifier –FC to the procedure code (not the device code) that reports the services provided to replace the device.

20.7 – Billing of 'C' HCPCS Codes by Non-OPPS Providers

(Rev. 976, Issued: 06-09-06, Effective: 10-01-06, Implementation: 10-02-06)

Prior to October 1, 2006, the "C" series of HCPCS codes were used exclusively by hospitals subject to OPPS to identify items that may have qualified for transitional pass through payment under OPPS or items or services for which an appropriate HCPCS code did not exist for the purposes of implementing the OPPS. The C-codes could not be used to bill services payable under other payment systems. CMS realized that these C-codes evolved and also target services that are uniquely hospital services that may be provided by an OPPS provider, other providers, or be paid under other payment systems.

Effective October 1, 2006, the following non-OPPS providers may elect to bill using the C-codes or an appropriate CPT code on Types of Bill (TOBs) 12X, 13X, or 85X:

- Critical Access Hospitals (CAHs);
- Indian Health Service Hospitals (IHS);
- Hospitals located in American Samoa, Guam, Saipan or the Virgin Islands; and
- Maryland waiver hospitals.

The OPPS providers shall continue to receive pass-through payment on items or services that qualify for pass through payment. Non-OPPS providers are not eligible for pass through payments.

The C-codes shall be replaced with permanent codes. Whenever a permanent code is established to replace a temporary code, the temporary code is deleted and cross-referenced to the new permanent code. Upon deletion of a temporary code, providers shall bill using the new permanent code.

Providers are encouraged to access the CMS Web site to view the quarterly HCPCS Code updates. The URL to view the quarterly updates is http://www.cms.hhs.gov/HCPCSReleaseCodeSets/.

The billing of C-codes by Method I and Method II Critical Access Hospitals (CAHs) is limited to the billing for facility (technical) services. The C-codes shall not be billed by Method II CAHs for professional services with revenue codes 96X, 97X, or 98X.

30 - OPPS Coinsurance

(Rev. 2141, Issued: 01-24-11, Effective: 01-01-11, Implementation: 01-03-11)

OPPS freezes coinsurance for outpatient hospital at 20 percent of the national median charge for the services within each APC (wage adjusted for the provider's geographic area), but coinsurance for an APC cannot be less than 20 percent of the APC payment rate. As the total payment to the provider increases each year based on market basket updates, the present or frozen coinsurance amount will become a smaller portion of the total payment until coinsurance represents 20 percent of the total payment. Once coinsurance becomes 20 percent of the payment amount, the annual updates will also increase coinsurance so that it continues to account for 20 percent of the total payment. As previously stated, the wage-adjusted coinsurance for a service under OPPS cannot exceed the inpatient deductible amount.

Section 111 of BIPA accelerates the reduction of beneficiary copayment amounts by providing that for services furnished on or after April 1, 2001, and before January 1, 2002, the national unadjusted copayment amount for any ambulatory payment classification (APC) group cannot exceed 57 percent of the APC payment rate. The statute makes further reductions in future years so that national unadjusted copayment amounts cannot exceed 55 percent of the APC rate in 2002 and 2003, 50 percent in 2004, 45 percent in 2005, and 40 percent in 2006 and later years.

The annual update of the OPPS Pricer includes updated copayment amounts.

For screening colonoscopies and screening flexible sigmoidoscopies, the coinsurance amount is 25 percent of the payment rate, prior to January 1, 2011. Coinsurance does not apply to screening colonoscopies, screening sigmoidoscopies, and other specified services furnished on or after January 1, 2011.

Coinsurance does not apply to influenza virus vaccines, pneumococcal pneumonia vaccines, and clinical diagnostic laboratory services (which includes screening pap smears and screening prostate-specific antigen testing).

See §30.2 below for more detail.

Future updates will be issued in a Recurring Update Notification.

30.1 - Coinsurance Election

(Rev. 771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

The transition to the standard Medicare coinsurance rate (20 percent of the APC payment rate) will be gradual. For those APC groups for which coinsurance is currently a relatively high proportion of the total payment, the process will be correspondingly lengthy. The law offers hospitals the option of electing to reduce coinsurance amounts and advertise their reduced rates for all OPPS services. They may elect to receive a coinsurance payment from Medicare beneficiaries that is less than the wage adjusted coinsurance

amount per APC. That amount will apply to all services within that APC. This coinsurance reduction must be offered to all Medicare beneficiaries.

Hospitals should review the list of APCs and their respective coinsurance amounts that is published in the **Federal Register** for the applicable year as a final rule. After adjusting those coinsurance amounts for the wage index applicable to their MSA, hospitals must notify their FIs if they wish to charge their Medicare beneficiaries a lesser amount. The election remains in effect until the following calendar year. The first election must be filed by July 1, 2000, for the period August 1, 2000, through December 31, 2000. Future calendar year elections must be made by December 1st of the year preceding the calendar year for which the election is being made.

Because the final rule on OPPS payment rates for 2002 was not published until March 1, 2002, providers were unable to make election decisions for 2002 by December 1 preceding the year the payment rates became effective, the typical deadline for making such elections. The deadline for providers to make elections to reduce beneficiary copayments for 2002 was extended until April 1, 2002. The elections are effective for services furnished on or after April 1, 2002.

The lesser amount elected:

- May not be less than 20 percent of the wage adjusted APC payment amount;
- May not be greater than the inpatient hospital deductible for that calendar year ($812 for 2002); and
- Will not be wage adjusted by the FI or CMS.

Once an election to reduce coinsurance is made, it cannot be rescinded or changed until the next calendar year. National unadjusted and minimum unadjusted coinsurance amounts will be posted each year in the addenda of the OPPS final rule (Form CMS-1005FC) on CMS' Web site (http://www.cms.hhs.gov).

This coinsurance election does not apply to partial hospitalization services furnished by CHMCs, vaccines provided by a CORF, vaccines, splints, casts, and antigens provided by HHAs, or splints, casts, and antigens provided to a hospice patient for the treatment of a non-terminal illness. It also does not apply to screening colonoscopies, screening sigmoidoscopies, or screening barium enemas, or to services not paid under OPPS.

Hospitals must utilize the following format for notification to the FI:

Provider number	1122334455		
Provider name	XYZ Hospital	Effective from	8/1/2000 - 12/31/2000
Provider contact	Joe Smith	Phone #	123-456-7890
Contact e-mail	Jsmith@XYZ.ORG	Fax #	123-456-7891

XYZ Hospital elects to reduce coinsurance to the amount shown for the following APCs:

APC____ Coinsurance___.__ APC____ Coinsurance___.__

APC____ Coinsurance___.__ APC____ Coinsurance___.__

APC____ Coinsurance___.__ APC____ Coinsurance___.__

APC____ Coinsurance___.__ APC____ Coinsurance___.__

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APC____ Coinsurance___.__ APC____ Coinsurance___.__

Return to:

Provider Audit & Reimbursement Dept.
Attn: John Doe
FI Address

The FI must validate that the reduced coinsurance amount elected by the hospital is not less than 20 percent of the wage adjusted APC amount nor more than the inpatient deductible for the year of the election, and must send an acknowledgment to the hospital that the election has been received, within 15 calendar days of receipt.

30.2 - Calculating the Medicare Payment Amount and Coinsurance

(Rev. 1, 10-03-03)
A-02-026

A program payment percentage is calculated for each APC by subtracting the unadjusted national coinsurance amount for the APC from the unadjusted payment rate and dividing the result by the unadjusted payment rate. The payment rate for each APC group is the basis for determining the total payment (subject to wage-index adjustment) that a hospital will receive from the beneficiary and the Medicare program. (A hospital that elects to reduce coinsurance, as described in §30.1, above, may receive a total payment that is less than the APC payment rate.) The Medicare payment amount takes into account the wage index adjustment and the beneficiary deductible and coinsurance amounts. In addition, the amount calculated for an APC group applies to all the services that are classified within that APC group. The Medicare payment amount for a specific service classified within an APC group under OPPS is calculated as follows:

Step 1 - Apply the appropriate wage index adjustment to the payment rate that is set annually for each APC group;

Step 2 - Subtract from the adjusted APC payment rate the amount of any applicable deductible;

Step 3 - Multiply the adjusted APC payment rate, from which the applicable deductible has been subtracted, by the program payment percentage determined for the APC group or 80 percent, whichever is lower. This amount is the preliminary Medicare payment amount;

Step 4 - Subtract the preliminary Medicare payment amount from the adjusted APC payment rate less the amount of any applicable deductible. If the resulting amount does not exceed the annual hospital inpatient deductible amount for the calendar year, the resulting amount is the beneficiary coinsurance amount. If the resulting amount exceeds the annual inpatient hospital deductible amount, the beneficiary coinsurance amount is limited to the inpatient hospital deductible and the Medicare program pays the difference to the provider.

Step 5 - If the wage-index adjusted coinsurance amount for the APC is reduced because it exceeds the inpatient deductible amount for the calendar year, add the amount of this reduction to the amount determined in Step 3 above to get the final Medicare payment amount.

EXAMPLE 1:

The wage-adjusted payment rate for an APC is $300; the program payment percentage for the APC group is 70 percent; the wage-adjusted coinsurance amount for the APC group is $90; and the beneficiary has not yet satisfied any portion of his or her $100 annual Part B deductible.

A. Adjusted APC payment rate: $300.

B. Subtract the applicable deductible: $300 - $100 = $200.

C. Multiply the remainder by the program payment percentage to determine the preliminary

Medicare payment amount: 0.7 x $200 = $140.

D. Subtract the preliminary Medicare payment amount from the adjusted APC payment rate less any unmet deductible to determine the coinsurance amount, which cannot exceed the inpatient hospital deductible for the calendar year: $200 - $140 = $60.

E. Calculate the final Medicare payment amount by adding the preliminary Medicare payment amount determined in step (C) to the amount that the coinsurance was reduced as a result of the inpatient hospital deductible limitation. $140 + $0 = $140.

In this case, the beneficiary pays a deductible of $100 and a $60 coinsurance, and the program pays $140, for a total payment to the provider of $300. Applying the program payment percentage ensures that the program and the beneficiary pay the same proportion of payment that they would have paid if no deductible were taken.

If the annual Part B deductible has already been satisfied, the calculation is as follows:

A. Adjusted APC payment rate: $300.

B. Subtract the applicable deductible: $300 - 0 = $300.

C. Multiply the remainder by the program payment percentage to determine the preliminary

Medicare payment amount: 0.7 x $300 = $210.

D. Subtract the preliminary Medicare payment amount from the adjusted APC payment rate less deductible to determine the coinsurance amount. The coinsurance amount cannot exceed the amount of the inpatient hospital deductible for the calendar year: $300 - $210 = $90.

E. Calculate the final Medicare payment amount by adding the preliminary Medicare payment amount determined in step (C) to the amount that the coinsurance was reduced as a result of the inpatient hospital deductible limitation: $210 + $0 = $210.

In this case, the beneficiary makes a $90 coinsurance payment and the program pays $210, for a total payment to the provider of $300.

EXAMPLE 2:

This example illustrates a case in which the inpatient hospital deductible limit on coinsurance amount applies. Assume that the wage-adjusted payment rate for an APC is $2,000; the wage-adjusted coinsurance amount for the APC is $900; the program payment percentage is 55 percent; and the inpatient hospital deductible amount for the calendar year is $776. The beneficiary has not yet satisfied any portion of his or her $100 Part B deductible.

A. Adjusted APC payment rate: $2,000.

B. Subtract the applicable deductible: $2,000 - $100 = $1,900.

C. Multiply the remainder by the program payment percentage to determine the preliminary Medicare payment amount: 0.55 x $1,900 = $1,045.

D. Subtract the preliminary Medicare payment amount from the adjusted APC payment rate less deductible to determine the coinsurance amount. The coinsurance amount cannot exceed the inpatient hospital deductible amount of $776: $1,900 - $1,045 = $855, but the coinsurance is limited to $776.

E. Calculate the final Medicare payment amount by adding the preliminary Medicare payment amount determined in step (C) to the amount that the coinsurance was reduced as a result of the inpatient hospital deductible limitation ($855 - $776 = $79). $1,045 + $79 = $1,124.

In this case, the beneficiary pays a deductible of $100 and a coinsurance that is limited to $776 and the program pays $1,124 (which includes the amount of the reduction in beneficiary coinsurance due to the inpatient hospital deductible limitation) for a total payment to the provider of $2,000.

For calendar year 2002, the national unadjusted copayment amount for an ambulatory payment classification (APC) is limited to 55 percent of the APC payment rate established for a procedure or service.

In addition the wage-adjusted copayment amount for a procedure or service cannot exceed the inpatient hospital deductible amount for 2002 of $812. These changes were implemented by changes to the OPPS Pricer effective for services furnished on or after January 1, 2002.

40 - Outpatient Code Editor (OCE)

(Rev. 1107, Issued: 11-09-06, Effective: 07-01-07, Implementation: 07-02-07)

The CMS incorporates new processing requirements in the Outpatient Code Editor (OCE) by releasing a new or updated version of the software each quarter. The OCE instructions and specifications are utilized under:

- The OPPS for hospital outpatient departments, Community Mental Health Centers (CMHC's) and for limited services provided in a Home Health Agency (HHA) not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness;

- The non-OPPS for Indian Health Service Hospitals, Critical Access hospitals (CAHs), Maryland hospitals, hospitals located in American Samoa, Guam, the Commonwealth of the Northern Mariana Islands. In addition claims from Virgin Island hospitals with dates of service 1/1/02 and later, and hospitals that furnish only inpatient Part B services with dates of service 1/1/02 and later are edited in the non-OPPS OCE; and

All other outpatient institutional claims.

40.1 - Integrated OCE (July 2007 and Later)

(Rev. 1590, Issued: 09-08-08, Effective: 10-01-08, Implementation: 10-06-08)

Effective for claims with dates of service July 1, 2007 and after, the non-Outpatient Prospective Payment System (OPPS) Outpatient Code Editor (OCE) will be integrated into the OPPS OCE. This integration will result in the routing of all institutional outpatient claims, including non-OPPS hospital claims, through a single integrated OCE eliminating the need to update two separate OCE software packages on a quarterly basis. **The integrated OCE does not change the current logic that is applied to outpatient bill types that already pass through the OPPS OCE software. It merely expands the software usage to include non-OPPS hospitals. This new software product will be referred to as the Integrated OCE (I/OCE).**

The I/OCE instructions and specifications are provided via Recurring Update Notifications. They are also posted on the Web at the following address:
http://www.cms.hhs.gov/OutpatientCodeEdit/02_OCEQtrReleaseSpecs.asp#TopOfPage

40.1.1 - Patient Status Code and Reason for Patient Visit for the Hospital OPPS

(Rev. 243, Issued 07-23-04, Effective: January 1, 2005/Implementation: January 3, 2005)

In order to ensure that OPPS claims are being submitted and processed to payment in accordance with OPPS payment policy, CMS must be able to monitor information reported by hospitals on Form CMS-1450 in Form Locators (FLs) 22 (Patient Status) and 76 (Reason for Patient Visit). This instruction requires the Shared System Maintainer to make changes to ensure that the information in FLs 22 and 76, from claims submitted on bill type 13x, is passed to the OPPS Outpatient Code Editor (OCE) and to the Common

Working File (CWF). This instruction also requires the Common Working File Maintainer to make changes to ensure that the information in FL 76, from claims submitted on bill type 13x, is passed to the National Claims History (NCH) files.

40.2 – Outpatient Prospective Payment System (OPPS) OCE (Prior to July 1, 2007)
(Rev. 1107, Issued: 11-09-06, Effective: 07-01-07, Implementation: 07-02-07)

The OPPS OCE performs the following two major functions:

- Edit claims data to identify errors and return a series of edit flags; and

- Assign an ambulatory payment classification (APC) number for each service covered under OPPS and return information to be used as input to the Pricer program.

Effective January 5, 2003, Medicare contractors will be receiving subsequent quarterly updates to these Outpatient Code Editor Specifications through a Recurring Update Notification.

40.2.1 - Patient Status Code and Reason for Patient Visit for the Hospital OPPS
(Rev. 1107, Issued: 11-09-06, Effective: 07-01-07, Implementation: 07-02-07)

In order to ensure that OPPS claims are being submitted and processed to payment in accordance with OPPS payment policy, CMS must be able to monitor information reported by hospitals on the claim including Patient Status and Reason for Patient Visit. This instruction requires the Shared System Maintainer to make changes to ensure that the information from claims submitted on bill type 13x, is passed to the OPPS Outpatient Code Editor (OCE) and to the Common Working File (CWF). This instruction also requires the Common Working File Maintainer to make changes to ensure that the information regarding Reason for Patient Visit is passed to the National Claims History (NCH) file.

40.3 – Non-OPPS OCE (Rejected Items and Processing Requirements Prior to 7/1/07
(Rev. 1107, Issued: 11-09-06, Effective: 07-01-07, Implementation: 07-02-07)

The following error types will be rejected or returned to the provider for development. (Numbers correspond to the Non –OPPS OCE documentation.)

1. Invalid Diagnosis or Procedure Code

The OCE checks each diagnosis code against a table of valid ICD-9-CM diagnosis codes and each procedure code against a table of valid HCPCS codes. If the reported code is not in these tables, the code is considered invalid.

For a list of all valid ICD-9-CM codes see “International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Volume I (Diseases),” The CMS approved ICD-9-CM addenda, and new codes are furnished by the FI for each hospital. For a list of valid HCPCS codes see “Physicians’ Healthcare Current Procedural Terminology, 4th Edition, CPT” and “CMS Healthcare Common Procedure Coding System (HCPCS).” Providers should review the medical record and/or fact sheet and enter the correct diagnosis and procedure codes before returning the bill.

2. **Invalid Fourth or Fifth Digit for Diagnosis Codes**

   The OCE identifies any diagnosis code that requires a fourth or fifth digit that is either missing or not valid for the code in question.

   For a list of all valid fourth and fifth digit ICD-9-CM codes see "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Volume I (Diseases)," CMS approved ICD-9-CM addenda, and new codes furnished by the FI. Providers should review the medical record and/or fact sheet and enter the correct diagnosis before returning the bill.

3. **E-Code as Principal Diagnosis**

   E codes describe the circumstances that caused an injury, not the nature of the injury, and therefore, are not used as a principal diagnosis. E-codes are all ICD-9-CM diagnosis codes that begin with the letter E. For a list of all E-codes, see "International Classification of Disease, 9th Revision, Clinical Modification (ICD-9-CM), Volume I (Diseases)." Providers should review the medical record and/or fact sheet and enter the correct diagnosis before returning the bill.

4. **Age Conflict**

   The OCE detects inconsistencies between a patient's age and any diagnosis on the patient's record.

5. **Sex Conflict**

   The OCE detects inconsistencies between a patient's sex and a diagnosis or procedure on the patient's bill.

6. **Questionable Covered Procedures**

   These are procedures that may be covered, depending upon the medical circumstances. For example, HCPCS code 19360 "Breast reconstruction with muscle or myocutaneous flap" is a condition that is not covered when performed for cosmetic purposes. However, if this procedure is performed as a follow-up to a radical mastectomy, it is covered.

7. **Noncovered Procedures**

   These are procedures that are not payable. The FI denies the bill.

8. **Medicare as Secondary Payer - MSP Alert (versions V1.0 and V1.1 only)**

   Diagnoses codes that identify situations that may involve automobile medical, no-fault or liability insurance. The provider must determine the availability of other insurance coverage before billing Medicare.

9. **Invalid Age**

If the age reported is not between 0 years and 124 years, the OCE assumes the age is in error.

If the beneficiary's age is established at over 124, enter with 123.

10. Invalid Sex

The sex code reported must be either 1 (male) or 2 (female). Usually, the FI can resolve the issue.

11. Date Range

This edit is used in internal FI operations.

12. Valid Date

The OCE checks the month, day, and year from FL 6 (from date). If the date is impossible, the FI returns the bill.

13. Unlisted Procedures

These are codes for surgical procedures (i.e., codes generally ending in 99).

40.4 - Paying Claims Outside of the IOCE

(Rev. 1649; Issued: 12-18-08; Effective/Implementation Date: 11-25-08)

All institutional outpatient claims are routed through the IOCE before they are processed to payment. There may be special circumstances, however, when it is necessary to pay claims bypassing IOCE edits. The CMS will notify the contractor of these instances. They include:

- New coverage policies are enacted by Congress with effective dates that preclude making the necessary changes timely; and

- Errors are discovered that cannot be corrected timely.

A/B MACs and FIs are responsible for reporting problems timely.

40.4.1 - Requesting to Pay Claims Without IOCE Approval

(Rev. 1649; Issued: 12-18-08; Effective/Implementation Date: 11-25-08)

The contractor may also request approval from the RO in specific situations to pay claims without first sending them through the IOCE. Examples of such situations are:

- A systems error cannot be corrected timely, and the provider's cash flow will be substantially impacted; and/or

- Administrative Law Judge (ALJ) decisions, court decisions, and CMS instructions in particular cases may necessitate that payment be made outside the normal process.

40.4.2 - Procedures for Paying Claims Without Passing through the IOCE

(Rev. 2117, Issued: 12-10-10, Effective: 01-12-11, Implementation: 01-12-11)

Before an outpatient claim may be paid without first going through the IOCE, the contractor shall obtain approval from CMS Central Office or the RO. In all instances involving payment outside the normal outpatient editing process, the contractor applies the following procedures:

- Contractors shall submit the claim overriding the IOCE using the appropriate field in FISS.
- Pay interest accrued through the date payment is made on clean claims. Do not pay any additional interest.
- Maintain a record of payment and implement controls to be sure that incorrect payment is not made, i.e., when the claim is paid without being subject to normal editing.
- Monitor IOCE software to determine when the impediment to processing is removed.
- Consider the claim processed for workload and expenditure reports when it is paid.
- Submit to the RO Consortium Contractor Manager (CCM) by the 20th of each month a monthly report of all outpatient claims paid without processing through the IOCE. The list of claims paid outside of the IOCE is to include the following information:
    - HIC
    - DCN
    - TOB
    - DOS (From/Through)
    - Provider Number
    - MCE/OCE OVR (Claim/Line)
    - Reimbursement Amount
    - Receipt Date
    - Process Date
    - Paid Date

Also, include summary data for each edit code showing claim volume and payment. Any override approvals received and/or relevant JSM references should be annotated on the reports.

50 - Outpatient Pricer

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

Outpatient Pricer determines the amount to pay as well as deductions for deductible and coinsurance.

This CMS-developed software is updated on a quarterly basis to determine the APC line item price (as well as applicable coinsurance/deductible) based on data from the Outpatient Provider Specific File (OPSF), the beneficiary deductible record and the OCE output file. Pricer prepares an output data record with the following information:

- All information passed from the OCE;
- The APC line item payment amount;
- The APC line item deductible;
- The APC line item coinsurance amount;
- The total cash deductible applied to the OPPS services on the claim;
- The total blood deductible applied to the OPPS services on the claim;
- The APC line item blood deductible;
- The total outlier amount for the claim to be paid in addition to the line item APC payments. This amount is to be reported to CWF via value code 17 as is the process for inpatient outlier payments; and
- A Pricer assigned review code to indicate why or how Pricer rejected or paid the claim.

The Pricer implementation guide has information concerning Pricer processing reports, input parameters, and data requirements.

50.1 - Outpatient Provider Specific File

(Rev. 2311, Issued: 09-23-11, Effective: 01-01-12, Implementation: 01-03-12)

The Outpatient Provider Specific File (OPSF) contains the required information about each provider to enable the pricing software to calculate the payment amount. Data elements and formats are shown below. Contractors must maintain the accuracy of the data, and update the file as changes occur in data element values, e.g., changes in metropolitan statistical area (MSA), bed size, cost to charge ratio. An update is accomplished by preparing and adding an additional complete record showing new current values and the effective date of the change. The old record is retained without change.

Contractors must also furnish CMS a quarterly file in the same format.

NOTE: All data elements, whether required or optional, must have a default value of "0" (zero) if numerical, or blank if alphanumerical.

File Position	Format	Title	Description

1-10	X(10)	National Provider Identifier (NPI)	Alpha-numeric 10 character provider number.
11-16	X(6)	Provider Oscar Number	Alpha-numeric 6 character provider number.
17-24	9(8)	Effective Date	Must be numeric, CCYYMMDD. This is the effective date of the provider's first OPPS period. For subsequent OPPS periods, the effective date is the date of a change to the PROV file. If a termination date is present for this record, the effective date must be equal to or less than the termination date.
25-32	9(8)	Fiscal Year Beginning Date	Must be numeric, CCYYMMDD. Month: 01-12 Day:01-31 The date must be greater than 19990630.
33-40	9(8)	Report Date	Must be numeric, CCYYMMDD. Month: 01-12 Day:01-31 The created/run date of the PROV report for submittal to CO.
41-48	9(8)	Termination Date	Must be numeric, CCYYMMDD. Must be zeros or contain a termination date. (once the official "tie-out" notice from CMS is received). Must be equal to or greater than the effective date. (Termination date is the date on which the reporting intermediary ceased servicing the provider in question).
49	X(1)	Waiver Indicator	Enter a "Y" or "N." Y = waived (provider is not under OPPS) For End Stage Renal Disease (ESRD) facilities provider waived blended payment, pay full PPS. N = not waived (provider is under OPPS) For ESRD facilities provider did not waive blended payment. Pay according to transitional payment method for ESRD PPS through 2013.
50-54	9(5)	Intermediary Number	Enter the Intermediary #.
55-56	X(2)	Provider Type	This identifies providers that require special

			handling. Enter one of the following codes as appropriate. 00 or blanks = Short Term Facility 02 Long Term 03 Psychiatric 04 Rehabilitation Facility 05 Pediatric 06 Hospital Distinct Parts (Provider type "06" is effective until July 1, 2006. At that point, provider type "06" will no longer be used. Instead, contractors will assign a hospital distinct part as one of the following provider types: 49, 50, 51, 52, 53, or 54) 07 Rural Referral Center 08 Indian Health Service 13 Cancer Facility 14 Medicare Dependent Hospital (during cost reporting periods that began on or after April 1, 1990. 15 Medicare Dependent Hospital/Referral Center (during cost reporting periods that began on or after April 1, 1990. Invalid October 1, 1994 through September 30, 1997). 16 Re-based Sole Community Hospital 17 Re-based Sole Community Hospital /Referral Center 18 Medical Assistance Facility 21 Essential Access Community Hospital 22 Essential Access Community Hospital/Referral Center

			23 Rural Primary Care Hospital 32 Nursing Home Case Mix Quality Demonstration Project – Phase II 33 Nursing Home Case Mix Quality Demonstration Project – Phase III – Step 1 34 Reserved 35 Hospice 36 Home Health Agency 37 Critical Access Hospital 38 Skilled Nursing Facility (SNF) – For non-demo PPS SNFs – effective for cost reporting periods beginning on or after July 1, 1998 40 Hospital Based ESRD Facility 41 Independent ESRD Facility 42 Federally Qualified Health Centers 43 Religious Non-Medical Health Care Institutions 44 Rural Health Clinics-Free Standing 45 Rural Health Clinics-Provider Based 46 Comprehensive Outpatient Rehab Facilities 47 Community Mental Health Centers 48 Outpatient Physical Therapy Services 49 Psychiatric Distinct Part 50 Rehabilitation Distinct Part 51 Short-Term Hospital – Swing Bed

			52 Long-Term Care Hospital – Swing Bed 53 Rehabilitation Facility – Swing Bed 54 Critical Access Hospital – Swing Bed
57	X(1)	Special Locality Indicator	Indicates the type of special locality provision that applies. For End Stage Renal Disease (ESRD) facilities value "Y" equals low volume adjustment applicable.
58	X(1)	Change Code For Wage Index Reclassification	Enter "Y" if the hospital's wage index location has been reclassified for the year. Enter "N" if it has not been reclassified for the year. Adjust annually. Does not apply to ESRD Facilities.
59-62	X(4)	Actual Geographic Location—MSA	Enter the appropriate code for MSA, 0040–9965, or the rural area, (blank)(blank) 2-digit numeric State code, such as _ _ 3 6 for Ohio, where the facility is physically located.
63-66	X(4)	Wage Index Location—MSA	The appropriate code for the MSA, 0040-9965, or the rural area, (blank)(blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified for wage index. Leave blank or enter the actual location MSA if not reclassified. Does not apply to ESRD Facilities.
67-70	9V9(3)	Payment-to-Cost Ratio	Enter the provider's payment-to-cost ratio. Does not apply to ESRD Facilities.
71-72	9(2)	State Code	Enter the 2-digit state where the provider is located. Enter only the first (lowest) code for a given state. For example, effective October 1, 2005, Florida has the following State Codes: 10, 68 and 69. Contractors shall enter a "10" for Florida's State Code. List of valid State Codes is located in Pub. 100-07, Chapter 2, Section 2779A1.
73	X(1)	TOPs Indicator	Enter the code to indicate whether TOPs applies or not. Y = qualifies for TOPs N = does not qualify for TOPs

74	X(1)	Quality Indicator Field	Hospital: Enter the code to indicate whether the hospital meets data submission criteria per HOP QDRP requirements. 1 = Hospital quality reporting standards have been met or hospital is not required to submit quality data (e.g., hospitals that are specifically excluded from the IPPS or which are not paid under the OPPS, including psychiatric, rehabilitation, long-term care and children's and cancer hospitals, Maryland hospitals, Indian Health Service hospitals, or hospital units; or hospitals that are located in Puerto Rico or the U.S. territories). The reduction does not apply to hospices, CORFs, HHAs, CMHCs, critical access hospitals or to any other provider type that is not a hospital. Blank = Hospital does not meet criteria. Independent and Hospital-based End Stage Renal Disease (ESRD) Facilities: Enter the code applicable to the ESRD Quality Incentive Program (QIP): Blank = no reduction 1 = ½ percent payment reduction 2 = 1 percent payment reduction 3 = 1 ½ percent payment reduction 4 = 2 percent payment reduction
75	X(1)	Filler	Blank.
76-79	9V9(3)	Outpatient Cost-to-Charge Ratio	Derived from the latest available cost report data. See §10.11 of this chapter for instructions on how to calculate and report the Cost-to-Charge Ratio. Does not apply to ESRD Facilities.
80-84	X(5)	Actual Geographic Location CBSA	00001-89999, or the rural area, (blank (blank) (blank) 2 digit numeric State code such as _ _ _ 3 6 for Ohio, where the facility is physically located.

85-89	X(5)	Wage Index Location CBSA	Enter the appropriate code for the CBSA, 00001-89999, or the rural area, (blank)(blank)(blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the Actual Geographic Location CBSA, if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank. Does not apply to ESRD Facilities.
90-95	9(2) V9(4)	Special Wage Index	Enter the special wage index that certain providers may be assigned. Enter zeroes unless the Special Payment Indicator equals a "1" or "2."
96	X(1)	Special Payment Indicator	The following codes indicate the type of special payment provision that applies. Blank = not applicable Y = reclassified 1 = special wage index indicator 2 = both special wage index indicator and reclassified
97-100	9(4)	Reduced Coinsurance Trailer Count	Enter the number of APCs the provider has elected to reduce coinsurance for. The number cannot be greater than 999.

The contractor enters the number of APCs for which the provider has elected to reduce coinsurance. Cannot be greater than 999. Reduced Coinsurance Trailer Record - Occurs 0-999 times depending on the reduced Coinsurance Trailer Count in positions 97-100. Due to systems capacity limitations the maximum number of reduced coinsurance trailers allowable is 999 at this time.

1-4	9(4)	APC Classification - Enter the 4-digit APC classification for which the provider has elected to reduce coinsurance.
5-10	9(4)V9(2)	Reduced Coinsurance Amount - Enter the reduced coinsurance amount elected by the provider

The Shared system will verify that the last position of the record is equal to the number in file positions 97 through 100 multiplied by 10 plus 100 (last position of record = (# in file position 97-100)(10) + 100).

Future updates will be issued in a Recurring Update Notification.

50.2 - Deductible Application

(Rev. 1, 10-03-03)

A-03-066

Pricer determines the deductible for OPPS services on a claim, and the FI determines the deductible for other services on the same claim. Pricer will automatically apply the deductible to the APC line item with the largest national unadjusted coinsurance as a percent of the APC payment. Pricer then goes to the next largest coinsurance as a percent of the APC payment and so on until the deductible is met or no other payments can be used to satisfy the deductible. This method of applying the deductible is the most advantageous for the beneficiary. If less than $100, or less than the beneficiary's remaining deductible amount is applied, an additional deductible amount from other services, if applicable, is applied to the claim for other types of payments on the same claim before submitting to CWF.

The deductible does not apply to the influenza virus vaccines, pneumococcal pneumonia vaccine, clinical diagnostic laboratory services (which include screening pap smears), screening mammographies, screening pelvic examinations, and screening prostate examinations. Only influenza virus vaccine, pneumococcal pneumonia vaccine, screening pelvic examinations and screening prostate examinations are subject to OPPS.

50.3 - Transitional Pass-Throughs for Designated Drugs or Biologicals

(Rev. 1, 10-03-03)
A-03-066

Certain current designated drugs and biologicals are assigned to special APCs. OCE identifies these and assigns the appropriate APC. Pricer establishes payment at 95 percent of the average wholesale price minus the portion of the otherwise applicable APC payment amount. Pricer will determine the proper payment amount for these APCs as well as the coinsurance and any applicable deductible. All related payment calculations will be returned on the same APC line and identified as a designated drug and biological. Certain new designated drugs and biologicals may be approved for payment, and their payment will be calculated in the same manner as listed above for current designated drugs and biologicals. Pricer identifies these new designated drugs and biologicals separately from the current designated drugs and biologicals.

See §50.5.J below for a discussion of the 63.6 percent pro-rata reduction applicable to all status indicator G and/or H payments.

50.4 - Transitional Pass-Throughs for Designated Devices

(Rev. 1, 10-03-03)
A-03-066

Certain designated new devices are assigned to APCs and identified by the OCE as eligible for payment based on the reasonable cost of the new device reduced by the amount included in the APC for the procedure that reflects payment for the old device. Pricer will determine the proper payment amount for these APCs as well as the coinsurance and any applicable deductible. All related payment calculations will be returned on the same APC line and identified as a designated new device.

See chapter 17, for a table indicating device offset amounts for APCs that contain device costs.

50.5 - Changes to Pricer Logic Effective April 1, 2002

(Rev. 1, 10-03-03)
A-02-026

The following list contains a description of all OPPS Pricer logic changes that are effective beginning April 1, 2002.

A. New OPPS wage indexes will be effective April 1, 2002. These are the same wage indexes that were implemented on October 1, 2001, for inpatient hospitals. Some corrections have been made since the publication of the inpatient rule, and CMS is using the corrected wage indexes where applicable.

B. Inpatient hospitals considered reclassified on October 1, 2001, will be considered reclassified for OPPS on April 1, 2002.

C. Section 401 designations and floor MSA designations will be considered effective for OPPS on April 1, 2002.

D. New payment rates and coinsurance amounts were effective for OPPS on April 1, 2002, except those 55 APCs with coinsurance amounts limited to 55 percent of the payment rate, which were effective January 1, 2002. The coinsurance limit equal to the inpatient deductible of $812 remains effective January 1, 2002.

E. APC 339, for Observation, will be priced at 1 unit no matter how many units are submitted.

F. If a claim has more than 1 service with a status indicator (SI) of S or T and any lines with SI of S or T have less than $1.01 as charges, charges for all S and/or T lines will be summed and the charges will then be divided up proportionately to the payment rate for each S or T line. The new charge amount will be used in place of the submitted charge amount in the line item outlier calculation.

EXAMPLE:

SI	Charges	Payment Rate	New Charges Amount
S	$19,999	$6,000	$12,000
T	$1	$3,000	$6,000
S	$0	$1,000	$2,000
	$20,000	$10,000	$20,000

Because total charges here are $20,000 and the first SI of S gets 6,000 of 10,000 total payment, the new charge for that line is 6,000/10,000 * $20,000 = $12,000.

G. All charges on lines with a SI of N (bundled services) on the claim will be summed and the charges will then be divided up proportionately to the payment rate for each S, T, V or X line. This proportional

amount will be added to the new charges amount from item F above or, if that doesn't apply, they will be added to the actual submitted charges for each S, T, V or X before making a line item outlier calculation.

H. Outliers will be calculated at a line item level. No outlier payment will be calculated for SIs of G, N or H, although charges for packaged services (SI=N) will be used in calculating outlier payments for other services as described in G. above. Pricer will use submitted charges as modified by items F and G above. The CMS changed the factor multiplied times the total claim payments from 2.5 to 3.5 and factor used to multiply the difference between claim payments and costs from .75 to .50. Pricer will keep the cost to charge ratio adjustment factor at .981956. Pricer will sum all line item outlier amounts and output them as a single total claim outlier amount, just as it outputs the outlier amount that contractors are to place in value code 17.

I. Any claim with one or more APCs that match those listed in Table 1 of the March 1, 2002, "Federal Register" will have all applicable APC offset amounts summed and wage adjusted. The total wage adjusted offset amount will be subtracted proportionately from the charges reduced to costs for any SI H devices that have a HCPCS code beginning with a C, i.e., C1713 through C2631.

J. A pro rata reduction of 63.6 percent applies to all SI G and/or H payments. For H, devices, the offset (or reduction) is applied to the final payment amount after all device offset amounts (see item I above) have been taken. For SI G, pass thru drugs, CMS determines the pass-through amount (PTA) by subtracting 5 times the minimum coinsurance from the Medicare payment amount. The CMS will multiply .364 times the PTA and add that amount to 5 times the minimum coinsurance to get the new Medicare payment amount.

K. The provider specific file for SNFs and HHAs that may be reimbursed for splints, casts and/or antigens under OPPS should have a cost to charge ratio of 0.000 (or 0.001 if the shared system will not allow 0.000. Pricer will not pay outliers for these services.

L. Pricer Drug Copayment Changes

APC	Drug Name	Corrected Copayment
726	Dexrazoxane	$27.85
1607	Eptifibatide	$1.62

50.6 - Changes to the OPPS Pricer Logic Effective January 1, 2003

(Rev. 1, 10-03-03)

The following list contains a description of all OPPS Pricer logic changes that are effective beginning January 1, 2003.

A. New OPPS wage indexes will be effective January 1, 2003. These are the same wage indexes that were implemented on October 1, 2002, for inpatient hospitals. Some corrections have been made since the publication of the inpatient rule and CMS are using the corrected wage indexes where applicable.

B. Inpatient hospitals considered reclassified on October 1, 2002, will be considered reclassified for OPPS on January 1, 2003.

C. Section 301 designations and floor MSA designations will be considered effective for OPPS on January 1, 2003.

D. New payment rates and coinsurance amounts will be effective for OPPS on January 1, 2003. Some APCs have coinsurance amounts limited to 55 percent of the payment rate effective January 1, 2003. Some APCs have a coinsurance limit equal to the inpatient deductible of $840 effective January 1, 2003.

E. If a claim has more than 1 service with a status indicator (SI) of T (SI of S has been removed from this rule) and any lines with SI T have less than $1.01 as charges, charges for all T lines will be summed and the charges will then be divided up proportionately to the payment rate for each T line. The new charge amount will be used in place of the submitted charge amount in the line item outlier calculation.

EXAMPLE:

SI	Charges	Payment Rate	New Charges Amount
T	$19,999	$6,000	$12,000
T	$1	$3,000	$ 6,000
T	$0	$1,000	$ 2,000
	$20,000	$10,000	$20,000

Because total charges here are $20,000 and the first SI of T gets 6,000 of 10,000 total payment, the new charge for that line is 6,000/10,000 x $20,000 = $12,000.

F. For outliers, CMS will change the factor multiplied times the total line item payments from 3.5 to 2.75 and the factor used to multiply the difference between line item payments and costs from .50 to .45. The CMS will eliminate the cost to charge ratio adjustment factor of .981956 from outlier and device calculations.

G. Any claim having one or more APCs that match those listed in the Device Offset Table (Table 11) published in the November 1, 2002, "Federal Register" and a HCPCS code with status indicator (SI) H, will have all applicable APC offset amounts (multiplied by the number of units and the multiple procedure discount factor applicable to that line item) summed and wage adjusted. If there are more units of APCs with offset amounts than there are units of SI H devices that have an active (non-deleted) device category HCPCS code beginning with a C, i.e., those codes listed in section XXII B. of this PM, the total wage adjusted offset amount will be multiplied by the number of units of SI H devices that have a HCPCS code beginning with a C and then divided by the number of units of APCs with offset amounts. The total wage adjusted offset amount will then be subtracted proportionately from the charges reduced to costs for any SI H devices that have a HCPCS code beginning with a C.

H. The pro rata reduction of 63.6 percent applicable to all SI G and/or H payments is eliminated.

50.7 - Changes to the OPPS Pricer Logic, Effective January 1, 2003 Through January 1, 2006

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

For January Pricers occurring between CY 2003 and 2006, you may find the updates outlined in the following CRs:

January 2004 – CR 3007, http://www.cms.hhs.gov/Transmittals/Downloads/R32OTN.pdf
January 2005 – CR 3586, http://www.cms.hhs.gov/transmittals/Downloads/R385CP.pdf
January 2006 – CR 4250, http://www.cms.hhs.gov/transmittals/downloads/R804CP.pdf

50.8 – Annual Updates to the OPPS Pricer for Calendar Year (CY) 2007 and Later

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

Starting with the January 2007 update, all annual updates within the OPPS Pricer are explained within recurring update notifications located at the Hospital OPPS Transmittals Web site found at: http://www.cms.hhs.gov/HospitalOutpatientPPS/HOPPSTrans/.

60 - Billing for Devices Eligible for Transitional Pass-Through Payments and Items Classified in "New Technology" APCs

(Rev. 1336; Issued: 09-14-07; Effective/Implementation Dates: 10-01-07)

The list of devices eligible for transitional pass-through payments changes as new device categories are approved for pass-through payment status on an ongoing basis, and as device categories expire from transitional pass-through payment and their costs are included in APC rates for associated surgical procedures. To view or download the latest complete list of currently payable and previously payable pass-through device categories, refer to http://www.cms.hhs.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage. Please note that this link may change depending on CMS Web design requirements.

Hospitals are required to report device category codes that have expired from pass-through payment on claims when such devices are used in conjunction with procedures billed and paid for under the OPPS. In a Federal Register notice dated November 15, 2004 we summarized several provisions (69 FR 65762) related to the required reporting of HCPCS codes for devices.

The most recent information concerning applications requesting CMS to establish coding and payment and eligibility requirements for additional (new) device categories for pass-through payment is located on the CMS Web site at http://www.cms.hhs.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage This Web link may change from time to time, depending on CMS Web design requirements.

60.1 - Categories for Use in Coding Devices Eligible for Transitional Pass-Through Payments Under the Hospital OPPS

(Rev. 1336; Issued: 09-14-07; Effective/Implementation Dates: 10-01-07)

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 requires establishing categories for purposes of determining transitional pass-through payment for devices, effective April 1, 2001. Each category is defined as a separate code in the C series or occasionally a code in another series (e.g., certain codes in the L series) of HCPCS. C-codes are assigned by CMS for this purpose when other HCPCS codes for the eligible item do not exist. Only devices specifically described by the long descriptions associated with the currently payable pass-through category codes are qualified for transitional pass-through payments. The complete list of currently and previously payable pass-through category codes can be viewed and/or downloaded from the CMS Web site, currently at http://www.cms.hhs.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage.

Each item that qualifies for transitional pass-through payments fits in one of the device categories currently active for pass-through payments. Devices may be billed using the currently active category codes for pass-through payments, as long as they:

- Meet the definition of a device that qualifies for transitional pass-through payments and other requirements and definitions put forth below in §60.3.

- Are described by the long descriptor associated with a currently active pass-through device category HCPCS code assigned by CMS and

- Are described according to the definitions of terms and other general explanations issued by CMS to accompany coding assignments in program instructions. The current definitions and explanations are located with the latest complete list of currently payable and previously payable pass-through device categories, found at http://www.cms.hhs.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage. Please note that this link may change depending on CMS Web design requirements.

If a device does not meet the description and other coding instructions for currently payable categories, even though it appears to meet the other requirements in this section, it may not be billed using one of the HCPCS codes for currently payable categories for transitional pass-through payments unless an applicable category is established by CMS, as discussed in section 60.3 below.

Transitional pass-through payment for a device is based on the charge on the individual provider's bill, reduced to cost, and subject (in some instances) to a deduction that represents the cost of similar devices already included in the APC payment rate of the APC billed with the device category and, possibly, a pro-rata reduction (see chapter 17). The PRICER software determines the reduction to cost and the deduction for similar devices.

The eligibility of a device category for transitional pass-through payments is temporary, lasting for at least 2 but no more than 3 years. (The initial categories expired on January 1, 2003 or on January 1, 2004. The underlying provision is permanent, and categories established later have expired or will expire in successive years.) At the time of expiration, APC payment rates are adjusted to reflect the costs of devices (and drugs and biologicals) that received transitional pass-through payments. These adjustments are based on claims

data that reflect the use of transitional pass-through devices, drugs and biologicals in conjunction with the associated procedures.

60.2 - Roles of Hospitals, Manufacturers, and CMS for Billing for Transitional Pass-Through Items

(Rev. 1336; Issued: 09-14-07; Effective/Implementation Dates: 10-01-07)

In general, hospitals are ultimately responsible for the content of the bills they present to Medicare. If hospitals have questions about appropriate coding that they cannot resolve on their own, the appropriate first step would be to review the HCPCS codes and/or the regulation governing payment for the year of service. CMS does not have to have qualified a particular device for transitional pass-through payment before a hospital can bill for the device. Hospitals are expected to make appropriate coding decisions based on these instructions and other information available to them.

Many device manufacturers routinely provide hospital customers with information about appropriate coding of their devices. This may be helpful but does not supersede Federal requirements.

60.3 - Devices Eligible for Transitional Pass-Through Payments

(Rev. 1336; Issued: 09-14-07; Effective/Implementation Dates: 10-01-07)

The definition of and criteria for devices eligible for establishment of new categories for transitional pass-through payments was most recently discussed and defined in a final rule with comment period published in the "Federal Register" on November 1, 2002, (67 FR 66781). Two of the criteria were also modified by means of a final rule with comment period published in the "Federal Register" on November 10, 2005 (70 FR 68628). The regulations regarding transitional pass-through payment for devices are compiled at 42 CFR 419.66. Additionally, the eligibility criteria for CMS to establish a new category for pass-through payment are discussed on the CMS Web site at http://www.cms.hhs.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage.

60.4 - General Coding and Billing Instructions and Explanations

(Rev. 1702, Issued: 03-13-09, Effective: 04-01-09, Implementation: 04-06-09)

Explanations of Terms

Device Kits

Manufacturers frequently package a number of individual items used with a device in a particular procedure in a kit. Generally, to avoid complicating the device pass-through category list unnecessarily and to avoid the possibility of double coding, CMS has not established HCPCS codes for such kits. However, hospitals may purchase and use such kits. If the kits contain individual items that separately qualify for transitional pass-through payments, these items should be separately billed using applicable HCPCS codes. Hospitals may not bill for transitional pass-through payments for supplies that may be contained in kits.

Reporting Multiple Units of Pass-Through Device Categories

Hospitals must bill for multiple units of items that qualify for transitional pass-through payments when such items are used with a single procedure by entering the number of units used on the bill.

Reporting of Multiple Device Categories

For items with multiple component devices that fall in more than one category (e.g., kits or systems other than those explicitly identified in the long descriptors), hospitals should code the appropriate category separately for each component. For example, the "Rotablator Rotational Angioplasty System (with catheter and advancer)" consists of both a catheter and an advancer/sheath. Hospitals should report category C1724 for the catheter and C1894 for the advancer/sheath.

Also, for items packaged as kits that contain a catheter and an introducer, hospitals should report both appropriate categories. For example, the "Clinicath 16G Peripherally Inserted Central Catheter (PICC) Dual-Lumen PolyFlow Polyurethane" contains a catheter and an introducer. To appropriately bill for this item, hospitals should report category C1751 for the catheter and C1894 for the introducer. (Please note that the device categories C1724, C1894 and C1751 are no longer eligible for pass-through payments, but are used here for illustrative purposes for reporting multiple categories. However, hospitals should continue to report devices on claims in this manner even after the category is no longer eligible for pass-through payment.)

Reprocessed Devices

Hospitals may bill for transitional pass-through payments only for those devices that are "single use." Reprocessed devices may be considered "single use" if they are reprocessed in compliance with enforcement guidance of the Food and Drug Administration (FDA) relating to the reprocessing of devices applicable at the time the service is delivered. The FDA phased in new enforcement guidance relating to reprocessing during 2001 and 2002. For further information, see FDA's guidance document entitled "Enforcement Priorities for Single-Use Devices Reprocessed by Third Parties and Hospitals," published August 14, 2000, or any later FDA guidance or enforcement documents currently in effect. For a complete list of currently and previously payable device categories related to pass-through payments and specific definitions of such device categories, refer to
http://www.cms.hhs.gov/HospitalOutpatientPPS/Downloads/DeviceCats_OPPSUpdate.pdf

60.5 - Services Eligible for New Technology APC Assignment and Payments
(Rev. 1336; Issued: 09-14-07; Effective/Implementation Dates: 10-01-07)

Under OPPS, services eligible for payment through New Technology APCs are those codes that are assigned to the series of New Technology APCs published in Addendum B of the latest OPPS update. OPPS considers any HCPCS code assigned to these APCs to be a "new technology procedure or service." Procedures for applying for assignment of new services to New Technology APCs may be found on the CMS Web site, currently at
http://www.cms.hhs.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage. Please note that this link may change depending on CMS Web design requirements.

The list of HCPCS codes indicating the APCs to which each is assigned can be found in Addendum B of the latest OPPS update regulation each year at

http://www.cms.hhs.gov/HospitalOutpatientPPS/HOPPSTrans/list.asp#TopOfPage. Please note that this link may change depending on CMS Web design requirements.

61 - Billing for Devices Under the OPPS

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

Future updates will be issued in a Recurring Update Notification.

61.1 - Requirement that Hospitals Report Device Codes on Claims on Which They Report Specified Procedures

(Rev. 1702, Issued: 03-13-09, Effective: 04-01-09, Implementation: 04-06-09)

Effective January 1, 2005, hospitals paid under the OPPS (bill types 12X and 13X) that report procedure codes that require the use of devices must also report the applicable HCPCS codes and charges for all devices that are used to perform the procedures where such codes exist and are designated with a status indicator of "N" (for packaged payment) or "H" (for pass-through device payment) in the OPPS Addendum B that applies to the date of service. If there are device HCPCS codes with status indicators other than "N" or "H" that describe devices that are used to perform the procedure or that are furnished because they are necessary for the function of an implanted device, hospitals should report the charges for those other devices on an uncoded revenue code line, but should not report the HCPCS codes for those items. Typically, payment for the costs of all internal and external components required for the function of a nonpass-through device is packaged into the APC payment for the associated procedure in which the device is used. Accurate reporting of HCPCS codes and charges for these internal and external device components is necessary so that the OPPS payment for the associated procedures will be correct in future years in which the claims are used to set the APC payment rates.

Manufacturers frequently package a number of individual items used with a device in a particular procedure. In cases of devices that are described by device category HCPCS codes whose pass-through status has expired, or HCPCS codes that describe devices without pass-through status, and that are packaged in kits with other items used in a particular procedure, hospitals may consider all kit costs in their line-item charge for the associated device/device category HCPCS code that is assigned status indicator "N" for packaged payment. That is, hospitals may report the total charge for the whole kit with the associated device/device category HCPCS code. Payment for device/device category HCPCS codes without pass-through status is packaged into payment for the procedures in which they are used, and these codes are assigned status indicator "N." In the case of a device kit, should a hospital choose to report the device charge alone under a device/device category HCPCS code with SI="N," the hospital should report charges for other items that may be included in the kit on a separate line on the claim. Hospitals may use the same revenue code to report all components of the kit.

61.2 - Edits for Claims on Which Specified Procedures are to be Reported With Device Codes and For Which Specific Devices are to be Reported With Procedure Codes

(Rev. 1336; Issued: 09-14-07; Effective/Implementation Dates: 10-01-07)

The OCE will return to the provider any claim that reports a HCPCS code for a procedure listed in the table of device edits that does not also report at least one device HCPCS code required for that procedure as listed on the CMS Web site at http://www.cms.hhs.gov/HospitalOutpatientPPS/. The table shows the effective

date for each edit. If the claim is returned to the provider for failure to pass the edits, the hospital will need to modify the claim by either correcting the procedure code or ensuring that one of the required device codes is on the claim before resubmission. While all devices that have device HCPCS codes and that were used in a given procedure should be reported on the claim, where more than one device code is listed in the table of device edits for a given procedure code, only one of the possible device codes is required to be on the claim for payment to be made, unless otherwise specified.

Device edits do not apply to the specified procedure code if the provider reports one of the following modifiers with the procedure code:

52 - Reduced Services;
73 -- Discontinued outpatient procedure prior to anesthesia administration; and
74 -- Discontinued outpatient procedure after anesthesia administration.

Where a procedure that normally requires a device is interrupted, either before or after the administration of anesthesia if anesthesia is required or at any point if anesthesia is not required, and the device is not used, hospitals should report modifier 52, 73 or 74 as applicable. The device edits are not applied in these cases. The OCE will also return to the provider claims for which specified devices are billed without the procedure code that is necessary for the device to have therapeutic benefit to the patient. These edits are also listed on the CMS Web site at http://www.cms.hhs.gov/HospitalOutpatientPPS/. The table shows the effective date for each edit. If the claim is returned to the provider for failure to pass the edits, the hospital will need to modify the claim by either correcting the device code or ensuring that one of the required procedure codes is on the claim before resubmission.

61.3 - Billing for Devices Furnished Without Cost to an OPPS Hospital or Beneficiary or for Which the Hospital Receives a Full or Partial Credit and Payment for OPPS Services Required to Furnish the Device

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

61.3.1 - Reporting and Charging Requirements When a Device is Furnished Without Cost to the Hospital

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

Effective January 1, 2007, the definition of modifier –FB is "**Item Provided Without Cost to Provider, Supplier or Practitioner, or Credit Received for Replacement Device (Examples, but not Limited to: Covered Under Warranty, Replaced Due to Defect, Free Samples).**"

When a hospital furnishes a device received without cost or with full credit from a manufacturer, the hospital must append modifier –FB to the procedure code (not the device code) that reports the service provided to furnish the device. The hospital must report a token charge for the device (less than $1.01) in the covered charge field.

This includes circumstances in which the cost of a replacement device is less than the cost of the device being replaced, such that the hospital incurs no net cost for the device being inserted. For example, if a device that originally cost $20,000 fails and is replaced by a device that costs $16,000 and for which the

manufacturer gives a credit of $16,000, there is no cost to the hospital for the device being inserted and the hospital would append modifier –FB to the procedure code and report a token charge for the device.

61.3.2 - Reporting and Charging Requirements When the Hospital Receives Full Credit for the Replaced Device against the Cost of a More Expensive Replacement Device

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

When a hospital replaces a device with a more expensive device and receives a credit in the amount that the device being replaced would otherwise cost, the hospital must append modifier –FB to the procedure code (not on the device code) that reports the service provided to replace the device. The hospital must charge the difference between its usual charge for the device being implanted and its usual charge for the device for which it received credit. This charge should be billed in the covered charge field.

Hospitals should not report modifier –FB when the hospital receives a partial credit for a replacement device when the amount of the credit is less than the amount that the device would otherwise cost the hospital. For example, a device fails in the 6th month of a 1 year warranty and under the terms of the warranty, the hospital receives a credit of 50 percent of the cost of a replacement device. The hospital should not append modifier –FB to the procedure code in which the device is implanted. See the Medicare Claims Processing Manual, Pub 100-04, Chapter 4, §61.3.3 for billing instructions pertaining to partial credit situations.

61.3.3 - Reporting Requirements When the Hospital Receives Partial Credit for the Replacement Device

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

When a hospital receives a partial credit of 50 percent or more of the cost of a new replacement device due to warranty, recall, or field action, the hospital must append modifier –FC to the procedure code (not on the device code) that reports the service provided to replace the device.

61.3.4 - Medicare Payment Adjustment

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

Effective January 1, 2007, Medicare payment is reduced by the full offset amount for specified procedure codes reported with modifier –FB. Effective January 1, 2008, Medicare payment is reduced by the partial offset amount for specified procedure codes reported with modifier –FC. Effective January 1, 2009, payment is only reduced for procedure codes that map to the Ambulatory Payment Classification groups (APCs) on the list of APCs subject to the adjustment that are reported with modifier –FB or –FC and that are present on claims with specified device HCPCS codes.

The Integrated Code Editor (I/OCE) assigns a payment adjustment flag when a procedure code in an APC subject to an offset adjustment is billed with modifier –FB or –FC and a specified device HCPCS code. The payment adjustment flag communicates to the OPPS PRICER that the payment for the procedure code line is to be reduced by the established full or partial offset amount for the APC to which the procedure code is assigned. The I/OCE uses the offset APC payment rate (APC payment amount minus the established offset amount) as the rate used in the I/OCE's determination of which multiple procedure line(s) will be discounted.

The OPPS PRICER then applies the multiple procedure discounting and terminated procedure discounting factors after offsetting the unadjusted APC payment rate. The offset reduction also is made to the unadjusted payment rate before wage adjustment, which ensures that the beneficiary's coinsurance is based on the reduced amount.

NOTE: The tables of APCs and devices to which the offset reductions apply, and the full and partial offset amounts, are available on the CMS Web site at: www.cms.hhs.gov/HospitalOutpatientPPS/.

61.4 - Billing and Payment for Brachytherapy Sources
(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

61.4.1 - Billing for Brachytherapy Sources - General
(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

Brachytherapy sources (e.g., brachytherapy devices or seeds, solutions) are paid separately from the services to administer and deliver brachytherapy in the OPPS, per section 1833(t)(2)(H) of the Act, reflecting the number, isotope, and radioactive intensity of devices furnished, as well as stranded versus non-stranded configurations of sources. Therefore, providers must bill for brachytherapy sources in addition to the brachytherapy services with which the sources are applied, in order to receive payment for the sources. The list of separately payable sources is found in Addendum B of the most recent OPPS annual update published in the Federal Register, as well as in the recurring update notifications of the current year for billing purposes. New sources meeting the OPPS definition of a brachytherapy source may be added for payment beginning any quarter, and the new source codes and descriptors are announced in the recurring update notifications.

Each unit of a billable source is identified by the unit measurement in the respective source's long descriptor. Seed-like sources are generally billed and paid "per source" based on the number of units of the source HCPCS code reported, including the billing of the number of sources within a stranded configuration of sources. Providers therefore must bill the number of units of a source used with the brachytherapy service rendered.

61.4.2 - Definition of Brachytherapy Source for Separate Payment
(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

Brachytherapy sources eligible for separate billing and payment must be radioactive sources, meaning that the source contains a radioactive isotope. Separate brachytherapy source payments reflect the number, isotope, and radioactive intensity of sources furnished to patients, as well as stranded and non-stranded configurations.

61.4.3 - Billing of Brachytherapy Sources Ordered for a Specific Patient
(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

A hospital may report and charge Medicare and the Medicare beneficiary for all brachytherapy sources that are ordered by the physician for a specific patient, acquired by the hospital, and used in the care of the patient. Specifically, brachytherapy sources prescribed by the physician in accordance with high quality clinical care, acquired by the hospital, and actually implanted in the patient may be reported and charged. In the case where most, but not all, prescribed sources are implanted in the patient, CMS will consider the

relatively few brachytherapy sources that were ordered but not implanted due to specific clinical considerations to be used in the care of the patient and billable to Medicare under the following circumstances. The hospital may charge for all sources if they were specifically acquired by the hospital for the particular patient according to a physician's prescription for the sources that was consistent with standard clinical practice and high quality brachytherapy treatment, in order to ensure that the clinically appropriate number of sources was available for the implantation procedure, and they were not implanted in any other patient. Those sources that were not implanted must have been disposed of in accordance with all appropriate requirements for their handling. In general, the number of sources used in the care of the patient but not implanted would not be expected to constitute more than a small fraction of the sources actually implanted in the patient. Under these circumstances, the beneficiary is liable for the copayment for all the sources billed to Medicare.

61.4.4 - Billing for Brachytherapy Source Supervision, Handling and Loading Costs

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

Providers should report charges related to supervision, handling, and loading of radiation sources, including brachytherapy sources, in one of two ways:

1. Report the charge separately using CPT code 77790 (Supervision, handling, loading of radiation source), in addition to reporting the associated HCPCS procedure code(s) for application of the radiation source;

2. Include the supervision, handling, and/or loading charges as part of the charge reported with the HCPCS procedure code(s) for application of the radiation source.

Do not bill a separate charge for brachytherapy source storage costs. These costs are treated as part of the department's overhead costs.

70 - Transitional Corridor Payments

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) established transitional payments to limit provider's losses under the OPPS; the additional payments are for 3 1/2 years for community mental health centers (CMHCs) and most hospitals, and permanent for cancer hospitals effective August 1, 2000.

Section 405 of BIPA provides that children's hospitals described in §1886(d)(1)(B)(iii) are held harmless permanently for purposes of calculating TOP amounts, retroactive to August 1, 2000. Some rural hospitals are also held harmless for several years after the implementation of the OPPS, as discussed in detail below. Contractors determine TOPs eligibility and calculate interim TOPs.

Beginning September 1, 2000, and every month thereafter until further notice, the shared system maintainers must provide contractors with software that gathers all data required to calculate a TOP amount for each hospital and CMHC. The software must calculate and pay the TOP amount for OPPS services on claims processed during the preceding month, maintain an audit trail (including the ability to generate a hardcopy report) of these TOP amounts, and transfer to the PS&R system any necessary data. TOP amounts should be paid before the next month begins and they are not subject to normal payment floor requirements.

Several items contained in the Inpatient or Outpatient Provider Specific File (IPSF or OPSF) are needed to determine TOP eligibility for each hospital or CMHC. They are:

- The provider number;
- Fiscal year begin date;
- The provider type;
- Actual geographic location – CBSA-(from the IPSF);
- Wage index location - CBSA-(from the IPSF); and
- Bed size (from the IPSF)

Pursuant to §403 of BIPA, a TOP may be made to hospitals and CMHCs that did not file a cost report for the cost reporting period ending in calendar year 1996. The law was amended to provide that if a hospital did not file a cost report for a cost reporting period ending in calendar year 1996, the payment-to-cost ratio used in calculating a TOP will be based on the hospital's first cost report for a period ending after calendar year 1996 and before calendar year 2001. This provision is effective retroactively to August 1, 2000.

Future updates will be issued in a Recurring Update Notification.

70.1 - Transitional Outpatient Payments (TOPs) for CY 2000 and CY 2001

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

Monthly TOPs calculations that contractors are required to calculate are described below. This calculation is effective for services provided between August 1, 2000, and December 31, 2001.

Step 1 – Compute the pre-BBA amount for each month by first multiplying the total charges for covered services for all OPPS services on claims paid during the month and reduce the total charges to cost by multiplying them by the outpatient cost to charge ratio and then multiplying this amount by the provider-specific payment-to-cost ratio (PSPCR).

Step 2 – Add together the total Medicare program payments, unreduced coinsurance and deductible applied for all APCs, as well as all outlier payments and transitional pass-through payments for drugs, biologicals and/or devices for those same claims paid during the month as those used in Step 1. If the result is greater than the result of step 1, go to step 9. No transitional payment is due this month.

Step 3 - If the hospital is a children's hospital, a small rural hospital with not more than 100 beds or a cancer hospital, go to step 4. If any other type of hospital, divide the result of step 2 by the result of step 1, skip step 4 and perform step 5, 6, 7, or 8 as appropriate.

Step 4 - If the hospital is a children's hospital, a small rural hospital with not more than 100 beds or a cancer hospital, subtract the result of step 2 from the result of step 1 and pay .85 times this amount. Do not perform steps 5-8.

Step 5 - If the result of step 3 is equal to or greater than .9 but less than 1.0, subtract the result of step 2 from the result of step 1, and multiply the difference by .8 and pay .85 times this amount.

Step 6 - If the result of step 3 is equal to or greater than .8 but less than .9, subtract .7 times the result of step 2 from .71 times the result of step 1, and pay .85 times this amount.

Step 7 - If the result of step 3 is equal to or greater than .7 but less than .8, subtract .6 times the result of step 2 from .63 times the result of step 1, and pay .85 times this amount.

Step 8 - If the result of step 3 is less than .7, multiply the result of step 1 by .21 and pay .85 times this amount.

Step 9 - When the result of step 2 is greater than the result of step 1 for the final month of a provider's cost report period, do nothing more. When the result of step 2 is greater than the result of step 1 for any other month, store all step 1 and step 2 totals and include these totals with the totals for the next month's TOP calculation.

70.2 - Transitional Outpatient Payments (TOPs) for CY 2002

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

For services provided during calendar years 2002, TOPs were gradually reduced for all providers except those hospitals that receive hold harmless TOPs (cancer hospitals, children's hospitals, and rural hospitals having 100 or fewer beds). To avoid TOP overpayments, contractors were instructed to revise the monthly interim TOP calculations to reflect the new calculation.

Monthly TOPs calculations that contractors are required to calculate are described below. This calculation is effective for services provided between January 1, 2002, and December 31, 2002.

Step 1 – Compute the pre-BBA amount for each month by first multiplying the total charges for covered services for all OPPS services on claims paid during the month and reduce the total charges to cost by multiplying them by the outpatient cost-to- charge ratio and then multiplying this amount by the provider-specific payment-to-cost ratio (PSPCR).

Step 2 – Add together the total Medicare program payments, unreduced coinsurance and deductible applied for all APCs, as well as all outlier payments and transitional pass-through payments for drugs, biologicals and/or devices for those same claims paid during the month as those used in Step 1. If the result is greater than the result of step 1, go to step 8. No transitional payment is due this month.

Step 3 - If the hospital is a children's hospital, a small rural hospital with not more than 100 beds or a cancer hospital go to step 4. If any other type of hospital, divide the result of step 2 by the result of step 1, skip step 4 and perform steps 5, 6, or 7 as appropriate.

Step 4 - If the hospital is a children's hospital, a small rural hospital with not more than 100 beds or a cancer hospital, subtract the result of step 2 from the result of step 1 and pay .85 times this amount. Do not perform steps 5-7.

Step 5 - If the result of step 3 is equal to or greater than .9 but less than 1.0, subtract the result of step 2 from the result of step 1, and multiply the difference by .7 and pay .85 times this amount.

Step 6 - If the result of step 3 is equal to or greater than .8 but less than .9, subtract .6 times the result of step 2 from .61 times the result of step 1, and pay .85 times this amount.

Step 7 - If the result of step 3 is less than .8, multiply the result of step 1 by .13 and pay .85 times this amount.

Step 8 - When the result of step 2 is greater than the result of step 1 for the final month of a provider's cost report period, do nothing more. When the result of step 2 is greater than the result of step 1 for any other month, store all step 1 and step 2 totals and include these totals with the totals for the next month's TOP calculation.

70.3 - Transitional Outpatient Payments (TOPs) for CY 2003

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

For services provided during calendar years 2003, TOPs continued to decrease for all providers except those hospitals that receive hold harmless TOPs (cancer hospitals, children's hospitals, and rural hospitals having 100 or fewer beds). To avoid TOP overpayments, contractors were instructed to revise the monthly interim TOP calculations to reflect the new calculation.

Monthly TOPs calculations that contractors are required to calculate are described below. This calculation is effective for services provided between January 1, 2003, and December 31, 2003.

Step 1 – Compute the pre-BBA amount for each month by first multiplying the total charges for covered services for all OPPS services on claims paid during the month and reduce the total charges to cost by multiplying them by the outpatient cost to charge ratio and then multiplying this amount by the provider-specific payment-to-cost ratio (PSPCR).

Step 2 – Add together the total Medicare program payments, unreduced coinsurance and deductible applied for all APCs, as well as all outlier payments and transitional pass-through payments for drugs, biologicals and/or devices for those same claims paid during the month as those used in Step 1. If the result is greater than the result of step 1, go to step 7. No transitional payment is due this month.

Step 3 - If the hospital is a children's hospital, a small rural hospital with not more than 100 beds or a cancer hospital go to step 4. If any other type of hospital, divide the result of step 2 by the result of step 1, skip step 4 and perform step 5 or 6 as appropriate.

Step 4 - If the hospital is a children's hospital, a small rural hospital with not more than 100 beds or a cancer hospital, subtract the result of step 2 from the result of step 1 and pay .85 times this amount. Do not perform steps 5-6.

Step 5 - If the result of step 3 is equal to or greater than .9 but less than 1.0, subtract the result of step 2 from the result of step 1, and multiply the difference by .6 and pay .85 times this amount.

Step 6 - If the result of step 3 is less than .9, multiply the result of step 1 by .06 and pay .85 times this amount.

Step 7 - When the result of step 2 is greater than the result of step 1 for the final month of a provider's cost report period, do nothing more. When the result of step 2 is greater than the result of step 1 for any other month, store all step 1 and step 2 totals and include these totals with the totals for the next month's TOP calculation.

70.4 - Transitional Outpatient Payments (TOPs) for CY 2004 and CY 2005

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

Section 411 of the Medicare Modernization Act (MMA) provided that for services provided on or after January 1, 2004, TOPs are discontinued for all CMHCs and all hospitals except for rural hospitals having 100 or fewer beds, sole community hospitals (SCHs) which are located in rural areas, and cancer and children's hospitals. For CMHCs and hospitals for which TOPs will be discontinued, interim TOPs are to be paid for services furnished through December 31, 2003.

Hold harmless TOPs shall continue for services rendered through December 31, 2005, for rural hospitals having 100 or fewer beds. Cancer hospitals and children's hospitals are permanently held harmless. In addition, hold harmless TOPs are paid to sole community hospitals that are located in rural areas, with respect to services furnished during the period that begins with the provider's first cost reporting period beginning on or after January 1, 2004, and ends on December 31, 2005. **NOTE:** If a qualifying SCH has a cost reporting period that begins on a date other than January 1, TOPs and interim TOPs payments will not be paid for services furnished after December 31, 2003, and before the beginning of the provider's next cost reporting period. If a hospital qualifies as both a rural hospital having 100 or fewer beds and as a SCH located in a rural area, for purposes of § 70.4, the hospital will be treated as a rural hospital having 100 or fewer beds, thereby avoiding a gap in payment if the cost reporting period does not begin on January 1.

If the contractor identifies additional hospitals that are eligible for TOPs payments, the contractor shall make the appropriate interim payments retroactive to January 1, 2004, for small rural hospitals and retroactive to the provider's first day of the cost reporting period beginning on or after January 1, 2004 for rural SCHs having greater than 100 beds.

For 2004-2005, providers will receive interim TOPs payments of 85 percent, and will receive the additional 15 percent (to reach 100 percent) at cost report settlement.

Monthly TOPs calculations that contractors are required to calculate are described below. This calculation is effective for services provided between January 1, 2004, and December 31, 2005.

Step 1 – Compute the pre-BBA amount for each month by first multiplying the total charges for covered services for all OPPS services on claims paid during the month and reduce the total charges to cost by multiplying them by the outpatient cost-to-charge ratio and then multiplying this amount by the provider-specific payment-to-cost ratio (PSPCR).

Step 2 – Add together the total Medicare program payments, unreduced coinsurance and deductible applied for all APCs, as well as all outlier payments and transitional pass-through payments for drugs, biologicals and/or devices for those same claims paid during the month as those used in Step 1. If the result is greater than the result of step 1, go to step 4. No transitional payment is due this month.

Step 3 - If the hospital is a children's hospital, a small rural hospital with not more than 100 beds, a rural sole community hospital, or a cancer hospital, subtract the result of step 2 from the result of step 1 and pay .85 times this amount.

Step 4 - When the result of step 2 is greater than the result of step 1 for the final month of a provider's cost report period, do nothing more. When the result of step 2 is greater than the result of step 1 for any other month, store all step 1 and step 2 totals and include these totals with the totals for the next month's TOP calculation.

70.5 - Transitional Outpatient Payments (TOPs) for CY 2006-CY 2008

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

Hold harmless transitional outpatient payments (TOPs) to small rural hospitals and rural sole community hospitals were scheduled to expire December 31, 2005. Section 5105 of The Deficit Reduction Act (DRA) of 2005 reinstituted these hold harmless payments through December 31, 2008, for rural hospitals having 100 or fewer beds that are not sole community hospitals. Small rural hospitals will continue to receive TOPs payments through December 31, 2008. Sole community hospitals are no longer eligible for TOPs payments. Essential Access Community Hospitals (EACHs) are considered to be sole community hospitals under section 1886(d)(5)(D)(iii)(III) of the Act. Therefore, EACHs are not eligible for TOPs payments for CY 2006-CY 2008. If a hospital qualifies as both a small rural hospital and a rural SCH, for purposes of receiving TOPs and interim TOPs in §70.5, the hospital will be treated as a rural SCH. These providers are not eligible for TOPs for services furnished on or after January 1, 2006.

The DRA specifies that providers will receive 95 percent of the hold harmless amount during 2006, 90% of the hold harmless amount in 2007, and 85 percent of the hold harmless amount in 2008. Interim TOPs payments will continue at 85 percent, and the provider will continue to receive additional payments at cost report settlement, similar to past policy.

For 2006, providers will continue to receive interim TOPS payments of 85 percent and will receive the additional 10 percent (to reach 95 percent) at cost report settlement. For 2007, providers will receive the additional 5 percent (to reach 90 percent) at cost report settlement. For 2008, providers will not receive any additional money at cost report settlement.

Cancer and children's hospitals are permanently held harmless and will continue to receive TOPs payments in 2006 and beyond.

Monthly TOPs calculations that contractors are required to calculate are described below. This calculation is effective for services provided between January 1, 2006, and December 31, 2008.

Step 1 – Compute the pre-BBA amount for each month by first multiplying the total charges for covered services for all OPPS services on claims paid during the month and reduce the total charges to cost by multiplying them by the outpatient cost-to-charge ratio and then multiplying this amount by the provider-specific payment-to-cost ratio (PSPCR).

Step 2 – Add together the total Medicare program payments, unreduced coinsurance and deductible applied for all APCs, as well as all outlier payments and transitional pass-through payments for drugs, biologicals and/or devices for those same claims paid during the month as those used in Step 1. If the result is greater than the result of step 1, go to step 5~~9~~. No transitional payment is due this month.

Step 3 - If the hospital is a children's hospital, a small rural hospital that is not also a SCH, EACH, or a cancer hospital, go to step 4.

Step 4 - If the hospital is a children's hospital, a small rural hospital with not more than 100 beds or a cancer hospital, subtract the result of step 2 from the result of step 1 and pay .85 times this amount.

Step 5 - When the result of step 2 is greater than the result of step 1 for the final month of a provider's cost report period, do nothing more. When the result of step 2 is greater than the result of step 1 for any other month, store all step 1 and step 2 totals and include these totals with the totals for the next month's TOP calculation.

70.6 - Transitional Outpatient Payments (TOPs) for CY 2009

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

Hold harmless transitional outpatient payments (TOPs) to small rural hospitals and rural sole community hospitals that were scheduled to expire December 31, 2008. Section 147 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) extends the hold harmless provision for small rural hospitals with 100 or fewer beds through December 31, 2009, at 85 percent of the hold harmless amount. Section 147 also provides 85 percent of the hold harmless amount from January 1, 2009, through December 31, 2009, to sole community hospitals with 100 or fewer beds. Essential Access Community Hospitals (EACHs) are considered to be sole community hospitals under section 1886(d)(5)(D)(iii)(III) of the Act. Therefore, EACHs are also eligible for TOPs for CY 2009.

Cancer and children's hospitals are permanently held harmless and continue to receive TOPs payments in CY 2009.

Monthly TOPs calculations that contractors are required to calculate are described below. This calculation is effective for services provided between January 1, 2009, and December 31, 2009.

Step 1 – Compute the pre-BBA amount for each month by first multiplying the total charges for covered services for all OPPS services on claims paid during the month and reduce the total charges to cost by multiplying them by the outpatient cost-to-charge ratio and then multiplying this amount by the provider-specific payment-to-cost ratio (PSPCR).

Step 2 – Add together the total Medicare program payments, unreduced coinsurance and deductible applied for all APCs, as well as all outlier payments (including reconciled outlier payments and the time value of money) and transitional pass-through payments for drugs, biologicals and/or devices for those same claims paid during the month as those used in Step 1. If the result is greater than the result of step 1, go to step 4. No transitional payment is due this month.

Step 3 - If the hospital is a children's hospital, a cancer hospital, a rural hospital with 100 or fewer beds, or a sole community hospital (including EACHs) with 100 or fewer beds, subtract the result of step 2 from the result of step 1 and pay .85 times this amount. If the hospital is not one of the hospital types listed above, no payment is made.

Step 4 - When the result of step 2 is greater than the result of step 1 for the final month of a provider's cost report period, do nothing more. When the result of step 2 is greater than the result of step 1 for any other month, store all step 1 and step 2 totals and include these totals with the totals for the next month's TOP calculation.

70.7 - Transitional Outpatient Payments (TOPs) for CY 2010 through *CY* 2012

(Rev. 2531, 08-24-12, Effective:10-01-12, Implementation:10-01-12)

Hold harmless transitional outpatient payments (TOPs) to small rural hospitals and rural sole community hospitals were scheduled to expire December 31, 2009. Section 3121 of the Affordable Care Act extended the hold harmless provision for small rural hospitals with 100 or fewer beds through December 31, 2010, at 85 percent of the hold harmless amount. Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs) are no longer limited to those with 100 or fewer beds effective January 1, 2010 through December 31, 2010 and these providers will receive TOPs payments at 85 percent of the hold harmless amount until December 31, 2010. Section 108 of the Medicare and Medicaid Extenders Act of 2010 (MEA) further extended the hold harmless provision for rural hospitals with 100 or fewer beds and to all SCHs (and EACHs) regardless of bed size through December 31, 2011 at 85 percent of the hold harmless amount.

Section 308 of the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA) *as amended by section 3002 of the Middle Class Tax Relief and Jobs Creation Act,* extends the Outpatient Hold-Harmless provision, effective for dates of service on or after January 1, 2012, through *December 31*, 2012, to rural hospitals with 100 or fewer beds.

Section 308 of the Temporary Payroll Tax Cut Continuation Act of 2011 also extended through February 29, 2012 the hold harmless provision for SCHs (and EACHs) without the bed size limitation. However, section 3002 of the Middle Class Tax Relief and Jobs Creation Act extended through December 31, 2012, the hold harmless provision for SCHs (and EACHs) that have no more than 100 beds.

Cancer and children's hospitals are permanently held harmless under section 1833(t)(7)(D)(ii) of the Social Security Act.

Monthly TOPs calculations that contractors are required to calculate are described below. This calculation is effective for services provided *by SCH (and EACHs) with more than 100 beds* between January 1, 2010 and

February 29, 2012. *This calculation is effective for services provided by rural hospitals with 100 or fewer beds and SCHs (and EACHs) with 100 or fewer beds between January 1, 2010 and December 31, 2012.*

Step 1 – Compute the pre-BBA amount for each month by first multiplying the total charges for covered services for all OPPS services on claims paid during the month and reduce the total charges to cost by multiplying them by the outpatient cost-to-charge ratio and then multiplying this amount by the provider-specific payment-to-cost ratio (PSPCR).

Step 2 – Add together the total Medicare program payments, unreduced coinsurance and deductible applied for all APCs, as well as all outlier payments (including reconciled outlier payments and the time value of money) and transitional pass-through payments for drugs, biologicals and/or devices for those same claims paid during the month as those used in Step 1. If the result is greater than the result of step 1, go to step 4. No transitional payment is due this month.

Step 3 - If the hospital is a children's hospital, a rural hospital with 100 or fewer beds, or a sole community hospital (including EACHs), subtract the result of step 2 from the result of step 1 and pay .85 times this amount. If the hospital is not one of the hospital types listed above, no payment is made.

Step 4 - When the result of step 2 is greater than the result of step 1 for the final month of a provider's cost report period, do nothing more. When the result of step 2 is greater than the result of step 1 for any other month, store all step 1 and step 2 totals and include these totals with the totals for the next month's TOP calculation.

70.8 - TOPs Overpayments

(Rev. 2141, Issued: 01-24-11, Effective: 01-01-11, Implementation: 01-03-11)

Because the revised TOP calculations are often implemented in the system after their effective date, overpayments or underpayments in interim TOPs to providers are expected.

Unless directed by CMS, retroactive calculations of monthly interim TOP amounts are not necessary because any difference in interim TOP payments and actual TOP amounts determined on the cost report will be taken into account in the cost report settlement process, including tentative settlements.

If mutually agreed upon by both the contractor and the provider, the contractor can pay less than 85 percent of the monthly TOP payment to that provider, to avoid significant overpayments throughout the year that must be paid back to the contractor at cost report settlement.

Contractors should advise providers of the revised TOP calculations and other changes in OPPS using their normal communication protocols (Web site, regularly scheduled bulletins, electronic bulletin boards, or listserv).

80 - Shared system Requirements to Incorporate Provider-Specific Payment-to-Cost Ratios into the Calculation of Interim Transitional Outpatient Payments Under OPPS

(Rev. 1, 10-03-03)

A-01-44

80.1 - Background - Payment-to-Cost Ratios

(Rev. 1060, Issued: 09-18-06, Effective: 10-01-06, Implementation: 10-02-06)

Under regulations at 42 CFR 419.70, hospitals and community mental health centers (CMHCs) that are subject to the OPPS may be eligible to receive a transitional corridor payment, frequently referred to as a TOP. The purpose of the TOP is to restore some of the decrease in the payment that a provider may experience under the OPPS. Providers that are eligible for TOPs receive monthly interim payments. However, the final TOP amount is calculated based on the provider's settled cost report. Final TOP payments for a calendar year are based on the difference between what the provider was paid under the OPPS, and the provider's "pre-Balanced Budget Act (BBA) amount." The pre-BBA amount is an estimate of what the provider would have been paid during the calendar year for the same services under the system that was in effect prior to OPPS. If the pre-BBA amount exceeds the actual OPPS payments a provider received during a calendar year, qualifying cancer centers and children's hospitals are permanently held harmless, and will receive the entire amount of the difference between their OPPS payments and their pre-BBA amount. Other hospitals and CMHCs may receive a portion of the difference as a TOP, depending on the rules listed above.

The pre-BBA amount is calculated by multiplying the provider's PCR, based on the provider's base year cost report, times the reasonable costs the provider incurred during a calendar year to furnish the services that were paid under the OPPS. For most hospitals and CMHCs, the base year cost report used to calculate the payment-to-cost ratio is the cost report that ended during calendar year 1996. However, if a hospital or CMHC did not file a cost report that ended in calendar year 1996, the payment-to cost ratio will be calculated using the provider's first cost report that ended after calendar year 1996 and before calendar year 2001.

80.2 - Using the Newly Calculated PCR for Determining Final TOP Amounts

(Rev. 1, 10-03-03)

A-01-44

Final TOP amounts are determined for each calendar year, based on the calendar year or portion of a calendar year that falls within a provider's cost reporting period. The PCR is one factor used on Worksheet E, Part B, of the hospital cost report (Form CMS-2552 - 96), and Worksheet J-3 of the CMHC cost report (Form CMS-2088) in calculating the provider's final TOP amount.

Once calculated, the provider's PCR will be used to calculate the provider's pre- BBA amount for all calendar years for which the provider may be eligible for a TOP payment. The PCR will not change each year.

80.3 - Using the Newly Calculated PCR for Determining Interim TOPs

(Rev. 1060, Issued: 09-18-06, Effective: 10-01-06, Implementation: 10-02-06)

Providers that are eligible for TOPs receive monthly interim payments. Initially, the calculation of the monthly payment used a national uniform PCR of 80 percent for all providers. After FIs calculated a provider-specific PCR, no later than October 1, 2001, that PCR shall be used in calculating monthly interim payments to the provider. The shared systems maintainers will populate the PCR field of the Provider Specific File (formerly cost-of-living adjustment field) to reflect the provider-specific PCR.

The shared systems maintainers will revise the monthly TOPs calculation to use the provider-specific PCR, taken from the Provider Specific File, in lieu of the national PCR of 80 percent. If the value in the PCR

field in the Provider Specific File is blank (i.e., the FI has not yet calculated a provider-specific PCR), the FI must immediately calculate a provider-specific PCR and cannot continue to use the national PCR of 80 percent. The change to the provider-specific file and the change in the calculation of TOPs payments were effective on July 1, 2001.

90 - Discontinuation of Value Code 05 Reporting

(Rev. 1777; Issued: 07-24-09; Effective Date: 01-01-08; Implementation Date: 01-04-10)

Value code 05, "Professional Component Included in Charges and Also Billed Separately to Carrier," was discontinued with the implementation of OPPS, including claims for Critical Access Hospitals and other hospitals not subject to OPPS.

100 - Medicare Summary Notice (MSN)

(Rev. 1, 10-03-03)

Effective for claims with dates of service on or after August 1, 2000, FIs must modify the MSN for services provided by providers under OPPS to reflect the addition of an APC number. This APC number should be placed next to the HCPCS code included under the "Services Provided" column, and must be within a parenthesis. The coinsurance column should reflect the coinsurance amount for which the beneficiary is responsible.

In addition, the back of the notice must be modified. In place of the current language, the notice should reflect the following language:

> THE AMOUNT YOU MAY BE BILLED for Part B services includes:
>
> Annual deductible, the first $100 of Medicare Part B charges each year;
>
> After the deductible has been met for the year, depending on services received, a coinsurance amount (20 percent of the amount charged), or a fixed copayment for each service; and
>
> Charges for services or supplies that are not covered by Medicare. You may not have to pay for certain denied services. If so, a note on the front will tell you.

The Spanish version should read as follows:

> La cantidad por la cual usted podría ser facturado incluye:
>
> Un deducible anual, los primeros $100 de Medicare Parte B de cargos aprobados cada año, Después de que haya cumplido con el deducible, dependiendo de los servicios recibidos, un coaseguro (20% de la cantidad cobrada), o un copago fijo por cada servicio; y
>
> Cargos por servicios/suministros que no están cubiertos por Medicare. Es posible que usted no tenga que pagar por ciertos cargos se servicios denegados. De ser el caso, una NOTA en la parte del frente le indicará.

Also, FIs print the following message in the General Information Section:

> If the coinsurance amount you paid is more than the amount shown on your notice, you are entitled to a refund. Please contact your provider.

Spanish Version:

Si la cantidad de coaseguro que usted pagó es mayor que la cantidad que muestra su notificación, tiene derecho a un reembolso. Por favor comuníquese con su proveedor.

110 - Procedures for Submitting Late Charges Under OPPS

(Rev. 1, 10-03-03)

A-01-93

Hospitals and CMHCs may not submit a late charge bill (code 5 in the third position of the bill type) for bill types 12X, 13X, 14X, and 76X effective for claims with dates of service on or after August 1, 2000. They must submit an adjustment bill for any services required to be billed with HCPCS codes, units and line item dates of service. A "7" in the third position of the bill type indicates an adjustment. See Chapter 25 for additional instructions for reporting adjustments. Separate bills containing only late charges will not be permitted for these bill types.

The submission of an adjustment bill, instead of a late charge bill, will ensure proper duplicate detection, bundling, correct application of coverage policies and proper editing by OCE and payment under OPPS.

120 - General Rules for Reporting Outpatient Hospital Services

(Rev. 1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

Hospitals use the ANSI X12N 837 I or the hardcopy Form CMS-1450 UB-04 to bill for covered outpatient services (type of bill 13X or 83X, and 85X). See:

- Medicare Benefit Policy Manual, Chapter 6, for definition of an outpatient;
- Medicare Claims Processing Manual, Chapter 3, "Inpatient Part A Hospital Billing," for outpatient services treated as inpatient services; and
- Medicare Claims Processing Manual, Chapter 25, for general instructions for completing the ANSI X12N 837 I or the hardcopy Form CMS-1450 UB-04.

The HCPCS code is used to describe services where payment is under the Hospital OPPS or where payment is under a fee schedule or other outpatient payment methodology. Line item dates of service are reported for every line where a HCPCS code is required under OPPS. For providers paid via OPPS, FIs return to provider (RTP) bills where a line item date of service is not entered for each HCPCS code reported, or if the line item dates of service reported are outside of the statement-covers period. This includes those claims where the "from and through" dates are equal.

NOTE: Effective for dates of service on or after January 1, 2008, the FI no longer processes claims on TOB 83X for ASCs. All IHS ASC providers must submit their claims to the designated carrier.

120.1 - Bill Types Subject to OPPS

(Rev. 795, Issued: 12-30-05; Effective: 10-01-04; Implementation: 04-03-06)

The following bill types are subject to OPPS:

- All outpatient hospital Part B bills (bill types 12X, 13X with condition code 41 14X and 13X without condition code 41) with the exception of bills from hospitals in Maryland, Indian Health Service, CAHs, hospitals located in Saipan, American Samoa, the Virgin Islands and Guam; and hospitals that provide Part B only services to their inpatients. Effective 4/1/06 the 14X type of bill is for non-patient laboratory specimens and is no longer applicable for partial hospitalization billing.
- CMHC bills (bill type 76X);
- CORF claims for hepatitis B vaccines (bill type 75X);
- HHA claims for antigens, hepatitis B vaccines, splints and casts (bill type 34X); and
- For splints, casts and antigens when provided to hospice patients for treatment of a non-terminal illness by other than a hospital outpatient department. This requires reporting of condition code 07.

As a result, FIs shall instruct CORFs, HHAs, and other providers to report HCPCS for these services, in order to assure payment under this system. Payment will continue to be made for vaccines provide to hospice patients by the Medicare Part B carrier. The appropriate HCPCS codes are as follows:

Antigens	95144-95149, 95165, 95170, 95180, and 95199
Vaccines	90657-90659, 90732, 90744, 90746, 90747, 90748, G0008, G0009, and G0010
Splints	29105-29131, 29505-29515
Casts	29000-29085, 29305, 29325-29445, 29450, 29700-29750, 29799

NOTE: FIs shall advise their HHAs to report the above HCPCS codes with the exception of vaccines under Revenue Code 0550 (Skilled Nursing). The only time revenue code 0550 may be reported is when the HHA is billing for antigens, splints, or casts. See Chapter 18 for the reporting of vaccines by HCPCS codes.

120.2 - Routing of Claims

(Rev. 1, 10-03-03)

A-02-00-026

Effective April 1, 2002, the following types of bills (TOBs) should be rerouted back to the OPPS OCE:

22X	Skilled Nursing Facility (SNF) Inpatient Part B
23X	SNF/Outpatient
24X	SNF Part B
32X	Home Health Agency (HHA) visits under a Part B Plan of Treatment (POT)
33X	HHA visits under a Part A (POT)
34X	HHA visits under a POT
71X	Rural Health Clinic

72X Hospital Based or Independent Renal Dialysis Center

73X Federally Qualified Health Center

74X Other Rehabilitation Facilities

75X Comprehensive Outpatient Rehabilitation Facility (CORF)

81X Hospice (non-hospital based)

82X Hospice (hospital based)

Claims containing the above TOBs, other than 32X and 33X, with services that span beyond April 1, 2001, must be split prior to their submittal. For example, if a claim contains services prior to and after April 1, 2002, the provider must submit two separate claims. One for the services prior to April 1, 2002, which will be routed to the non-OPPS OCE and another claim for the services April and later which will be routed to the OPPS OCE. In the event the FI receives a claim containing pre- and post-April 1, 2002, dates of service, return it to the provider requesting that the claim be split as indicated above.

Claims containing the above TOBs with dates of service January 1, 2002, through March 31, 2002, should continue to be routed through the non-OPPS OCE.

NOTE: TOBs (12X, 13X, 14X, and 85X) from Critical Access Hospitals, Maryland Hospitals, Indian Health Service Hospitals, U.S. Virgin Island Hospitals, and those hospitals located in the Pacific (American Samoa, Guam, and Saipan) do not have to be rerouted since they are sent through the non-OPPS OCE.

140 - All-Inclusive Rate Hospitals

(Rev. 1, 10-03-03)
A-01-93, A-03-066

All-inclusive rate hospitals are required to code with HCPCS the outpatient services they provide and bill charges at the HCPCS level. In addition, they are required to follow bill reporting instructions contained in §30. Unlike other hospitals, all-inclusive rate hospitals do not have outpatient departmental cost-to-charge ratios from prior year cost reports that may be used for calculating outlier payments, device pass-through payments, or interim transitional corridor payments. As a result, FIs use the statewide average urban or rural outpatient cost-to-charge ratio, as appropriate, for all-inclusive rate hospitals. In the future, once cost and charge data for an all-inclusive rate hospital is available, the FI will be able to apply a cost-to-charge ratio that is specific to the hospital.

141 – Maryland Waiver Hospitals

(Rev. 771; Issued: 12-02-05; Effective Date: 01-03-06; Implementation Date: 01-03-06)

In accordance with §1814 (b)(3) of the Act, services provided by hospitals in Maryland subject to the Health Services Cost Review Commission are paid according to the terms of the waiver, that is 94% of submitted charges subject to any unmet Part B deductible and coinsurance. Payment should not be made under a fee schedule or other payment method for outpatient items and services provided except the following situations:

- Non-patient laboratory specimens are paid under the clinical diagnostic laboratory fee schedule (bill type 14X); and

Ambulance services which are subject to the ambulance fee schedule.

150 - Hospitals That Do Not Provide Outpatient Services

(Rev. 1, 10-03-03)
HO-440.1, A-00-21, A-02-064

Covered Part B-only services furnished to inpatients when they are furnished by a hospital that does no Medicare billing for hospital outpatients services under Part B are excluded from OPPS. The Part B-only services, which are payable for hospital inpatients who have either exhausted their Part A benefits or who are not entitled to Part A benefits, are specified in Chapter 3. These services include, but are not limited to, diagnostic tests; x-ray and radioactive isotope therapy; surgical dressings; limb braces and trusses; and artificial limbs and eyes. Medicare payment for excluded Part B-only services furnished by these hospitals is determined using the method under which the hospital was paid prior to OPPS.

Hospitals must notify their FI if they do not submit claims for outpatient Part B services, so that their claims can be excluded from the OPPS. The hospital must also notify the FI if it begins to furnish Part B outpatient services. OPPS will apply at that time unless other exclusions are applicable.

160 - Clinic and Emergency Visits

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

CMS has acknowledged from the beginning of the OPPS that CMS believes that CPT Evaluation and Management (E/M) codes were designed to reflect the activities of physicians and do not describe well the range and mix of services provided by hospitals during visits of clinic and emergency department patients. While awaiting the development of a national set of facility-specific codes and guidelines, providers should continue to apply their current internal guidelines to the existing CPT codes. Each hospital's internal guidelines should follow the intent of the CPT code descriptors, in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the codes. Hospitals should ensure that their guidelines accurately reflect resource distinctions between the five levels of codes.

Effective January 1, 2007, CMS is distinguishing between two types of emergency departments: Type A emergency departments and Type B emergency departments.

A Type A emergency department is defined as an emergency department that is available 24 hours a day, 7 days a week and is either licensed by the State in which it is located under applicable State law as an emergency room or emergency department or it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

A Type B emergency department is defined as an emergency department that meets the definition of a "dedicated emergency department" as defined in 42 CFR 489.24 under the EMTALA regulations. It must meet at least one of the following requirements:

(1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;

(2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or

(3) During the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

Hospitals must bill for visits provided in Type A emergency departments using CPT emergency department E/M codes. Hospitals must bill for visits provided in Type B emergency departments using the G-codes that describe visits provided in Type B emergency departments.

Hospitals that will be billing the new Type B ED visit codes may need to update their internal guidelines to report these codes.

Emergency department and clinic visits are paid in some cases separately and in other cases as part of a composite APC payment. See section 10.2.1 of this chapter for further details.

160.1 - Critical Care Services

(Rev. 2141, Issued: 01-24-11, Effective: 01-01-11, Implementation: 01-03-11)

Hospitals should separately report all HCPCS codes in accordance with correct coding principles, CPT code descriptions, and any additional CMS guidance, when available. Specifically with respect to CPT code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes), hospitals must follow the CPT instructions related to reporting that CPT code. Prior to January 1, 2011, any services that CPT indicates are included in the reporting of CPT code 99291 (including those services that would otherwise be reported by and paid to hospitals using any of the CPT codes specified by CPT) should not be billed separately by the hospital. Instead, hospitals should report charges for any services provided as part of the critical care services. In establishing payment rates for critical care services, and other services, CMS packages the costs of certain items and services separately reported by HCPCS codes into payment for critical care services and other services, according to the standard OPPS methodology for packaging costs.

Beginning January 1, 2011, in accordance with revised CPT guidance, hospitals that report in accordance with the CPT guidelines will begin reporting all of the ancillary services and their associated charges separately when they are provided in conjunction with critical care. CMS will continue to recognize the existing CPT codes for critical care services and will establish payment rates based on historical data, into which the cost of the ancillary services is intrinsically packaged. The I/OCE conditionally packages payment for the ancillary services that are reported on the same date of service as critical care services in order to avoid overpayment. The payment status of the ancillary services does not change when they are not

provided in conjunction with critical care services. Hospitals may use HCPCS modifier -59 to indicate when an ancillary procedure or service is distinct or independent from critical care when performed on the same day but in a different encounter.

Beginning January 1, 2007, critical care services will be paid at two levels, depending on the presence or absence of trauma activation. Providers will receive one payment rate for critical care without trauma activation and will receive additional payment when critical care is associated with trauma activation.

To determine whether trauma activation occurs, follow the National Uniform Billing Committee (NUBC) guidelines in the Claims Processing Manual, Pub 100-04, Chapter 25, §75.4 related to the reporting of the trauma revenue codes in the 68x series. The revenue code series 68x can be used only by trauma centers/hospitals as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons. Different subcategory revenue codes are reported by designated Level 1-4 hospital trauma centers. Only patients for whom there has been prehospital notification based on triage information from prehospital caregivers, who meet either local, state or American College of Surgeons field triage criteria, or are delivered by inter-hospital transfers, and are given the appropriate team response can be billed a trauma activation charge.

When critical care services are provided without trauma activation, the hospital may bill CPT code 99291, Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes (and 99292, if appropriate). If trauma activation occurs under the circumstances described by the NUBC guidelines that would permit reporting a charge under 68x, the hospital may also bill one unit of code G0390, which describes trauma activation associated with hospital critical care services. Revenue code 68x must be reported on the same date of service. The OCE will edit to ensure that G0390 appears with revenue code 68x on the same date of service and that only one unit of G0390 is billed. CMS believes that trauma activation is a one-time occurrence in association with critical care services, and therefore, CMS will only pay for one unit of G0390 per day.

The CPT code 99291 is defined by CPT as the first 30-74 minutes of critical care. This 30 minute minimum has always applied under the OPPS. The CPT code 99292, Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes, remains a packaged service under the OPPS, so that hospitals do not have the ongoing administrative burden of reporting precisely the time for each critical service provided. As the CPT guidelines indicate, hospitals that provide less than 30 minutes of critical care should bill for a visit, typically an emergency department visit, at a level consistent with their own internal guidelines.

Under the OPPS, the time that can be reported as critical care is the time spent by a physician and/or hospital staff engaged in active face-to-face critical care of a critically ill or critically injured patient. If the physician and hospital staff or multiple hospital staff members are simultaneously engaged in this active face-to-face care, the time involved can only be counted once.

- Beginning in CY 2007 hospitals may continue to report a charge with RC 68x without any HCPCS code when trauma team activation occurs. In order to receive additional payment when critical care services are associated with trauma activation, the hospital must report G0390 on the same date of service as RC 68x, in addition to CPT code 99291 (or 99292, if appropriate.)

- Beginning in CY 2007 hospitals should continue to report 99291 (and 99292 as appropriate) for critical care services furnished without trauma team activation. CPT 99291 maps to APC 0617 (Critical Care). (CPT 99292 is packaged and not paid separately, but should be reported if provided.)

Critical care services are paid in some cases separately and in other cases as part of a composite APC payment. See Section 10.2.1 of this chapter for further details.

Future updates will be issued in a Recurring Update Notification.

170 - Hospital and CMHC Reporting Requirements for Services Performed on the Same Day

(Rev. 763, Issued: 11-25-05, Effective/Implementation Dates: N/A)

When reporting a HCPCS code for a separately payable, non-repetitive hospital OPPS service, report charges for all services and supplies associated with that service, that were furnished on the same date (services subject to the 3-day payment window are an exception to this OPPS policy).

When a hospital provides electroconvulsive therapy (ECT) on the same day as partial hospitalization services, both the ECT and partial hospitalization services should be reported on the same hospital claim. In this instance, the claim should contain condition code 41. As noted above, report charges for all services and supplies associated with the ECT service, which were furnished on the same date(s) on the same claim.

NOTE: For a list of revenue codes that are considered repetitive services, see Chapter 1, §50.2.2.

EXAMPLE 1

If a patient receives a laboratory service on May 1st and has an emergency room (ER) visit on the same day, one bill may be submitted since the laboratory service is paid under the clinical diagnostic laboratory fee schedule and not subject to OPPS. In this situation, the laboratory service was not related to the ER visit or done in conjunction with the ER visit.

EXAMPLE 2

If the patient receives physical therapy on July 7th, 29th, and 30th, and receives services in the ER on July 28th, the provider shall submit separate claims since the isolated individual service (ER visit) did not occur on the same day as the repetitive service (physical therapy).

EXAMPLE 3

If a patient has an ER visit (OPPS service) on May 15th and also receives a physical therapy visit (repetitive, non-OPPS service) on the same day (as well as other physical therapy visits provided May 1st through May 31st) the services shall be billed on separate claims. The provider would bill the ER service on one claim and the therapy services on the monthly repetitive claim. Please note, as stated above, the procedures for billing repetitive services remains in effect under OPPS. Therefore, in this example, it would not be appropriate to submit one therapy claim for services provided May 1st through May 15th, a second claim for the ER visit provided on May 15th, and a third claim for therapy visits provided on May 16th

through May 31st. Providers shall not split repetitive services in mid-month when another outpatient service occurs.

EXAMPLE 4

If a patient receives chemotherapy, or radiation therapy, clinical laboratory services, a CT scan and an outpatient consultation on the same date of service, the hospital may report all services on the same claim or may submit multiple claims. Chemotherapy, while commonly administered in multiple encounters across a span of time, is not a repetitive service as defined in Chapter 1, Section 50.2.2. The clinical laboratory services may be reported either on the single consolidated claim or on a separate claim that reports the services furnished on the same date as the laboratory services.

180 - Accurate Reporting of Surgical and Medical Procedures and Services

(Rev. 1109, Issued: 11-09-06, Effective: 10-01-05, Implementation: 04-02-07)

180.1 - General Rules

(Rev. 1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

Hospitals subject to OPPS are required, beginning with claims with dates of service on or after August 1, 2000, to report in Form Locator 6 "Statement Covers Period From Date" the earliest date that services were rendered. As a result, preoperative laboratory services will always have a line item date of service within the "from and through" dates on the claim.

Indian Health Service hospitals continue to bill for surgeries utilizing bill type 83X. For other hospitals outpatient surgery subject to the ASC payment limit with dates of service prior to August 1, 2000, is reported on bill type 83X, and surgeries performed August 1, 2000 and later are reported with bill type 13X.

NOTE: Effective for dates of service on or after January 1, 2008, the FI no longer processes claims on TOB 83X for ASCs. All IHS ASC providers must submit their claims to the designated carrier.

180.2 - Selecting and Reporting Procedure Codes

(Rev. 1, 10-03-03)
A-01-50, A3-3626.4.B.3

Using medical records as basic sources, hospitals report HCPCS surgical procedure codes for outpatient surgery in FL 44 adjacent to the revenue code for the operating room or other room used for the surgery. The bill includes the hospital's charges for the surgery as well as all other services provided on the day the procedure was performed.

When multiple surgical procedures are performed at the same session, it is not necessary to bill separate charges for each procedure. It is acceptable to bill a single charge under the revenue code that describes where the procedure was performed (e.g., operating room, treatment room, etc.) on the same line as one of the surgical procedure CPT/HCPCS codes and bill the other procedures using the appropriate CPT/HCPCS code and the same revenue code, but with "0" charges in the charge field.

In the past, some hospitals billed a single emergency room (ER) visit charge, which included charges for any surgical procedures that were performed in the ER at the time of the ER visit. Under the OPPS, CMS requires hospitals to bill a separate charge for ER visits and surgical procedures effective with claims with dates of service on or after July 1, 2001. If a surgical procedure is performed in the ER, the charge for the procedure must be billed with the emergency room revenue code. If an ER visit occurs on the same day, a charge should be billed for the ER visit and a separate charge should be billed for the surgical procedure(s) performed. As described above, a single charge may be billed for all surgical procedures if more than one is performed in the ER during the same session.

EXAMPLE: The following is an example of how a claim should be completed under these reporting requirements:

Date of Service	**Revenue Code**	**HCPCS**	**Modifier**	**Charges**
7/5/2001	0450	99283	25	$150
7/5/2001	0450	12011		$300
7/5/2001	0450	12035		
7/5/2001	0250			$70
7/5/2001	0270			$85

The charge for both surgical procedures in this example is reflected in the $300 charge shown on the line with procedure code 12011.

180.3 - Unlisted Service or Procedure

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

An unlisted HCPCS code represents an item, service, or procedure for which there is no specific CPT or Level II alphanumeric HCPCS code. The CPT code book lists a number of unlisted service or procedure codes, which can be found at the end of a section or subsection. Alternatively, a summary list of the unlisted CPT codes can be found in the Guidelines section for each chapter of the CPT code book. The long descriptors for these codes start with the term “Unlisted” and the last 2 digits of the codes often end in “99.”

Under the OPPS, CMS generally assigns the unlisted service or procedure codes to the lowest level APC within the most appropriate clinically related series of APCs. Payment for items reported with unlisted codes is often packaged.

For non-OPPS payment purposes, when an unlisted service or procedure code is reported, a report describing the service or procedure shall be submitted with the claim. Pertinent information includes a definition or description of the nature, extent, and need for the procedure or service, as well as the provider’s time, effort, and equipment necessary to provide the service.

When a Medicare contractor receives a claim with an unlisted HCPCS code for non-OPPS payment, the contractor shall verify that no existing HCPCS code adequately describes the procedure or service. Unlisted codes should be reported only if no other specific HCPCS codes adequately describe the procedure or service. If an unlisted code is submitted on a claim and the contractor has verified that the code submitted is correct, the contractor pays the claim using the unlisted code, based on the applicable non-OPPS payment methodology. However, if it is determined that an unlisted code was submitted in error because the procedure or service is described by a specific HCPCS code, the contractor shall advise the hospital or CAH of the appropriate code and process the claim. If a procedure or service reported with an unlisted code is reported frequently, the contractor shall advise the provider that a request for a specific CPT code or alphanumeric HCPCS code should be made.

The latest list of "Unlisted" CPT codes for procedures and services can be found at http://www.cms.hhs.gov/HospitalOutpatientPPS/. Medicare contractors shall review this list once a year since it is updated annually on or about January 1 of the calendar year.

Future updates will be issued in a Recurring Update Notification.

180.4 - Proper Reporting of Condition Code G0 (Zero)
(Rev. 1, 10-03-03)

Hospitals subject to OPPS report Condition Code G0 on FLs 24-30 (or the corresponding electronic location) when multiple medical visits occurred on the same day in the same revenue center but the visits were distinct and constituted independent visits. An example of such a situation would be a beneficiary going to the emergency room twice on the same day, in the morning for a broken arm and later for chest pain.

Multiple medical visits on the same day in the same revenue center may be submitted on separate claims. Hospitals should report condition code G0 on the second claim. Appropriate reporting of Condition Code G0 allows for accurate payment under OPPS in this situation. The OCE contains an edit that will reject multiple medical visits on the same day with the same revenue code without the presence of Condition Code G0.

To further illustrate, the following table describes actions the OCE takes when multiple medical visits occur on the same day in the same revenue code center:

Evaluation and Management (E&M)	**Revenue Center**	**Condition Code**	**OCE Action**
2 or more	Two or more E&M codes have the same revenue center	No G0	Assign medical APC to each line item with E&M code and deny all line items with E&M code except the line item with the highest APC payment
2 or more	Two or more E&M codes have the same revenue center	G0	Assign medical APC to each line item with E&M code.

180.5 - Proper Reporting of Condition Codes 20 and 21
(Rev. 1, 10-03-03)

Hospitals and CMHCs report condition codes 20 and 21 when they realize the services are excluded from coverage but:

- The beneficiary has requested a formal determination (condition code 20) (claim may contain both covered and noncovered charges); or

- The provider is requesting a denial notice from Medicare to bill Medicaid or other insurers (condition code 21).

The FIs advise hospitals and CMHCs when billing condition code 21 that a separate claim must be submitted. Claims with condition code 21 must be submitted with all noncovered charges.

180.6 – Emergency Room (ER) Services That Span Multiple Service Dates
(Rev. 2361, Issued: 11-25-11, Effective: 01-01-12 and 04-01-12, Implementation; 04-02-12)

Emergency room (ER) services provided by hospital outpatient departments (OPPS & Non-OPPS) should be billed in the following manner:

- Emergency room services are reported under the 045x revenue code

- The line item date of service for the ER encounter is the date the patient entered the ER even if the patients encounter spans multiple service dates

- For all other services related to the ER encounter (i.e., lab, radiology, etc) the line item date of service reported is the date the service was actually rendered

Note: For patients in a Skilled Nursing Facility (SNF) see Chapter 6, Section 20.1.2.2 "Emergency Services" for special billing instructions using the ET modifier. Chapter 6, Section 20.1.2.2 applies to hospital ER services spanning multiple service dates that are provided to patients in a Part A SNF stay and related CWF SNF consolidated billing edits.

For patients with end stage renal disease (ESRD) see Chapter 8, Section 50.1.6 for billing instructions requiring the use of the ET modifier. Chapter 8, Section 50.1.6 applies to hospital ER services spanning multiple service dates including laboratory services.

180.7 - Inpatient-only Services
(Rev. 2483, Issued: 06-08-12, Effective: 07-01-12, Implementation: 07-02-12)

Section 1833(t)(1)(B)(i) of the Act allows CMS to define the services for which payment under the OPPS is appropriate and the Secretary has determined that the services designated to be "inpatient only" services are not appropriate to be furnished in a hospital outpatient department. "Inpatient only" services are generally, but not always, surgical services that require inpatient care because of the nature of the procedure, the

typical underlying physical condition of patients who require the service, or the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged. An example of an "inpatient only" service is CPT code 33513, "Coronary artery bypass, vein only; four coronary venous grafts." The designation of services to be "inpatient-only" is open to public comment each year as part of the annual rulemaking process. Procedures removed from the "inpatient only" list may be appropriately furnished in either the inpatient or outpatient settings and such procedures continue to be payable when furnished in the inpatient setting.

There is no payment under the OPPS for services that CMS designates to be "inpatient-only" services. These services have an OPPS status indicator of "C" in the OPPS Addendum B and are listed together in Addendum E of each year's OPPS/ASC final rule. For the most current Addendum B and for Addendum E published with the OPPS notices and regulations, see http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html.

Excluding the handful of exceptions discussed below, CMS does not pay for an "inpatient-only" service furnished to a person who is registered in the hospital as an outpatient and reports the service on the outpatient hospital bill type (TOB 13X). CMS also does not pay for all other services on the same day as the "inpatient only" procedure.

There are two exceptions to the policy of not paying for outpatient services furnished on the same day with an "inpatient-only" service that would be paid under the OPPS if the inpatient service had not been furnished:

Exception 1: If the "inpatient-only" service is defined in CPT to be a "separate procedure" and the other services billed with the "inpatient-only" service contain a procedure that can be paid under the OPPS and that has an OPPS SI=T on the same date as the "inpatient-only" procedure, then the "inpatient-only" service is denied but CMS makes payment for the separate procedure and any remaining payable OPPS services. The list of "separate procedures" is available with the Integrated Outpatient Code Editor (I/OCE) documentation. See http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/.

Exception 2: If an "inpatient-only" service is furnished but the patient expires before inpatient admission or transfer to another hospital and the hospital reports the "inpatient only" service with modifier "CA", then CMS makes a single payment for all services provided on that day, including the "inpatient only" procedure, through one unit of APC 0375, (Ancillary outpatient services when the patient expires.) Hospitals should report modifier CA on only one procedure.

As stated in §10.12, inpatient only procedures that are provided to a patient in the outpatient setting during the 3 calendar days (or 1 calendar day for a non-subsection (d) hospital) preceding the date of the inpatient admission that would otherwise be deemed related to the admission are not paid for by CMS and must be submitted on a no-pay claim (Type of Bill (TOB) 110). If there are covered services/procedures provided during the same stay as the non- covered inpatient only procedure (see the two exceptions stated above), hospitals are then required to submit two claims:

- One claim with covered service(s)/procedure(s) on a TOB 11X (with the exception of 110), and,
- The other claim with the non-covered service(s)/procedure(s) on a TOB 110 (no-pay claim).

NOTE: Both the covered and non-covered claim must have a matching Statement Covers Period.

200 - Special Services for OPPS Billing

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

200.1 - Billing for Corneal Tissue

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

Corneal tissue will be paid on a cost basis, not under OPPS. To receive cost based reimbursement hospitals must bill charges for corneal tissue using HCPCS code V2785.

200.2 - Hospital *Dialysis* Services For Patients *With and Without* End Stage Renal Disease (ESRD)

(Rev. 2455, Issued: 04-26-12, Effective: 10-01-12, Implementation; 10-01-12)

Effective with claims with dates of service on or after August 1, 2000, hospital-based *End Stage Renal Disease (*ESRD*)* facilities must submit *services covered under the ESRD benefit in 42 CFR 413.174 (maintenance* dialysis and those items and services directly related to dialysis *such as* drugs, supplies) on a separate claim from services not *covered under the ESRD benefit*. Items and services not *covered under the ESRD benefit* must be billed by the hospital using the hospital bill type *and be paid under the Outpatient Prospective Payment System (OPPS) (or to a CAH at reasonable cost)*. *Services covered under the* ESRD *benefit in 42 CFR 413.174 must be billed on* the ESRD bill type *and must be paid under the ESRD PPS*. This requirement is necessary to properly pay *only* unrelated ESRD services *(those not covered under the ESRD benefit)* under OPPS *(or to a CAH at reasonable cost)*.

Medicare does not allow payment for routine *or related* dialysis treatments*, which are covered and paid under the ESRD PPS, when* furnished to ESRD patients in the outpatient department of a hospital. However, in certain medical situations in which the ESRD *out*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 *(which are not covered under the ESRD benefit)* furnished to ESRD *out*patients in the outpatient department of a hospital. Payment *for* unscheduled dialysis f*urnished to* ESRD *out*patients *and paid under the OPPS is limited to* 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 *the* Healthcare Common Procedure Coding System (HCPCS) code G0257 (Unscheduled or emergency *dialysis* treatment for an ESRD patient in a *hospital* outpatient department *that is not certified as an* ESRD facility).

HCPCS code G0257 may only be reported on type of bill 13X (hospital outpatient service) or type of bill 85X (critical access hospital) because HCPCS code G0257 only reports services for hospital outpatients with ESRD and only these bill types are used to report services to hospital outpatients. Effective for services on and after October 1, 2012, claims containing HCPCS code G0257 will be returned to the provider for correction if G0257 is reported with a type of bill other than 13X or 85X (such as a 12x inpatient claim).

HCPCS code 90935 (Hemodialysis procedure with single physician evaluation) may be reported and paid only if one of the following two conditions is met:

1) *The patient is a hospital inpatient with or without ESRD and has no coverage under Part A, but has Part B coverage. The charge for hemodialysis is a charge for the use of a prosthetic device. See Benefits Policy Manual 100-02 Chapter 15 section 120. A. The service must be reported on a type of bill 12X or type of bill 85X. See the Benefits Policy Manual 100-02 Chapter 6 section 10 (Medical and Other Health Services Furnished to Inpatients of Participating Hospitals) for the criteria that must be met for services to be paid when a hospital inpatient has Part B coverage but does not have coverage under Part A; or*

2) *A hospital outpatient does not have ESRD and is receiving hemodialysis in the hospital outpatient department. The service is reported on a type of bill 13X or type of bill 85X.*

CPT code 90945 (Dialysis procedure other than hemodialysis (e.g. peritoneal dialysis, hemofiltration, or other continuous replacement therapies)), with single physician evaluation, may be reported by a hospital paid under the OPPS or CAH method I or method II on type of bill 12X, 13X or 85X.

200.3 - Billing Codes for Intensity Modulated Radiation Therapy (IMRT) and Stereotactic Radiosurgery (SRS)

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

200.3.1 - Billing for IMRT Planning and Delivery

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

Effective for services furnished on or after April 1, 2002, HCPCS codes G0174 (IMRT delivery) and G0178 (IMRT planning) are no longer valid codes. HCPCS code G0174 has been replaced with CPT codes 77418 and 0073T for IMRT delivery and HCPCS code G0178 with CPT code 77301. Therefore, hospitals must use CPT codes 77418 or 0073T for IMRT delivery and CPT code 77301 for IMRT planning. Any of the CPT codes 77401 through 77416 or 77418 may be reported on the same day as long as the services are furnished at separate treatment sessions. In these cases, modifier -59 must be appended to the appropriate codes. Additionally, in the context of billing 77301, regardless of the same or different dates of service, CPT codes 77014, 77280-77295, 77305-77321, 77331, 77336, and 77370 may only be billed in addition to 77301 if they are not provided as part of developing the IMRT treatment plan.

77301	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications
77418	Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session
0073T	Compensator-based beam modulation treatment delivery of inverse planned treatment using three or more high resolution (milled or cast) compensator convergent beam modulated fields, per treatment session

200.3.2 - Additional Billing Instructions for IMRT Planning

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

Payment for the services identified by CPT codes 77014, 77280-77295, 77305-77321, 77331, 77336, and 77370 is included in the APC payment for IMRT planning when these services are performed as part of developing an IMRT plan that is reported using CPT code 77301. Under those circumstances, these codes should not be billed in addition to CPT code 77301 for IMRT planning.

200.3.3 - Billing for Multi-Source Photon (Cobalt 60-Based) Stereotactic Radiosurgery (SRS) Planning and Delivery

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

Effective for services furnished on or after January 1, 2006, hospitals must bill for multi-source photon (cobalt 60-based) SRS planning using existing CPT codes that most accurately describe the service furnished, and HCPCS code G0243 for the delivery. For CY 2007, HCPCS code G0243 is no longer be reportable under the hospital OPPS because the code has been deleted and replaced with CPT code 77371, effective January 1, 2007.

77371	Radiation treatment delivery, stereotactic radiosurgery (SRS) (complete course of treatment of cerebral lesion[s] consisting of 1 session); multi-source Cobalt 60 based.

Payment for CPT code 20660 is included in CPT code 77371; therefore, hospitals should not report 20660 separately.

200.3.4 - Billing for Linear Accelerator (Robotic Image-Guided and Non-Robotic Image-Guided) SRS Planning and Delivery

(Rev. 2234, Issued: 05-27-11, Effective: 07-01-11, Implementation: 07-05-11)

Effective for services furnished on or after January 1, 2006, hospitals must bill using existing CPT codes that most accurately describe the service furnished for both robotic and non-robotic image-guided SRS planning. For robotic image-guided SRS delivery, hospitals must bill using HCPCS code G0339 for the first session and HCPCS code G0340 for the second through the fifth sessions. For non-robotic image-guided SRS delivery, hospitals must bill G0173 for delivery if the delivery occurs in one session, and G0251 for delivery per session (not to exceed five sessions) if delivery occurs during multiple sessions.

Linear Accelerator-Based Robotic Image-Guided SRS	
Planning	Use existing CPT codes
Delivery	G0339 (complete, 1st session) G0340 (2nd – 5th session)

Linear Accelerator-Based Non-Robotic Image-Guided SRS	
Planning	Use existing CPT codes
Delivery	G0173 (single session) G0251 (multiple)

HCPCS Code	Long Descriptors
G0173	Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, complete course of treatment in one session, all lesions.
G0251	Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum 5 sessions per course of treatment.
G0339	Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment.
G0340	Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment.

200.4 - Billing for Amniotic Membrane

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

Hospitals should report HCPCS code V2790 (Amniotic membrane for surgical reconstruction, per procedure) to report amniotic membrane tissue when the tissue is used. A specific procedure code associated with use of amniotic membrane tissue is CPT code 65780 (Ocular surface reconstruction; amniotic membrane transplantation). Payment for the amniotic membrane tissue is packaged into payment for CPT code 65780 or other procedures with which the amniotic membrane is used.

200.5 - Reserved

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

200.6 - Billing and Payment for Alcohol and/or Substance Abuse Assessment and Intervention Services

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

For CY 2008, the CPT Editorial Panel has created two new Category I CPT codes for reporting alcohol and/or substance abuse screening and intervention services. They are CPT code 99408 (Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes); and CPT code 99409 (Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes). However, screening services are not covered by Medicare without specific statutory authority, such as has been provided for mammography, diabetes, and colorectal cancer screening. Therefore, beginning January 1, 2008, the OPPS recognizes two parallel G-codes (HCPCS codes G0396 and G0397) to allow for appropriate reporting and payment of alcohol and substance abuse structured assessment and intervention services that are not provided as screening services, but that are performed in the context of the diagnosis or treatment of illness or injury.

Contractors shall make payment under the OPPS for HCPCS code G0396 (Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST) and brief intervention, 15 to 30 minutes) and HCPCS code G0397, (Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST) and intervention greater than 30 minutes), only when reasonable and necessary (i.e., when the service is provided to evaluate patients with signs/symptoms of illness or injury) as per section 1862(a)(1)(A) of the Act.

HCPCS codes G0396 and G0397 are to be used for structured alcohol and/or substance (other than tobacco) abuse assessment and intervention services that are distinct from other clinic and emergency department visit services performed during the same encounter. Hospital resources expended performing services described by HCPCS codes G0396 and G0397 may not be counted as resources for determining the level of a visit service and vice versa (i.e., hospitals may not double count the same facility resources in order to reach a higher level clinic or emergency department visit). However, alcohol and/or substance structured assessment or intervention services lasting less than 15 minutes should not be reported using these HCPCS codes, but the hospital resources expended should be included in determining the level of the visit service reported.

200.7 - Billing for Cardiac Echocardiography Services

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

200.7.1 - Cardiac Echocardiography Without Contrast

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

Hospitals are instructed to bill for echocardiograms without contrast in accordance with the CPT code descriptors and guidelines associated with the applicable Level I CPT code(s) (93303-93350).

200.7.2 - Cardiac Echocardiography With Contrast

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

Hospitals are instructed to bill for echocardiograms with contrast using the applicable HCPCS code(s) included in Table 200.7.2 below. Hospitals should also report the appropriate units of the HCPCS codes for the contrast agents used in the performance of the echocardiograms.

Table 200.7.2 – HCPCS Codes For Echocardiograms With Contrast

HCPCS	Long Descriptor
C8921	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; complete
C8922	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; follow-up or limited study
C8923	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography
C8924	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study
C8925	Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report
C8926	Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
C8927	Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis
C8928	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, during rest

	and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report
C8929	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography
C8930	Transthoracic echocardiography, with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision

200.8 - Billing for Nuclear Medicine Procedures

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

Beginning January 1, 2008, the I/OCE began editing for the presence of a radiolabeled product when a separately payable nuclear medicine procedure is present on a claim. Hospitals should include radiolabeled product HCPCS codes on the same claim as a nuclear medicine procedure beginning on January 1, 2008.

Hospitals are required to submit the HCPCS code for the radiolabeled product on the same claim as the HCPCS code for the nuclear medicine procedure. Hospitals are also instructed to submit the claim so that the services on the claim each reflect the date the particular service was provided. Therefore, if the nuclear medicine procedure is provided on a different date of service from the radiolabeled product, the claim will contain more than one date of service. More information regarding these edits is available on the OPPS Web site at http://www.cms.hhs.gov/HospitalOutpatientPPS/.

Hospitals are instructed to use HCPCS code C9898 (Radiolabeled product provided during a hospital inpatient stay) on outpatient claims for nuclear medicine procedures to indicate that a radiolabeled product that provides the radioactivity necessary for the reported diagnostic nuclear medicine procedure was provided during a hospital inpatient stay. This HCPCS code is assigned status indicator "N" because no separate payment is made for the code under the OPPS. The effective date of the code is January 1, 2008, the date the nuclear medicine procedure-to-radiolabeled product edits were initially implemented. Because the Medicare claims processing system requires that there be a charge for each HCPCS code reported on the claim, hospitals should always report a token charge of less than $1.01 for HCPCS code C9898. The date of service reported on the claim for HCPCS code C9898 should be the same as the date of service for the nuclear medicine procedure HCPCS code, which should always accompany the reporting of HCPCS code C9898. HCPCS code C9898 should never be reported on a claim without a diagnostic nuclear medicine procedure that is subject to the nuclear medicine procedure-to-radiolabeled product edits.

More information regarding these edits is available on the OPPS Web site at http://www.cms.hhs.gov/HospitalOutpatientPPS

Future updates to this section will be communicated in a Recurring Update Notification.

200.9 - Billing for "Sometimes Therapy" Services that May be Paid as Non-Therapy Services for Hospital Outpatients

(Rev. 1924, Issued: 02-26-10, Effective: 04-01-10, Implementation: 04-05-10)

Section 1834(k) of the Act, as added by Section 4541 of the BBA, allows payment at 80 percent of the lesser of the actual charge for the services or the applicable fee schedule amount for all outpatient therapy services; that is, physical therapy services, speech-language pathology services, and occupational therapy services. As provided under Section 1834(k)(5) of the Act, a therapy code list was created based on a uniform coding system (that is, the HCPCS) to identify and track these outpatient therapy services paid under the Medicare Physician Fee Schedule (MPFS).

The list of therapy codes, along with their respective designation, can be found on the CMS Website, specifically at http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage. Two of the designations that are used for therapy services are: "always therapy" and "sometimes therapy." An "always therapy" service must be performed by a qualified therapist under a certified therapy plan of care, and a "sometimes therapy" service may be performed by an individual outside of a certified therapy plan of care.

Under the OPPS, separate payment is provided for certain services designated as "sometimes therapy" services if these services are furnished to hospital outpatients as a non-therapy service, that is, without a certified therapy plan of care. Specifically, to be paid under the OPPS for a non-therapy service, hospitals SHOULD NOT append the therapy modifier GP (physical therapy), GO (occupational therapy), or GN (speech language pathology), or report a therapy revenue code 042x, 043x, or 044x in association with the "sometimes therapy" codes listed in the table below.

To receive payment under the MPFS, when "sometimes therapy" services are performed by a qualified therapist under a certified therapy plan of care, providers should append the appropriate therapy modifier GP, GO, or GN, and report the charges under an appropriate therapy revenue code, specifically 042x, 043x, or 044x. This instruction does not apply to claims for "sometimes therapy" codes furnished as therapy services in the hospital outpatient department and paid under the OPPS.

Effective January 1, 2010, CPT code 92520 (Laryngeal function studies (i.e., aerodynamic testing and acoustic testing)), is newly designated as a "sometimes therapy" service under the MPFS. CPT code 92520 is not a new code, however, its "sometimes therapy" designation is new and effective January 1, 2010. Under the OPPS, hospitals will receive separate payment when they bill CPT code 92520 as a non-therapy service.

The list of HCPCS codes designated as "sometimes therapy" services that may be paid as non-therapy services when furnished to hospital outpatients as of January 1, 2010, is displayed in the table below.

Services Designated as "Sometimes Therapy" that May be Paid as Non-Therapy Services for Hospital Outpatients as of January 1, 2010

HCPCS Code	Long Descriptor
92520	Laryngeal function studies (i.e., aerodynamic testing and acoustic testing)
97597	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters
97598	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area greater than 20 square centimeters
97602	Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (e.g., wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session
97605	Negative pressure wound therapy (e.g., vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters
97606	Negative pressure wound therapy (e.g., vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters
0183T	Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day

230 - Billing and Payment for Drugs and Drug Administration

(Rev. 573, Issued: 06-03-05, Effective: 01-01-05, Implementation: 06-01-05)

This section provides billing guidance and payment instructions for hospitals when providing drugs and drug administration services in the hospital outpatient department.

230.1 - Coding and Payment for Drugs and Biologicals, and Radiopharmaceuticals

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)
This section provides hospitals with coding instructions and payment information for drugs paid under OPPS. For additional information on coding and payment for drugs and biologicals under the OPPS, see the Medicare Claims Processing Manual, Chapter 17 "Drugs and Biologicals."

230.2 - Coding and Payment for Drug Administration

(Rev. 2141, Issued: 01-24-11, Effective: 01-01-11, Implementation: 01-03-11)

A. Overview

Drug administration services furnished under the Hospital Outpatient Prospective Payment System (OPPS) during CY 2005 were reported using CPT codes 90780, 90781, and 96400-96459.

Effective January 1, 2006, some of these CPT codes were replaced with more detailed CPT codes incorporating specific procedural concepts, as defined and described by the CPT manual, such as initial, concurrent, and sequential.

Hospitals are instructed to use the full set of CPT codes, including those codes referencing concepts of initial, concurrent, and sequential, to bill for drug administration services furnished in the hospital outpatient department beginning January 1, 2007. In addition, hospitals are instructed to continue billing the HCPCS codes that most accurately describe the service(s) provided.

Hospitals are reminded to bill a separate Evaluation and Management code (with modifier 25) only if a significant, separately identifiable E/M service is performed in the same encounter with OPPS drug administration services.

B. Billing for Infusions and Injections

Beginning in CY 2007, hospitals were instructed to use the full set of drug administration CPT codes (90760-90779; 96401-96549), (96413-96523 beginning in CY 2008) (96360-96549 beginning in CY 2009) when billing for drug administration services provided in the hospital outpatient department. In addition, hospitals are to continue to bill HCPCS code C8957 (Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump) when appropriate. Hospitals are expected to report all drug administration CPT codes in a manner consistent with their descriptors, CPT instructions, and correct coding principles. Hospitals should note the conceptual changes between CY 2006 drug administration codes effective under the OPPS and the CPT codes in effect beginning January 1, 2007, in order to ensure accurate billing under the OPPS. Hospitals should report all HCPCS codes that describe the drug administration services provided, regardless of whether or not those services are separately paid or their payment is packaged.

Medicare's general policy regarding physician supervision within hospital outpatient departments meets the physician supervision requirements for use of CPT codes 90760-90779, 96401-96549, (96413-96523 beginning in CY 2008). (Reference: Pub.100-02, Medicare Benefit Policy Manual, Chapter 6, §20.4.)

Drug administration services are to be reported with a line item date of service on the day they are provided. In addition, only one initial drug administration service is to be reported per vascular access site per encounter, including during an encounter where observation services span more than 1 calendar day.

C. Payments For Drug Administration Services

For CY 2007, OPPS drug administration APCs were restructured, resulting in a six-level hierarchy where active HCPCS codes have been assigned according to their clinical coherence and resource use. Contrary to the CY 2006 payment structure that bundled payment for several instances of a type of service (non-chemotherapy, chemotherapy by infusion, non-infusion chemotherapy) into a per-encounter APC payment, structure introduced in CY 2007 provides a separate APC payment for each reported unit of a separately payable HCPCS code.

Hospitals should note that the transition to the full set of CPT drug administration codes provides for conceptual differences when reporting, such as those noted below.

- In CY 2006, hospitals were instructed to bill for the first hour (and any additional hours) by each type of infusion service (non-chemotherapy, chemotherapy by infusion, non-infusion chemotherapy). Beginning in CY 2007, the first hour concept no longer exists. CPT codes in CY 2007 and beyond allow for only one initial service per encounter, for each vascular access site, no matter how many types of infusion services are provided; however, hospitals will receive an APC payment for the initial service and separate APC payment(s) for additional hours of infusion or other drug administration services provided that are separately payable.

- In CY 2006, hospitals providing infusion services of different types (non-chemotherapy, chemotherapy by infusion, non-infusion chemotherapy) received payment for the associated per-encounter infusion APC even if these infusions occurred during the same time period. Beginning in CY 2007, hospitals should report only one initial drug administration service, including infusion services, per encounter for each distinct vascular access site, with other services through the same vascular access site being reported via the sequential, concurrent or additional hour codes. Although new CPT guidance has been issued for reporting initial drug administration services, Medicare contractors shall continue to follow the guidance given in this manual.

  (**NOTE:** This list above provides a brief overview of a limited number of the conceptual changes between CY 2006 OPPS drug administration codes and CY 2007 OPPS drug administration codes - this list is not comprehensive and does not include all items hospitals will need to consider during this transition)

For APC payment rates, refer to the most current quarterly version of Addendum B on the CMS Web site at http://www.cms.hhs.gov/HospitalOutpatientPPS/.

D. Infusions Started Outside the Hospital

Hospitals may receive Medicare beneficiaries for outpatient services who are in the process of receiving an infusion at their time of arrival at the hospital (e.g., a patient who arrives via ambulance with an ongoing intravenous infusion initiated by paramedics during transport). Hospitals are reminded to bill for all

services provided using the HCPCS code(s) that most accurately describe the service(s) they provided. This includes hospitals reporting an initial hour of infusion, even if the hospital did not initiate the infusion, and additional HCPCS codes for additional or sequential infusion services if needed.

231 - Billing and Payment for Blood, Blood Products, and Stem Cells and Related Services Under the Hospital Outpatient Prospective Payment System (OPPS)

(Rev. 1702, Issued: 03-13-09, Effective: 04-01-09, Implementation: 04-06-09)

231.1 - When a Provider Paid Under the OPPS Does Not Purchase the Blood or Blood Products That It Procures from a Community Blood Bank, or When a Provider Paid Under the OPPS Does Not Assess a Charge for Blood or Blood Products Supplied by the Provider's Own Blood Bank Other Than Blood Processing and Storage

(Rev. 1702, Issued: 03-13-09, Effective: 04-01-09, Implementation: 04-06-09)

When an OPPS provider furnishes blood or a blood product collected by its own blood bank for which only processing and storage costs are assessed, or when an OPPS provider procures blood or a blood product from a community blood bank for which it is charged only the processing and storage costs incurred by the community blood bank, the OPPS provider bills the processing and storage charges using Revenue Code 0390 (Blood Processing/Storage), 0392 (Blood Processing/Storage; Processing and Storage), or 0399 (Blood Processing /Storage; Other Processing and Storage), along with the appropriate blood HCPCS code, the number of units transfused, and the line item date of service (LIDOS). Processing and storage costs may include blood product collection, safety testing, retyping, pooling, irradiating, leukocyte-reducing, freezing, and thawing blood products, along with the costs of blood delivery, monitoring, and storage. In general, such categories of processing costs are not patient-specific. There are specific blood HCPCS codes for blood products that have been processed in varying ways, and these codes are intended to make payment for the variable resource costs of blood products that have been processed differently.

Most OPPS providers obtain blood or blood products from community blood banks that charge only for processing and storage, and not for the blood itself. These hospitals should follow the instructions outlined in this section. Those OPPS providers that incur a charge for the blood product itself, in addition to the charge for processing and storage, should follow the coding requirements outlined in §231.2.

231.2 - When a Provider Paid Under the OPPS Purchases Blood or Blood Products from a Community Blood Bank or When a Provider Paid Under the OPPS Assesses a Charge for Blood or Blood Products Collected By Its Own Blood Bank That Reflects More Than Blood Processing and Storage

(Rev. 1702, Issued: 03-13-09, Effective: 04-01-09, Implementation: 04-06-09)

If an OPPS provider pays for the actual blood or blood product itself, in addition to paying for processing and storage costs when blood or blood products are supplied by either a community blood bank or the OPPS provider's own blood bank, the OPPS provider must separate the charge for the unit(s) of blood or blood product(s) from the charge for processing and storage services. The OPPS provider reports charges for the blood or blood product itself using Revenue Code series 038X (excluding 0380, which is not a valid revenue code for Medicare billing) with the LIDOS, the number of units transfused, and the appropriate blood product HCPCS code and HCPCS modifier BL. The OPPS provider reports charges for processing and

storage services on a separate line using Revenue Code 0390, 0392, or 0399 with the LIDOS, the number of units transfused, and the appropriate blood product HCPCS code and HCPCS modifier BL. The same LIDOS, the same number of units, the same HCPCS code, and HCPCS modifier BL must be reported on **both** lines. This requirement applies to all OPPS providers that transfuse blood and incur charges for both the blood itself and processing and storage.

Effective for services furnished on or after July 1, 2005, the I/OCE will return to providers any claim that reports a charge for blood or blood products using Revenue Code 038X without a separate line for processing and storage services using Revenue Code 0390, 0392, or 0399. Moreover, in order to process to payment, both lines must report the same line item date of service, the same number of units, and the same HCPCS code accompanied by modifier BL. Payment for blood and blood products is based on the Ambulatory Payment Classification (APC) Group to which its HCPCS code is assigned, multiplied by the number of units transfused.

Units of whole blood or packed red cells for which only processing and storage charges are reported are not subject to the blood deductible. The Medicare blood deductible is applicable only if the OPPS provider purchases whole blood or packed red cells from a community blood blank or if the OPPS provider assesses a charge that reflects more than blood processing and storage for whole blood or packed red cells collected by its owns blood bank. If the beneficiary has not already fulfilled the annual blood deductible or replaced the blood, OPPS payment will be made for processing and storage costs only. The beneficiary is liable for the blood portion of the payment as the blood deductible. In order to ensure correct application of the Medicare blood deductible, providers should report charges for whole units of packed red cells using Revenue Code 381 (Packed red cells), and should report charges for whole units of whole blood using Revenue Code 382 (Whole blood). Revenue Codes 381 and 382 should be used only to report charges for packed red cells and whole blood, respectively.

Please note that most hospitals obtain blood or blood products from community blood banks that charge only for processing and storage, rather than for the blood itself. The blood coding requirements discussed in this section do not apply to blood and blood products carrying only a processing and storage fee; when billing only for blood processing and storage, OPPS providers should follow the coding requirements outlined in §231.1.

EXAMPLE: An OPPS provider purchases 2 units of leukocyte-reduced red blood cells from a community blood bank and incurs a charge for the red cells themselves, and a charge for the blood bank's processing and storage of the red blood cell unit. The OPPS provider further incurs costs related to additional processing and storage of the red blood cell units after the OPPS provider has received the 2 units. A Medicare beneficiary is transfused the two units of leukocyte-reduced red blood cells.

The OPPS provider should report the charges for 2 units of P9016 by separately billing the red blood cell charges and the total processing and storage charges incurred. The charges for the red blood cell units are to be reported on one line with the date the blood was transfused, Revenue Code series 038X (excluding 380), 2 units, HCPCS code P9016, and modifier BL. The total charges for processing and storage are to be reported on the same claim, on a separate line, showing the date the blood was transfused, Revenue Code 390, 0392, or 399, 2 units, HCPCS code P9016, and modifier BL. Note that HCPCS modifier BL is reported on both lines.

231.3 - Billing for Autologous Blood (Including Salvaged Blood) and Directed Donor Blood

(Rev. 496, Issued: 03-04-05, Effective: 07-01-05, Implementation: 07-05-05)

In general, when autologous (predeposited or obtained through intra- or postoperative salvage) or directed-donor transfusion is performed, OPPS providers should bill for the transfusion service and the number of units of the appropriate HCPCS code that describes the blood product. Payment for the product is intended to cover the costs associated with providing the autologous or directed donor blood product service (e.g., collection, processing, transportation, and storage). OPPS providers should bill the transfusion service and the blood product HCPCS code on the date that the transfusion took place and not on the date when the autologous blood was collected.

When an autologous blood product is collected but not transfused, OPPS providers should bill CPT 86890 (autologous blood or component, collection, processing, and storage; predeposited) or 86891(autologous blood or component, collection, processing, and storage; intra- or postoperative salvage) and the number of units collected but not transfused. CPT 86890 and 86891 are intended to provide payment for the additional resources needed to provide these services, which are not captured when a blood product HCPCS code is not billed. Because billing 86890 or 86891 is only indicated when autologous blood is collected but not transfused, the OPPS provider should bill 86890 or 86891 on the date when the OPPS provider is certain the blood will not be transfused (i.e., date of a procedure or date of outpatient discharge), rather than on the date of the product's collection or receipt from the supplier.

When a directed donor blood product is collected but not transfused to the initial targeted recipient or to any other patient, refer to the section 231.7 titled "Billing for Unused Blood."

231.4 - Billing for Split Unit of Blood

(Rev. 1487, Issued: 04-08-08, Effective: 04-01-08, Implementation: 04-07-08)

HCPCS code P9011 was created to identify situations where one unit of blood or a blood product is split and some portion of the unit is transfused to one patient and the other portions are transfused to other patients or to the same patient at other times. When a patient receives a transfusion of a split unit of blood or blood product, OPPS providers should bill P9011 for the blood product transfused, as well as CPT 86985 (Splitting, blood products) for each splitting procedure performed to prepare the blood product for a specific patient.

Providers should bill split units of packed red cells and whole blood using Revenue Code 389 (Other blood), and should not use Revenue Codes 381 (Packed red cells) or 382 (Whole blood). Providers should bill split units of other blood products using the applicable revenue codes for the blood product type, such as 383 (Plasma) or 384 (Platelets), rather than 389. Reporting revenue codes according to these specifications will ensure the Medicare beneficiary's blood deductible is applied correctly.

EXAMPLE: OPPS provider splits off a 100cc aliquot from a 250 cc unit of leukocyte-reduced red blood cells for a transfusion to Patient X. The hospital then splits off an 80cc aliquot of the remaining unit for a transfusion to Patient Y. At a later time, the remaining 70cc from the unit is transfused to Patient Z.

In billing for the services for Patient X and Patient Y, the OPPS provider should report the charges by billing P9011 and 86985 in addition to the CPT code for the transfusion service, because a specific splitting service was required to prepare a split unit for transfusion to each of those patients. However, the OPPS provider should report only P9011 and the CPT code for the transfusion service for Patient Z because no

additional splitting was necessary to prepare the split unit for transfusion to Patient Z. The OPPS provider should bill Revenue Code 0389 for each split unit of the leukocyte-reduced red blood cells that was transfused.

231.5 - Billing for Irradiation of Blood Products

(Rev. 496, Issued: 03-04-05, Effective: 07-01-05, Implementation: 07-05-05)

In situations where a beneficiary receives a medically reasonable and necessary transfusion of an irradiated blood product, an OPPS provider may bill the specific HCPCS code which describes the irradiated product, if a specific code exists, in addition to the CPT code for the transfusion. If a specific HCPCS code for the irradiated blood product does not exist, then the OPPS provider should bill the appropriate HCPCS code for the blood product, along with CPT code 86945 (irradiation of blood product, each unit).

EXAMPLE: If an OPPS provider transfuses the product described by P9040 (red blood cells, leukocytes reduced, irradiated, each unit), it would not be appropriate to bill an additional CPT code for irradiation of the blood product since charges for irradiation should be included in the charge for P9040.

231.6 - Billing for Frozen and Thawed Blood and Blood Products

(Rev. 1487, Issued: 04-08-08, Effective: 04-01-08, Implementation: 04-07-08)

In situations where a beneficiary receives a transfusion of frozen blood or a blood product which has been frozen and thawed for the patient prior to the transfusion, an OPPS provider may bill the specific HCPCS code which describes the frozen and thawed product, if a specific code exists, in addition to the CPT code for the transfusion.. If a specific HCPCS code for the frozen and thawed blood or blood product does not exist, then the OPPS provider should bill the appropriate HCPCS code for the blood product, along with CPT codes for freezing and/or thawing services that are not reflected in the blood product HCPCS code.

EXAMPLE: If an OPPS provider transfuses the product described by P9057 (red blood cells, frozen/deglycerolized/washed, leukocytes reduced, irradiated, each unit), it would not be appropriate to bill additional CPT codes for freezing and/or thawing since charges for freezing and thawing should be included in the charge for P9057.

If a blood product has been frozen and/or thawed in preparation for a transfusion, but the patient does not receive the transfusion of the blood product, the OPPS provider may bill the patient for the CPT code that describes the freezing and/or thawing services specifically provided for the patient. Similar to billing for autologous blood collection when blood is not transfused, the OPPS provider should bill the freezing and/or thawing services on the date when the OPPS provider is certain the blood product will not be transfused (e.g., date of a procedure or date of outpatient discharge), rather than on the date of the freezing and/or thawing services.

The following chart of blood and blood products indicates whether providers should bill separately for freezing and thawing using the available CPT codes.

HCPCS/CPT	**Short Descriptor**	Billing of Freezing/Thawing
P9010	Whole blood for transfusion	Freezing and thawing are separately billable

P9011	Blood split unit	Freezing and thawing are separately billable
P9012	Cryoprecipitate each unit	**Freezing and thawing codes not separately billable**
P9016	RBC leukocytes reduced	Alternative P-code for frozen/thawed product available
P9017	Plasma 1 donor frz w/in 8 hr	**Freezing and thawing codes not separately billable**
P9019	Platelets, each unit	Freezing and thawing are separately billable
P9020	Plaelet rich plasma unit	Freezing and thawing are separately billable
P9021	Red blood cells unit	Alternative P-code for frozen/thawed product available
P9022	Washed red blood cells unit	Freezing and thawing are separately billable
P9023	Frozen plasma, pooled, sd	**Freezing and thawing codes not separately billable**
P9031	Platelets leukocytes reduced	Freezing and thawing are separately billable
P9032	Platelets, irradiated	Freezing and thawing are separately billable
P9033	Platelets leukoreduced irrad	Freezing and thawing are separately billable
P9034	Platelets, pheresis	Freezing and thawing are separately billable
P9035	Platelet pheres leukoreduced	Freezing and thawing are separately billable
P9036	Platelet pheresis irradiated	Freezing and thawing are separately billable
P9037	Plate pheres leukoredu irrad	Freezing and thawing are separately billable
P9038	RBC irradiated	Freezing and thawing are separately billable
P9039	RBC deglycerolized	**Freezing and thawing codes not separately billable**
P9040	RBC leukoreduced irradiated	Alternative P-code for frozen/thawed product available
P9043	Plasma protein fract,5%,50ml	Concept not applicable
P9044	Cryoprecipitate reduced plasma	**Freezing and thawing codes not separately billable**
P9048	Plasmaprotein fract,5%,250ml	Concept not applicable
P9050	Granulocytes, pheresis unit	Concept not applicable
P9051	Blood, l/r, cmv-neg	Freezing and thawing are separately billable
P9052	Platelets, hla-m, l/r, unit	Freezing and thawing are separately billable
P9053	Plt, pher, l/r cmv-neg, irr	Freezing and thawing are separately billable
P9054	Blood, l/r, froz/degly/wash	**Freezing and thawing codes not separately billable**
P9055	Plt, aph/pher, l/r, cmv-neg	Freezing and thawing are separately billable
P9056	Blood, l/r, irradiated	Freezing and thawing are separately billable
P9057	RBC, frz/deg/wsh, l/r, irrad	**Freezing and thawing codes not separately billable**
P9058	RBC, l/r, cmv-neg, irrad	Freezing and thawing are separately billable
P9059	Plasma, frz between 8-24hour	**Freezing and thawing codes not separately billable**
P9060	Fr frz plasma donor retested	**Freezing and thawing codes not separately billable**

231.7 - Billing for Unused Blood

(Rev. 1487, Issued: 04-08-08, Effective: 04-01-08, Implementation: 04-07-08)

When blood or blood products which the OPPS provider has collected in its own blood bank or received from a community blood bank are not used, processing and storage costs incurred by the community blood bank and the OPPS provider cannot be charged to the beneficiary. However, certain patient-specific blood preparation costs incurred by the OPPS provider (e.g., blood typing and cross-matching) can be charged to the beneficiary under Revenue Code Series 30X or 31X. Patient-specific preparation charges should be billed on the dates the services were provided.

Processing and storage costs for unused blood products should be reported as costs under cost centers for blood on the OPPS provider's Medicare Cost Report. These are costs that are not considered patient-specific blood preparation services. Costs for unused blood products which have been purchased also should be reported as costs under cost centers for blood on the Medicare Cost Report.

Where blood or a blood product is split or irradiated specifically with the intent of transfusion to a beneficiary but is not then used, the hospital may bill for the services of splitting or irradiating the unit of blood, but may not bill for the HCPCS code for the blood product that was not transfused. The date of service must be the date on which the decision not to use the blood was made and indicated in the patient's medical record. Where the unit of blood is split or irradiated and stored without specific intention to administer it to a Medicare beneficiary at the time of splitting or irradiation and is not subsequently transfused, there is no service to be reported.

231.8 - Billing for Transfusion Services

(Rev. 496, Issued: 03-04-05, Effective: 07-01-05, Implementation: 07-05-05)

To report charges for transfusion services, OPPS providers should bill the appropriate CPT code for the specific transfusion service provided under Revenue Code 391 (Blood Administration). Transfusion services codes are billed on a per service basis, and not by the number of units of blood product transfused. For payment, a blood product HCPCS code is required when billing a transfusion service code. A transfusion APC will be paid to the OPPS provider for transfusing blood products once per day, regardless of the number of units or different types of blood products transfused.

231.9 - Billing for Pheresis and Apheresis Services

(Rev. 496, Issued: 03-04-05, Effective: 07-01-05, Implementation: 07-05-05)

Apheresis/pheresis services are billed on a per visit basis and not on a per unit basis. OPPS providers should report the charge for an Evaluation and Management (E&M) visit only if there is a separately identifiable E&M service performed which extends beyond the evaluation and management portion of a typical apheresis/pheresis service. If the OPPS provider is billing an E&M visit code in addition to the apheresis/pheresis service, it may be appropriate to use the HCPCS modifier -25.

231.10 - Billing for Autologous Stem Cell Transplants

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

The hospital bills and shows all charges for autologous stem cell harvesting, processing, and transplant procedures based on the status of the patient (i.e., inpatient or outpatient) when the services are furnished. It shows charges for the actual transplant, described by the appropriate ICD-9-CM procedure or CPT codes, in

revenue center code 0362 (Operating Room Services; Organ Transplant, Other than Kidney) or another appropriate cost center.

The CPT codes describing autologous stem cell harvesting procedures may be billed and are separately payable under the Outpatient Prospective Payment System (OPPS) when provided in the hospital outpatient setting of care. Autologous harvesting procedures are distinct from the acquisition services described in Pub. 100-04, Chapter 3, §90.3.3 and §231.11 of this chapter for allogeneic stem cell transplants, which include services provided when stem cells are obtained from a donor and not from the patient undergoing the stem cell transplant.

The CPT codes describing autologous stem cell processing procedures also may be billed and are separately payable under the OPPS when provided to hospital outpatients.

231.11 - Billing for Allogeneic Stem Cell Transplants

(Rev. 1980, Issued: 06-04-10, Effective: 07-01-10, Implementation: 07-06-10)

1. Definition of Acquisition Charges for Allogeneic Stem Cell Transplants

Acquisition charges for allogeneic stem cell transplants include, but are not limited to, charges for the costs of the following services:

- National Marrow Donor Program fees, if applicable, for stem cells from an unrelated donor;
- Tissue typing of donor and recipient;
- Donor evaluation;
- Physician pre-procedure donor evaluation services;
- Costs associated with harvesting procedure (e.g., general routine and special care services, procedure/operating room and other ancillary services, apheresis services, etc.);
- Post-operative/post-procedure evaluation of donor; and
- Preparation and processing of stem cells.

Payment for these acquisition services is included in the OPPS APC payment for the allogeneic stem cell transplant when the transplant occurs in the hospital outpatient setting, and in the MS-DRG payment for the allogeneic stem cell transplant when the transplant occurs in the inpatient setting. The Medicare contractor does not make separate payment for these acquisition services, because hospitals may bill and receive payment only for services provided to the Medicare beneficiary who is the recipient of the stem cell transplant and whose illness is being treated with the stem cell transplant. Unlike the acquisition costs of solid organs for transplant (e.g., hearts and kidneys), which are paid on a reasonable cost basis, acquisition costs for allogeneic stem cells are included in prospective payment. Recurring update notifications describing changes to and billing instructions for various payment policies implemented in the OPPS are issues annually.

Acquisition charges for stem cell transplants apply only to allogeneic transplants, for which stem cells are obtained from a donor (other than the recipient himself or herself). Acquisition charges do not apply to autologous transplants (transplanted stem cells are obtained from the recipient himself or herself), because autologous transplants involve services provided to the beneficiary only (and not to a donor), for which the hospital may bill and receive payment (see Pub. 100-04, chapter 3, §90.3.3 and §231.10 of this chapter for information regarding billing for autologous stem cell transplants).

2. Billing for Acquisition Services

The hospital bills and shows acquisition charges for allogeneic stem cell transplants based on the status of the patient (i.e., inpatient or outpatient) when the transplant is furnished. See Pub. 100-04, chapter 3, §90.3.3 for instructions regarding billing for acquisition services for allogeneic stem cell transplants that are performed in the inpatient setting.

When the allogeneic stem cell transplant occurs in the outpatient setting, the hospital identifies stem cell acquisition charges for allogeneic bone marrow/stem cell transplants separately in FL 42 of Form CMS-1450 (or electronic equivalent) by using revenue code 0819 (Other Organ Acquisition). Revenue code 0819 charges should include all services required to acquire stem cells from a donor, as defined above, and should be reported on the same date of service as the transplant procedure in order to be appropriately packaged for payment purposes.

The transplant hospital keeps an itemized statement that identifies the services furnished, the charges, the person receiving the service (donor/recipient), and whether this is a potential transplant donor or recipient. These charges will be reflected in the transplant hospital's stem cell/bone marrow acquisition cost center. For allogeneic stem cell acquisition services in cases that do not result in transplant, due to death of the intended recipient or other causes, hospitals include the costs associated with the acquisition services on the Medicare cost report.

In the case of an allogeneic transplant in the hospital outpatient setting, the hospital reports the transplant itself with the appropriate CPT code, and a charge under revenue center code 0362 or another appropriate cost center. Selection of the cost center is up to the hospital.

231.12 - Correct Coding Initiative (CCI) Edits

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

The OPPS providers should be aware that certain CCI edits may apply when billing for blood and blood product services. The OPPS providers should consult the most current list of CCI edits to determine whether they apply to the services or HCPCS blood product codes being reported. A file with the most current list of CCI edits applicable to Medicare Part B services paid by fiscal intermediaries under the OPPS is available at:
http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHOPPS/list.asp

240 - Inpatient Part B Hospital Services

(Rev. 1628, Issued: 11-03-08, Effective: 01-01-09, Implementation: 01-05-09)

Inpatient Part B services which are paid under OPPS include:

- Diagnostic x-ray tests, and other diagnostic tests (excluding clinical diagnostic laboratory tests);
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;
- Surgical dressings applied during an encounter at the hospital and splints, casts, and other devices used for reduction of fractures and dislocations (splints and casts, etc., include dental splints);
- Implantable prosthetic devices;
- Hepatitis B vaccine and its administration, and certain preventive screening services (pelvic exams, screening sigmoidoscopies, screening colonoscopies, bone mass measurements, and prostate screening.)
- Bone Mass measurements;
- Prostate screening;
- Immunosuppressive drugs;
- Oral anti-cancer drugs;
- Oral drug prescribed for use as an acute anti-emetic used as part of an anti-cancer chemotherapeutic regimen; and
- Epoetin Alfa (EPO)

When a hospital that is not paid under the OPPS furnishes an implantable prosthetic device that meets the criteria for coverage in Medicare Benefits Policy Manual, Pub.100-02, Chapter 6, §10 to an inpatient who has coverage under Part B, payment for the implantable prosthetic device is made under the payment mechanism that applies to other hospital outpatient services (e.g., reasonable cost, all inclusive rate, waiver).

When a hospital that is paid under the OPPS furnishes an implantable prosthetic device to an inpatient who has coverage under Part B, but who does not have coverage of inpatient services on the date that the implanted prosthetic device is furnished, the hospital should report new HCPCS code, C9899, Implanted Prosthetic Device, Payable Only for Inpatients who do not Have Inpatient Coverage, that will be effective for services furnished on or after January 1, 2009. This code may be reported only on claims with TOB 12X when the prosthetic device is implanted on a day on which the beneficiary does not have coverage of the hospital inpatient services he or she is receiving. The line containing this new code will be rejected if it is reported on a claim that is not a TOB 12X or if it is reported with a line item date of service on which the beneficiary has coverage of inpatient hospital services. By reporting C9899, the hospital is reporting that all of the criteria for payment under Part B are met as specified in the Medicare Benefits Policy Manual, Pub.100-02, Chapter 6, §10, and that the item meets all Medicare criteria for coverage as an implantable prosthetic device as defined in that section.

Medicare contractors shall first determine that the item furnished meets the Medicare criteria for coverage as an implantable prosthetic device as specified in the Medicare Benefits Policy Manual, Pub. 100-02, Chapter 6, §10. If the item does not meet the criteria for coverage as an implantable prosthetic device, the contractor shall deny payment on the basis that the item is outside the scope of the benefits for which there is coverage for Part B inpatients. The beneficiary is liable for the charges for the noncovered item when the item does not meet the criteria for coverage as an implanted prosthetic device as specified in the Medicare Benefits Policy Manual, Pub.100-02, Chapter 6, §10.

If the contractor determines that the device is covered, the contractor shall determine if the device has pass through status under the OPPS. If so, the contractor shall establish the payment amount for the device at the product of the charge for the device and the hospital specific cost to charge ratio. Where the device does not have pass through status under the OPPS, the contractor shall establish the payment amount for the device at the amount for a comparable device in the DMEPOS fee schedule where there is such an amount. Payment under the DMEPOS fee schedule is made at the lesser of charges or the fee schedule amount and therefore if there is a fee for the specific item on the DMEPOS fee schedule, the payment amount for the item will be set at the lesser of the actual charges or the DMEPOS fee schedule amount. Where the item does not have pass through payment status and where there is no amount for a comparable device in the DMEPOS fee schedule, the contractor shall establish a payment amount that is specific to the particular implanted prosthetic device for the applicable calendar year. This amount (less applicable unpaid deductible and coinsurance) will be paid for that specific device for services furnished in the applicable calendar year unless the actual charge for the item is less than the established amount). Where the actual charge is less than the established amount, the contractor will pay the actual charge for the item (less applicable unpaid deductible and coinsurance).

In setting a contractor established payment rate for the specific device, the contractor takes into account the cost information available at the time the payment rate is established. This information may include, but is not limited to, the amount of device cost that would be removed from an applicable APC payment for implantation of the device if the provider received a device without cost or a full credit for the cost of the device.

If the contractor chooses to use this amount, see www.cms.hhs.gov/HospitalOutpatientPPS/ for the amount of reduction to the APC payment that would apply in these cases. From the OPPS webpage, select “Device, Radiolabeled Product, and Procedure Edits” from the list on the left side of the page. Open the file “Procedure to Device edits” to determine the HCPCS code that best describes the procedure in which the device would be used. Then identify the APC to which that procedure code maps from the most recent Addenda B on the OPPS webpage and open the file “FB/FC Modifier Procedures and Devices”. Select the applicable year’s file of APCs subject to full and partial credit reductions (for example: CY 2008 APCs Subject to Full and Partial Credit Reduction Policy”). Select the ”Full offset reduction amount” that pertains to the APC that is most applicable to the device described by C9899. It would be reasonable to set this amount as a payment for a device furnished to a Part B inpatient.

For example, if C9899 is reporting insertion of a single chamber pacemaker (C1786 or equivalent narrative description on the claim in “remarks”) the file of procedure to device edits shows that a single chamber pacemaker is the dominant device for APC 0090 (APC 0089 is for insertion of both pacemaker and electrodes and therefore would not apply if electrodes are not also billed). The table of offset reduction amounts for CY 2008 shows that the estimated cost of a single chamber pacemaker for APC 0090 is

$4881.77. It would therefore be reasonable for the contractor/MAC to set the payment rate for a single chamber pacemaker furnished to a Part B inpatient to $4881.77. In this case the coinsurance would be $936.75 (20 percent of $4881.77, which is less than the inpatient deductible).

The beneficiary coinsurance is 20 percent of the payment amount for the device (i.e. the pass through payment amount, the DMEPOS fee schedule amount, the contractor established amount, or the actual charge if less than the DMEPOS fee schedule amount or the contractor established amount for the specific device), not to exceed the Medicare inpatient deductible that is applicable to the year in which the implanted prosthetic device is furnished.

Inpatient Part B services paid under other payment methods include:

- Clinical diagnostic laboratory tests, prosthetic devices other than implantable ones and other than dental which replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices;

- Leg, arm, back and neck braces; trusses and artificial legs; arms and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition; take home surgical dressings; outpatient physical therapy; outpatient occupational therapy; and outpatient speech-language pathology services;

- Ambulance services;

- Screening pap smears, screening colorectal tests, and screening mammography;

- Influenza virus vaccine and its administration, pneumococcal vaccine and its administration;

- Diabetes self-management training;

- Hemophilia clotting factors for hemophilia patients competent to use these factors without supervision).

See Chapter 6 of the Medicare Benefit Policy Manual for a discussion of the circumstances under which the above services may be covered as Part B Inpatient services.

240.1 – Editing Of Hospital Part B Inpatient Services

(Rev. 1924, Issued: 02-26-10, Effective: 04-01-10, Implementation: 04-05-10)

Medicare pays under Part B for physician services and for non-physician medical and other health services listed in Section 240 above when furnished by a participating hospital to an inpatient of the hospital when patients are not eligible or entitled to Part A benefits or the patient has exhausted their Part A benefits.

The contractor shall set revenue code edits to prevent payment on Type of Bill 12x for claims containing the revenue codes listed in the table below.

010x	011x	012x	013x	014x	015x	016x	017x
018x	019x	020x	021x	022x	023x	0250	0251
0252	0253	0256	0257	0258	0259	0261	0269
0270	0273	0277	0279	029x	0339	036x	0370
0374	041x	045x	0472	0479	049x	050x	051x
052x	053x	0541	0542	0543	0544	0546	0547
0548	0549	055x	057x	058x	059x	060x	0630
0631	0632	0633	0637	064x	065x	066x	067x
068x	072x	0762	078x	079x	093x	0940	0941
0943	0944	0945	0946	0947	0949	095x	0960
0961	0962	0969	097x	098x	099x	100x	210x
310x	038x	039x					

When denying lines containing the above revenue codes on TOB 12x, the A/B MAC or FI shall use MSN message 21.21– This service was denied because Medicare only covers this service under certain circumstances.

The A/B MAC or FI shall place reason code M28 on the remittance advice when denying services reported under the specified revenue codes.

240.2 – Indian Health Service/Tribal Hospital Inpatient Social Admits

(Rev. 1446, Issued: 02-08-08; Effective: 07-01-08; Implementation: 07-07-08)

There may be situations when an American Indian/Alaskan Native (AI/AN) beneficiary is admitted to an IHS/Tribal facility for social reasons. These social admissions are for patient and family convenience and are not billable to Medicare. There are also occasions where IHS/Tribal hospitals elect to admit patients prior to a scheduled day of surgery, or place a patient in a room after an inpatient discharge. These services are also considered to be social admissions as well.

For patients in a social admission status requiring outpatient services at another facility, Medicare disallows payment for inpatient Part B ancillary services, Type of Bill (TOB) 12X during a social admission stay when there is another bill from a different facility for an outpatient service, TOB 13X or 72X. The Common Working File (CWF) returns an A/B crossover edit and creates an unsolicited response (IUR) in this situation.

The CWF also creates an IUR when a line item date of service on TOB 12X is equal to or one day following the discharge date on TOB 11X for the same provider.

The CWF bypasses both of these edits when the beneficiary is not entitled to Medicare Part A at the time the services on TOB 12X are rendered.

250 – Special Rules for Critical Access Hospital Outpatient Billing

(Rev. 1111, Issued: 11-09-06, Effective: 04-01-07, Implementation: 04-02-07)

For cost reporting periods beginning before October 1, 2000, a CAH will be paid for outpatient services under the method in §250.1. The BIPA legislation on payment for professional services at 115 percent of what would otherwise be paid under the fee schedule is effective for services furnished on or after July 1, 2001. This provision was implemented with respect to cost reporting periods starting on or after October 1, 2001.

For cost reporting period beginning on or after October 1, 2001, the CAH will be paid under the method in item 1 below unless it elects to be paid under the method in §250.1.

If a CAH elects payment under the elective method (cost-based facility payment plus fee schedule for professional services) for a cost reporting period, that election is effective for the entire cost reporting period to which it applies. If the CAH wishes to make a new election or change a previous election, that election should be made in writing, made on an annual basis and delivered to the appropriate FI, at least 30 days in advance of the beginning of the affected cost reporting period.

All outpatient CAH services, other than pneumococcal pneumonia vaccines, influenza vaccines, administration of the vaccines, screening mammograms, and clinical diagnostic laboratory tests are subject to Part B deductible and coinsurance. Regardless of the payment method applicable for a period, payment for outpatient CAH services is not subject to the following payment principles:

- Lesser of cost or charges,
- Reasonable compensation equivalent (RCE) limits,
- Any type of reduction to operating or capital costs under 42 CFR 413.124 or 413.30(j)(7), or
- Blended payment rates for ASC-type, radiology, and other diagnostic services.

See §250.4 below regarding payment for screening mammography services.

250.1 - Standard Method - Cost-Based Facility Services, With Billing of Carrier for Professional Services

(Rev. 976, Issued: 06-09-06, Effective: 10-01-06, Implementation: 10-02-06)

Effective for cost reporting periods beginning on or after January 1, 2004, payment for outpatient CAH services under this method will be made for the lesser of: 1) 80 percent of 101 percent of the reasonable cost of the CAH in furnishing those services, or 2) 101 percent of the reasonable cost of the CAH in furnishing those services, less applicable Part B deductible and coinsurance amounts.

Payment for professional medical services furnished in a CAH to CAH outpatients is made by the carrier on a fee schedule, charge, or other fee basis, as would apply if the services had been furnished in a hospital outpatient department. For purposes of CAH payment, professional medical services are defined as services provided by a physician or other practitioner, e.g., a physician assistant that could be billed directly to a

carrier under Part B of Medicare or a nurse practitioner that could be billed directly to a carrier under Part B of Medicare.

In general, payment for professional medical services, under the cost-based CAH payment plus professional services billed to the carrier method should be made on the same basis as would apply if the services had been furnished in the outpatient department of a hospital.

Bill type 85X is used for all outpatient services including services approved as ASC services. Non-patient laboratory specimens (those not meeting the criteria for reasonable cost payment in §250.6) will be billed on a 14X type of bill.

(See Section 260.6 – Clinical Diagnostic Laboratory Tests Furnished by CAHs.)

250.1.1 – Special Instructions for Non-covered Time Increments in Standard Method Critical Access Hospitals (CAHs)

(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

CAHs sometimes bill outpatient therapy services using HCPCS that by definition give specific time increments like those discussed in Chapter 5, sections 20 and 40. However, standard method CAHs are not subject to payment on a fee basis under the Medicare Physician Fee Schedule, therefore these CAHs should follow the instructions below if there is a need to bill non-covered increments.

When HCPCS codes required for reporting do not specify an increment of billing in their definition (i.e., 15 minute intervals), the unit for the line item is 1, and CAHs should follow the general instructions given for billing non-covered charges in Chapter 1, section 60, either by the line item or on no payment claims.

Several of the outpatient therapy HCPCS codes, however, are defined in specific time increments, and units reported on line items should be consistent with these definitions. In such cases, when both covered and non-covered increments are provided in the same visit on the same date of service, CAHs should bill as follows:

- Report covered and non-covered units in separate line items, even when part of the same visit, with one line item for all covered and non-covered increments in a visit, and another for all non-covered increments in that same visit;

- Use ABN-related modifiers when appropriate to explain non-coverage and payment liability of specific lines (i.e., -GY, see Chapter 1, section 60 for details on these modifiers);

- Do not report non-covered line items that are part of a partially covered service on a separate no payment claim (i.e., using condition code 21). Instead, always report them on the same claim with the separate lines for the covered portion of the service. No payment claims received for the same date, same beneficiary, same provider and same therapy service as a for-payment claim will be rejected. A distinct reason code will make providers aware of the reason for the rejection, and they can correct their billing to have covered and non-covered portions of the same service on the same claim;

- Do not report non-covered line items as part of the required reporting of value codes 50, 51 and 52 for covered visits (i.e., where all increments are non-covered and there are no covered charges for the line

item, since these line items are either part of an already counted partially covered visit, or an entirely non-covered visit); and

- Never split a single increment into a covered and non-covered portion.

250.2 - Optional Method for Outpatient Services: Cost-Based Facility Services Plus 115 percent Fee Schedule Payment for Professional Services

(Rev. 2395, Issued: 01-26-12, Effective: 01-01-12, Implementation: 07-02-12)

The BIPA legislation on payment for professional services at 115 percent of what would otherwise be paid under the fee schedule is effective for services furnished on or after July 1, 2001. A CAH may elect to be paid for outpatient services in any cost reporting period under this method by filing a written election with the intermediary on an annual basis at least 30 days before start of the Cost Reporting period to which the election applies. An election of this payment method, once made for a cost reporting period, remains in effect for all of that period for the CAH.

Effective for cost reporting periods beginning on or after October 1, 2010 if a CAH elected the optional method for its most recent cost reporting period beginning before October 1, 2010 or chooses to elect the optional method on or after October 1, 2010, that election remains in place until it is terminated, an annual election is no longer required. If a CAH elects the optional method on or after October 1, 2010, it must submit its request in writing to its fiscal intermediary or A/B MAC at least 30 days before the start of the first cost reporting period for which the election is effective. That election will not terminate unless the CAH submits a termination request to its fiscal intermediary or A/B MAC at least 30 days before the start of its next cost reporting period.

The Medicare Prescription Drugs, Improvement, and Modernization Act (MMA) of 2003, changed the requirement that each practitioner rendering a service at a CAH that has elected the optional method, reassign their billing rights to that CAH. This provision allows each practitioner to choose whether to reassign billing rights to the CAH or file claims for professional services through their carrier. The reassignment will remain in effect for that entire cost reporting period.

The individual practitioner must certify, using the Form CMS-855R, if he/she wishes to reassign their billing rights. The CAH must then forward a copy of Form CMS-855R to the intermediary or A/B MAC, and the appropriate carrier or A/B MAC, must have the practitioner sign an attestation that clearly states that the practitioner will not bill the carrier or A/B MAC for any services rendered at the CAH once the reassignment has been given to the CAH. This “attestation” will remain at the CAH.

For CAHs that elected the optional method before November 1, 2003, the provision is effective beginning on or after July 1, 2001. For CAHs electing the optional method on or after November 1, 2003, the provision is effective for cost reporting periods beginning on or after July 1, 2004. Under this election, a CAH will receive payment from their intermediary or A/B MAC for professional services furnished in that CAH’s outpatient department. Professional services are those furnished by all licensed professionals who otherwise would be entitled to bill the carrier or A/B MAC under Part B.

Payment to the CAH for each outpatient visit (reassigned billing) will be the sum of the following:

- For facility services, not including physician or other practitioner services, payment will be based on 101 percent of the reasonable costs of the services. On the ANSI X12N 837 I, list the facility service(s) rendered to outpatients using the appropriate revenue code. The FI or A/B MAC will pay 101 percent of the reasonable costs for the outpatient services less applicable Part B deductible and coinsurance amounts, plus:

- On a separate line, list the professional services, along with the appropriate HCPCS code (physician or other practitioner) in one of the following revenue codes - 096X, 097X, or 098X.

    - The FI or A/B MAC uses the Medicare Physician Fee Schedule (MPFS) supplementary file, established for use by the CORF, and the CORF Abstract File, to pay for all the physician/nonphysician practitioner services rendered in a CAH that elected the optional method. The data in the supplemental file are in the same format as the abstract file. Payment is based on the lesser of the actual charge or the facility-specific MPFS amount less deductible and coinsurance times 1.15; and

      For a non-participating physician service, a CAH must place modifier AK on the claim. Payment is based on the lesser of the actual charge or a reduced fee schedule amount of 95 percent. Payment is calculated as follows:

        - [(facility-specific MPFS amount times the non-participating physician reduction (0.95) minus (deductible and coinsurance] times 1.15.

        - If a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA) renders a service, the "GF" modifier must be on the applicable line:

            - GF - Services rendered in a CAH by a nurse practitioner (NP), clinical nurse specialist (CNS), certified registered nurse (CRN) or physician assistant (PA). (The "GF" modifier is not to be used for CRNA services. If a claim is received and it has the "GF" modifier for certified registered nurse anesthetist (CRNA) services, the claim is returned to the provider.) Also, while this national "GF" modifier includes CRNs, there is no benefit under Medicare law that authorizes payment to CRNs for their services. Accordingly, if a claim is received and it has the "GF" modifier for CRN services, no Medicare payment should be made.

            - Services billed with the "GF" modifier are paid based on the lesser of the actual charge or a reduced fee schedule amount of 85 percent. Payment is calculated **as follows:**

                - [(facility-specific MPFS amount times the nonphysician practitioner services reduction (0.85) minus (deductible and coinsurance)] times 1.15.

        - SB - Services rendered in a CAH by a certified nurse-midwife.

- For dates of service prior to January 1, 2011, certified nurse-midwife services billed with the "SB" modifier are paid based on the lesser of the actual charge or a reduced fee schedule amount of 65 percent. Payment is calculated **as follows:**

    - [(facility-specific MPFS amount times the certified nurse-midwife reduction (0.65) minus (deductible and coinsurance)] times 1.15.

    - For dates of service on or after January 1, 2011, Medicare covers the services of a certified nurse-midwife. The "SB" modifier is used to bill for the services and payment is based on the lesser of the actual charge or 100 percent of the MPFS. MPFS Payment is calculated **as follows**:

    - [(facility-specific MPFS amount) minus (deductible and coinsurance)] times 1.15.

- AH - Services rendered in a CAH by a clinical psychologist.

- Payment for the services of a clinical psychologist is based on the lesser of the actual charge or 100 percent of the MPFS. Payment is calculated **as follows:**

    - [(facility-specific MPFS amount) minus (deductible and coinsurance)] times 1.15.

- AE - Services rendered in a CAH by a nutrition professional/registered dietitian.

- Services billed with the "AE" modifier are paid based on the lesser of the actual charge or a reduced fee schedule amount of 85 percent. Payment is calculated **as follows:**

    - [(facility-specific MPFS amount times the registered dietitian reduction (0.85) minus (deductible and coinsurance)] times 1.15.
- Outpatient services, including ASC type services, rendered in an all-inclusive rate provider should be billed using the 85X type of bill (TOB). Non-patient laboratory specimens are billed on TOB 14X.

  The (MPFS) supplemental file is used for payment of all physician/professional services rendered in a CAH that has elected the optional method. If a HCPCS code has a facility rate and a non-facility rate, the facility rate is paid.

SUPPLEMENTAL FEE SCHEDULE
CRITICAL ACCESS HOSPITAL FEE SCHEDULE

DATA SET NAMES: MU00.@BF12390.MPFS.CYXX.SUPL.V1122.FI

This is the final physician fee schedule supplemental file.

RECORD LENGTH: 60

RECORD FORMAT: FB

BLOCK SIZE: 6000

CHARACTER CODE: EBCDIC

SORT SEQUENCE: Carrier, Locality HCPCS Code, Modifier

Data Element Name	Location	Picture	Value
1 - HCPCS	1-5	X(05)	
2 - Modifier	6-7	X(02)	
3 - Filler	8-9	X(02)	
4 - Non-Facility Fee	10-16	9(05)V99	
5 - Filler	17-17	X(01)	
6 - PCTC Indicator	18-18	X(01)	This field is only applicable when pricing Critical Access Hospitals (CAHs) that have elected the optional method (Method 2) of payment.
7 - Filler	19	X(1)	
8 - Facility Fee	20-26	9(05)V99	
9 - Filler	27-30	X(4)	
10 - Carrier Number	31-35	X(05)	
11 - Locality	36-37	X(02)	
12 - Filler	38-40	X(03)	
13 - Fee Indicator	41-41	X(1)	Field not populated— filled with spaces.
14 - Outpatient Hospital	42-42	X(1)	Field not populated—Filled with spaces.
15 - Status Code	43-43	X(1)	Separate instructions will be issued for the use of this field at a later date. This field indicates whether the code is in the physician fee schedule and whether it's separately payable if the service is covered.
16 - Filler	44-60	X(17)	

Physician Fee Schedule Payment Policy Indicator File Record Layout

The information on the Physician Fee Schedule Payment Policy Indicator file record layout is used to identify endoscopic base codes, payment policy indicators, global surgery indicators, diagnostic imaging family indicators, or the preoperative, intraoperative and postoperative percentages that are needed to determine if payment adjustment rules apply to a specific CPT code and the associated pricing modifier(s). See Chapter 12 of Pub. 100-04 for more information on payment policy indicators and payment adjustment rules.

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
File Year This field displays the effective year of the file.	4 Pic x(4)	1-4
HCPCS Code This field represents the procedure code. Each Current Procedural Terminology (CPT) code and alpha-numeric HCPCS codes A, C, T, and some R codes that are currently returned on the MPFS supplemental file will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order.	5 Pic x(5)	5-9
Modifier For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components: 26 = Professional component; and TC = Technical component. For services other than those with a professional and/or technical component, a blank will appear in this field with one exception: the presence of CPT modifier -53 which indicates that separate Relative Value Units (RVUs) and a fee schedule amount have been established for procedures which the physician terminated before completion. This modifier is used only with colonoscopy code 45378 and screening colonoscopy codes G0105 and G0121. Any other codes billed with modifier -53 are subject to medical review and priced by individual consideration. Modifier-53 = Discontinued Procedure - Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances, or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued.	2 Pic x(2)	10-11
Code Status This 1 position field provides the status of each code under the full fee schedule. Each status code is	1 Pic x(1)	12

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
explained in Pub. 100-04, Chapter 23, §30.2.2.		
Global Surgery This field provides the postoperative time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service. 000 = Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable. 010 = Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable. 090 = Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount. MMM = Maternity codes; usual global period does not apply. XXX = Global concept does not apply. YYY = Fiscal intermediary (FI) determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing. ZZZ = Code related to another service and is always included in the global period of the other service. (**NOTE**: Physician work is associated with intra-service time and in some instances the post service time.)	3 Pic x(3)	13-15

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
Preoperative Percentage (Modifier 56) This field contains the percentage (shown in decimal format) for the preoperative portion of the global package. For example, 10 percent will be shown as 010000. The total of the preoperative percentage, intraoperative percentage, and the postoperative percentage fields will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)	16-21
Intraoperative Percentage (Modifier 54) This field contains the percentage (shown in decimal format) for the intraoperative portion of the global package including postoperative work in the hospital. For example, 63 percent will be shown as 063000. The total of the preoperative percentage, intraoperative percentage, and the postoperative percentage fields will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)	22-27
Postoperative Percentage (Modifier 55) This field contains the percentage (shown in decimal format) for the postoperative portion of the global package that is provided in the office after discharge from the hospital. For example, 17 percent will be shown as 017000. The total of the preoperative percentage, intraoperative percentage, and the postoperative percentage fields will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)	28-33
Professional Component (PC)/Technical Component (TC) Indicator 0 = Physician service codes: This indicator identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 & TC cannot be used with these codes. The total Relative Value Units (RVUs) include values for	1 Pic x(1)	34

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
physician work, practice expense and malpractice expense. There are some codes with no work RVUs. 1 = Diagnostic tests or radiology services: This indicator identifies codes that describe diagnostic tests, e.g., pulmonary function tests, or therapeutic radiology procedures, e.g., radiation therapy. These codes generally have both a professional and technical component. Modifiers 26 and TC can be used with these codes. The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense. The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier equals the sum of RVUs for both the professional and technical component. 2 = Professional component only codes: This indicator identifies stand alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test. An example of a professional component only code is 93010, Electrocardiogram; interpretation and report. Modifiers 26 and TC cannot be used with these codes. The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense. 3 = Technical component only codes: This indicator identifies stand alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic tests only.		

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
An example of a technical component code is 93005, Electrocardiogram, tracing only, without interpretation and report. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers 26 and TC cannot be used with these codes. The total RVUs for technical component only codes include values for practice expense and malpractice expense only. 4 = Global test only codes: This indicator identifies stand alone codes for which there are associated codes that describe: a) the professional component of the test only and b) the technical component of the test only. Modifiers 26 and TC cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice expense, and malpractice expense. The total RVUs for global procedure only codes equals the sum of the total RVUs for the professional and technical components only codes combined. 5 = Incident to Codes: This indicator identifies codes that describe services covered incident to a physicians service when they are provided by auxiliary personnel employed by the physician and working under his or her direct supervision. Payment may not be made by carriers for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers 26 and TC cannot be used with these codes. 6 = Laboratory physician interpretation codes: This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier TC cannot be used with these codes. The total RVUs for laboratory physician		

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
interpretation codes include values for physician work, practice expense and malpractice expense. 7 = Physical therapy service: Payment may not be made if the service is provided to either a hospital outpatient or inpatient by an independently practicing physical or occupational therapist. 8 = Physician interpretation codes: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient. This applies only to code 85060. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the PPS rate. No payment is recognized for code 85060 furnished to hospital outpatients or non-hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test. 9 = Concept of a professional/technical component does not apply		
Multiple Procedure (Modifier 51) Indicator indicates which payment adjustment rule for multiple procedures applies to the service. 0 = No payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure, base payment on the lower of: (a) the actual charge or (b) the fee schedule amount for the procedure. 1 = Standard payment adjustment rules in effect before January 1, 1996, for multiple procedures apply. In the 1996 MPFSDB, this indicator only applies to codes with procedure status of "D." If a procedure is reported on the same day as another procedure with an indicator of 1,2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50	1 Pic (x)1	35

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
percent, 25 percent, 25 percent, 25 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage. 2 = Standard payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage. 3 = Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in the endoscopic base code field. Apply the multiple endoscopy rules to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). If an endoscopic procedure is reported with only its base procedure, do not pay separately for the base procedure. Payment for the base procedure is included in the payment for the other endoscopy. 4 = Subject to MPPR reduction. 9 = Concept does not apply.		
Bilateral Surgery Indicator (Modifier 50) This field provides an indicator for services subject to a payment adjustment.	1 Pic (x)1	36

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
0 = 150 percent payment adjustment for bilateral procedures does not apply. The bilateral adjustment is inappropriate for codes in this category because of: (a) physiology or anatomy, or (b) because the code descriptor specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure. 1 = 150 percent payment adjustment for bilateral procedures applies. If code is billed with the bilateral modifier base payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150 percent of the fee schedule amount for a single code. If code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any applicable multiple procedure rules. 2 = 150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure. 3 = The usual payment adjustment for bilateral procedures does not apply. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures. If a procedure is billed with the 50 modifier, base payment on the lesser of the total		

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
actual charges for **each** side or 100% of the fee schedule amount for **each** side. 9 = Concept does not apply.		
Assistant at Surgery (Modifiers AS, 80, 81 and 82) This field provides an indicator for services where an assistant at surgery may be paid: 0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity. 1 = Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid. 2 = Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid. 9 = Concept does not apply.	1 Pic (x)1	37
Co-Surgeons (Modifier 62) This field provides an indicator for services for which two surgeons, each in a different specialty, may be paid. 0 = Co-surgeons not permitted for this procedure. 1 = Co-surgeons could be paid; supporting documentation required to establish medical necessity of two surgeons for the procedure. 2 = Co-surgeons permitted; no documentation required if two specialty requirements are met. 9 = Concept does not apply.	1 Pic (x)1	38
Team Surgeons (Modifier 66) This field provides an indicator for services for	1 Pic (x)1	39

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
which team surgeons may be paid. 0 = Team surgeons not permitted for this procedure. 1 = Team surgeons could be paid; supporting documentation required to establish medical necessity of a team; pay by report. 2 = Team surgeons permitted; pay by report. 9 = Concept does not apply.		
Endoscopic Base Codes This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.	5 Pic (x) 5	40-44
Performance Payment Indicator (For future use)	1 Pic x (1)	45
Diagnostic Imaging Family Indicator 88 = Subject to the reduction for diagnostic imaging (effective for services January 1, 2011, and after). 99 = Concept Does Not Apply	2 Pic x (2)	46-47
Filler	30 Pic x(30)	48-75

Health Professional Shortage Area (HPSA) Incentive Payments for Physicians

Section 1833 (m) of the Social Security Act, provides incentive payments for physicians who furnish services in areas designated as HPSAs under section 332(a)(1)(A) of the Public Health Service (PHS) Act. This statute recognizes geographic-based, primary medical care and mental health HPSAs, are areas for receiving a 10 percent bonus payment. The Health Resources and Services Administration (HRSA), within the Department of Health & Human Services, is responsible for designating shortage areas.

Physicians, including psychiatrists, who provide covered professional services in a primary medical care HPSA, are entitled to an incentive payment. In addition, psychiatrists furnishing services in mental health HPSAs are eligible to receive bonus payments. The bonus is payable for psychiatric services furnished in either a primary care HPSA, or a mental health HPSA. Dental HPSAs remain ineligible for the bonus payment.

Physicians providing services in either rural or urban HPSAs are eligible for a 10 percent incentive payment. It is not enough for the physician merely to have his/her office or primary service location in a HPSA, nor must the beneficiary reside in a HPSA, although, frequently, this will be the case. The key to eligibility is where the service is actually provided (place of service). For example, a physician providing a

service in his/her office, the patient's home, or in a hospital, qualifies for the incentive payment as long as the specific location of the service provision is within an area designed as a HPSA. On the other hand, a physician may have an office in a HPSA, but go outside the office (and the designated HPSA area) to provide the service. In this case, the physician would not be eligible for the incentive payment.

If the CAH electing the Optional Method (Method II) is located within a primary medical care HPSA, and/or mental health HPSA, the physicians providing (outpatient) professional services in the CAH are eligible for HPSA physician incentive payments. Therefore, payments to such a CAH for professional services of physicians in the outpatient department will be 115 percent **times** the amount payable under fee schedule **times** 110 percent. An approved Optional Method CAH that is located in a HPSA County should notify you of its HPSA designation **in writing**. Once you receive the information, place an indicator on the provider file showing the effective date of the CAH's HPSA status. The CMS will furnish quarterly lists of mental health HPSAs to intermediaries.

The HPSA incentive payment is 10 percent of the amount actually paid, not the approved amount. Do not include the incentive payment in each claim. Create a utility file so that you can run your paid claims file for a quarterly log. From this log you will send a quarterly report to the CAHs for each physician payment, one month following the end of each quarter. The sum of the "10% of line Reimbursement" column should equal the payment sent along with the report to the CAH. If any of the claims included on the report are adjusted, be sure the adjustment also goes to the report. If an adjustment request is received after the end of the quarter, any related adjustment by the FI will be included on next quarter's report. The CAHs must be sure to keep adequate records to permit distribution of the HPSA bonus payment when received. If an area is designated as both a mental health HPSA and a primary medical care HPSA, only one 10 percent bonus payment shall be made for a single service.

250.2.1 - Billing and Payment in a Physician Scarcity Area (PSA)

(Rev. 1434; Issued: 02-05-08; Effective: 01-01-08; Implementation: 01-07-08)

Section 413a of the MMA 2003 requires that a new 5 percent bonus payment be established for physicians in designated physician scarcity areas. The payment should be made on a quarterly basis and placed on the quarterly report that is now being produced for the HPSA bonus payments.

Section 1861(r)(1), of the Act, defines physicians as doctors of medicine or osteopathy. Therefore, dentists, chiropractors, podiatrists, and optometrists are not eligible for the physician scarcity bonus as either primary care or specialty physicians. Only the primary care designations of general practice, family practice, internal medicine, and obstetrics/gynecology, will be paid the bonus for the ZIP codes designated as primary care scarcity areas. All physician provider specialties are eligible for the specialty physician scarcity bonus except the following: oral surgery (dentist only); chiropractic; optometry; and podiatry. The bonus is payable for dates of service January 1, 2005, through December 31, 2007. The Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 amended §1833(u)(1) of the Social Security Act and has extended payment of that bonus through June 30, 2008.

One of the following modifier(s) must accompany the HCPCS code to indicate type of physician:

AG – Primary Physician
AF – Specialty Physician

Modifiers AG and AF are not required for dates of service on or after January 1, 2005. Modifier AR, physician providing services in a physician scarcity area, may be required for claims with dates of service on or after January 1, 2005 to receive the PSA bonus. Refer to §250.2.2 of this chapter for more information on when modifier AR is required.

There may be situations when a CAH is not located in a bonus area but its outpatient department is in a designated bonus area, or vice versa. If a CAH has an off-site outpatient department/clinic the off-site department's complete address, including the ZIP code, must be placed on the claim as the service facility. The FISS must look at the service facility ZIP code to determine if a bonus payment is due.

For electronic claims, the service facility address should be in the 2310E loop of the 837I. On the hard copy UB-04 the address should be placed in "Remarks"; however, the ZIP code placement will be determined by the FI.

250.2.2 - Zip Code Files

(Rev. 2169, Issued: 03-03-11, Effective: 04-01-11, Implementation: 04-04-11)

The CMS provided a file of ZIP Codes for the primary care and specialist care Physician Scarcity Area (PSA) bonus payment. The file is effective for claims with dates of service January 1, 2005 through June 30, 2008. Prior to January 1, 2005, CMS posted on its Web site ZIP Codes that are eligible for the bonus payment. Through regularly scheduled bulletins and list serves, intermediaries must notify the CAH to verify their ZIP Code eligibility via the CMS Web site.

ZIP Code files for the automated payment of the Health Professional Shortage Area (HPSA) bonus payment will be developed and updated annually. Effective for claims with dates of service on or after January 1, 2009, only services provided in areas that are designated as of December 31 of the prior year are eligible for the HPSA bonus payment. Physicians providing services in areas that were designated as of December 31 of the prior year but not on the automated file may use the AQ modifier. Only services provided in areas that were designated as of December 31 of the prior year but not on the automated file may use the modifier. Services provided in areas that are designated throughout the year will not be eligible for the HPSA bonus payment until the following year, provided they are still designated on December 31. Services provided in areas that are de-designated throughout the year will continue to be eligible for the HPSA bonus through the end of the calendar year.

The contractors and standard systems will be provided with a file at the appropriate time prior to the beginning of the calendar year for which it is effective. This file will contain ZIP Codes that fully and partially fall within a HPSA bonus area for both mental health and primary care services. A recurring update notification will be issued for each annual update. Contractors will be informed of the availability of the file and the file name via an email notice.

Contractors will automatically pay bonuses for services rendered in ZIP Code areas that: 1) fully fall within a designated primary care or mental health full county HPSA; 2) are considered to fully fall in the county based on a determination of dominance made by the United States Postal Service (USPS); or 3) are fully within a non-full county HPSA area. Should a ZIP Code fall within both a primary care and mental health

HPSA, only one bonus will be paid on the service. Bonuses for mental health HPSAs will only be paid when performed by psychiatrists.

For services rendered in ZIP Code areas: 1) that do not fall within a designated full county HPSA; 2) are not considered to fall within the county based on a determination of dominance made by the USPS; or 3) are partially within a non-full county HPSA, the CAH must still submit a AQ modifier to receive payment for claims. To determine whether a modifier is needed, the CAH must review the information provided on the CMS Web site for HPSA designations to determine if their location is, indeed, within a HPSA bonus area.

For service rendered in ZIP Code areas that cannot automatically receive the bonus, it will be necessary to know the census tract of the area to determine if a bonus should be paid and a modifier submitted. Census tract data can be retrieved by visiting the U.S. Census Bureau Web site at www.Census.gov.

Special Incentive Remittance for CAHS

A Special Incentive Remittance for CAHs is generated on a quarterly basis that identifies beneficiary and claims information for which a HPSA, PSA, Primary Care Incentive Payment Program (PCIP) or HPSA Surgical Incentive Payment Program (HSIP) payment is being made. Since there is a possibility that more than one type of incentive payment may be paid for a single service, each type of incentive payment being made is identified on the remittance as follows:

1 = HPSA

2 = PSA

3 = HPSA and PSA

4 = HSIP

5 = HPSA and HSIP

6 = PCIP

7 = HPSA and PCIP

Space = Not Applicable

See sections 250.12 through 250.12.4 for more information on PCIP payments to CAHs paid under the optional method.

Use the information in the Professional Component/Technical Component (PC/TC) indicator field of the CORF extract of the Medicare Physician Fee Schedule Supplementary File to identify professional services eligible for HPSA and physician scarcity bonus payments. The following are the rules to apply in determining whether to pay the bonus on services furnished within a geographic HPSA billed with a QB or QU modifier for dates of service prior to January 01, 2006 or the AQ modifier for services on or after January 01, 2006, and/or whether to pay the bonus on services furnished within a Physician Scarcity Area with the AR modifier effective for dates of service January 01, 2005, through June 30, 2008.

(Field 20 on the full MPFS file layout)

PC/TC Indicator	Bonus Payment Policy
0	Physician services. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. ACTION: Pay the bonus
1	Globally billed. Only the professional component of this service qualifies for the bonus payment. The bonus cannot be paid on the technical component of globally billed services. ACTION: Return the service as unprocessable and notify the CAH that the professional component must be re-billed if it is performed within a qualifying bonus area. If the technical component is the only component of the service that was performed in the bonus area, there wouldn't be a qualifying service.
1	Professional Component (modifier 26). ACTION: Pay the bonus.
1	Technical Component (modifier TC). ACTION: Do not pay the bonus.
2	Professional Component only. ACTION: Pay the bonus.
3	Technical Component only. ACTION: Do not pay the bonus.
4	Global test only. Only the professional component of this service qualifies for the bonus payment. ACTION: Return the service as unprocessable. Instruct the provider to re-bill the service as separate professional and technical component procedure codes.
5	Incident to codes. ACTION: Do not pay the bonus.
6	Laboratory physician interpretation codes. ACTION: Pay the bonus
7	Physical therapy service. ACTION: Do not pay the bonus.

8	Physician interpretation codes. ACTION: Pay the bonus.
9	Concept of PC/TC does not apply. ACTION: Do not pay the bonus.

NOTE: Codes that have a status of "X" on the CORF extract Medicare Physician Fee Schedule Database (MFSDB) have been assigned PC/TC indicator 9 and are not considered physician services for MFSDB payment purposes. Therefore, neither the HPSA bonus nor the physician bonus payment (5 percent) will be paid for these codes.

250.3 – Payment for Anesthesia in a Critical Access Hospital (CAH)
(Rev 41, 12-08-03)

Payment for anesthesia services is based on the HCPCS FILE, the Anesthesia Conversion Factor File, and the CORF extract of the MPFS Summary File.

250.3.1 – Anesthesia File
(Rev. 41, 12-08-03)

Conversion Factor File = MU00.@BF12390.MPFS.CY04.ANES.V1023

Record Layout for the Anesthesia Conversion Factor File

Data Element Name	Picture	Location	Length
Carrier Number	X (5)	1-5	5
Locality Number	X (2)	13-14	2
Locality Name	X (30)	19-48	30
Anesthesia CF 2002	99V99	74-77	4

250.3.2 – Physician Rendering Anesthesia in a Hospital Outpatient Setting
(Rev. 2452, Issued: 04-26-12, Effective: 01-10-12, Implementation: 10-01-12)

When a medically necessary anesthesia service is furnished within a HPSA area by a physician, a HPSA bonus is payable. In addition to using the PC/TC indicator on the CORF extract of the MPFS Summary File to identify HPSA services, pay physicians the HPSA bonus when CPT codes 00100 through 01999 are billed with the following modifiers: QY, QK, AA, or GC and "QB" or "QU" in revenue code 963. Modifier QB or QU must be submitted to receive payment of the HPSA bonus for claims with dates of service prior to January 01, 2006. Effective for claims with dates of service on or after January 01, 2006, the modifier AQ, physician providing a service in a health professional shortage area, may be required to receive the HPSA bonus. Refer to §250.2.2 of this chapter for more information on when modifier AQ is required.

The modifiers signify that a physician performed an anesthesia service. Using the Anesthesia File (See Section above) the physician service will be 115 percent times the payment amount to be paid to a CAH on Method II payment plus 10 percent HPSA bonus payment.

Anesthesiology modifiers:

AA = anesthesia services performed personally by anesthesiologist.
GC =service performed, in part, by a resident under the direction of a teaching physician.
QK = medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.
QY = medical direction of one CRNA by an anesthesiologist.

Modifiers AA and GC result in physician payment at 100% of the allowed amount.
Modifiers QK and QY result in physician payment at 50% of the allowed amount.

Data elements needed to calculate payment:

- HCPCS plus Modifier,
- Base Units,
- Time units, based on standard 15 minute intervals,
- Locality specific anesthesia Conversion factor, and
- Allowed amount minus applicable deductions and coinsurance amount.

Formula 1: Calculate payment for a physician performing anesthesia alone

HCPCS = xxxxx
Modifier = AA
Base Units = 4
Anesthesia Time is 60 minutes. Anesthesia time units = 4 (60/15)
Sum of Base Units plus Time Units = 4 + 4 = 8
Locality specific Anesthesia conversion factor = $17.00 (varies by localities)
Coinsurance = 20%

Example 1: Physician personally performs the anesthesia case

Base Units plus time units - 4+4=8
Total units multiplied by the anesthesia conversion factor times .80
8 x $17= ($136.00 – (deductible*) x .80 = $108.80
Payment amount times 115 percent for the CAH method II payment.
$108.80 x 1.15 = $125.12 (Payment amount)
$125.12 x .10 = $12.51 (HPSA bonus payment)
*Assume the Part B deductible has already been met for the calendar year

Formula 2: Calculate the payment for the physician's medical direction service when the physician directs two concurrent cases involving CRNAs. The medical direction allowance is 50% of the allowance for the anesthesia service personally performed by the physician.

HCPCS = xxxxx
Modifier = QK
Base Units = 4
Time Units 60/15=4
Sum of base units plus time units = 8
Locality specific anesthesia conversion factor = $17(varies by localities)
Coinsurance = 20 %

(Allowed amount adjusted for applicable deductions and coinsurance and to reflect payment percentage for medical direction).

Example 2: Physician medically directs two concurrent cases involving CRNAs Base units plus time - 4+4=8
Total units multiplied by the anesthesia conversion factor times. 50 equal allowed amount minus any remaining deductible
8 x $17 = $136 x .50 = $68.00 –(deductible*) = $68.00
Allowed amount Times 80 percent times 1.15
$68.00 x .80 = $54.40 x 1.15 = 62.56 (Payment amount)
$62.56 x .10 = $6.26 (HPSA bonus payment)
*Assume the deductible has already been met for the calendar year.

NOTE: *For specific guidance on payment for Anesthesia and Teaching Services please review the following sections:*

- *Payment for Anesthesiology Services Pub.100-04, Chapter 12, Section 50*
- *Teaching Physician Services Pub.100-04, Chapter 12, Section 100.1.2 (4) Anesthesia.*

250.3.3 - Anesthesia and CRNA Services in a Critical Access Hospital (CAH)

(Rev. 616, Issued: 07-22-05, Effective: 10-01-02, Implementation: 01-03-06)

250.3.3.1 - Payment for CRNA Pass-Through Services

(Rev. 616, Issued: 07-22-05, Effective: 10-01-02, Implementation: 01-03-06)

If a CAH that meets the criteria for a pass-through exemption is interested in selecting the Method II option, it can choose this option for all outpatient professionals except the CRNA's and still retain the approved CRNAs exemption for both inpatient and outpatient professional services of CRNAs. The CAH, with an approved exemption, can choose to give up its exemption for both inpatient and outpatient professional services of CRNAs in order to include its CRNA outpatient professional services along with those of all other professional services under the Method II option. By choosing to include the CRNAs under the Method II for outpatient services, it loses its CRNA pass-through exemption for not only the outpatient CRNA services, but also the inpatient CRNA services. In this case the CAH would have to bill the Part B carrier for the CRNA inpatient professional services.

All intermediary payments for CRNA services are subject to cost settlement.

If a CAH that meets the criteria for a pass-through exemption is not interested in selecting the Method II option, the CAH can still receive the CRNA pass-through under the Standard Option (Method I). Below are the billing requirements for Method I.

Provider Billing Requirements for Method I

TOBs = 85X and 11X

Revenue Code 037X for CRNA technical services

Revenue Code 0964 for Professional services

HCPCS Code = Anesthesia HCPCS code (00100 through 01999 HCPCS range)

Units = Anesthesia

Reimbursement

Revenue Code 37X, CRNA technical service = Cost Reimbursement

Revenue Code 0964, CRNA professional service = Cost Reimbursement for both inpatient and outpatient

Deductible and coinsurance apply.

250.3.3.2 - Payment for Anesthesia Services by a CRNA (Method II CAH only)

(Rev. 2137, .Issued: 01-21-11, Effective: 07-01-07, Implementation: 07-05-11)

Provider Billing Requirements for Method II Receiving the CRNA Pass-Through

TOB = 85X

Revenue Code 037X = CRNA technical service

Revenue Code 0964 = CRNA professional service

HCPCS Code = Anesthesia HCPCS code (00100 through 01999 HCPCS range)

Units = Anesthesia

Reimbursement

Revenue Code 037X, CRNA technical service = cost reimbursement

Revenue Code 0964, CRNA professional service = cost reimbursement

Deductible and coinsurance apply.

Provider Billing Requirements for Method II CRNA – Gave up Pass-Through Exemption (or never had exemption)

TOB = 85X

Revenue Code = 037X for CRNA technical service

Revenue Code = 0964 for CRNA professional service

Reimbursement – For dates of service on or after July 1, 2007

Revenue Code 037X for CRNA technical service = cost reimbursement

Revenue Code 0964 for CRNA professional service = based on 100 percent of the allowed amount when not medically directed or 50 percent of the allowed amount when medically directed.

Providers bill a "QZ" modifier for non-medically directed CRNA services. Deductible and coinsurance apply.

How to calculate payment for anesthesia claims based on the formula – For dates of service on or after July 1, 2007

Identify anesthesia claims by HCPCS code range from 00100 through 01999
Non-medically directed CRNA

(Sum of base units plus time (anesthesia time divided by 15)) times conversion factor minus (deductible and coinsurance) times 1.15

Medically directed CRNA

(Sum of base units plus time (anesthesia time divided by 15)) times conversion factor times medically directed reduction (50 %) minus (deductible and coinsurance) times 1.15

Reimbursement – For dates of service prior to July1, 2007

Revenue Code 037X for CRNA technical service = cost reimbursement

Revenue Code 0964 for CRNA professional service = 115% times 80% (not medically directed) or 115% times 50% (medically directed) of allowed amount (Use Anesthesia formula) for outpatient CRNA professional services.

Providers a "QZ" modifier for non-medically directed CRNA services. Deductible and coinsurance apply.

How to calculate payment for anesthesia claims based on the formula - For dates of service prior to July 1, 2007

Add the anesthesia code base unit and time units. The time units are calculated by dividing actual anesthesia time (Units field on the UB92) by 15. Multiply the sum of base and time units by the locality specific anesthesia conversion factor (file name below).

The Medicare program pays the CRNA 80% of this allowable charge when not medically directed. Deductible and coinsurance apply.

If the CRNA is medically directed, pay 50% of the allowable charge. Deductible and coinsurance apply.

Base Formula

Number of minutes divided by 15, plus the base units = Sum of base units and time

Sum of base units and time times the conversion factor = allowed amount

Source

Number of minutes = Number of units on the claim (Units field of the UB04) Base Units = Anesthesia HCPCS

Conversion Factor = File – MU00.@BF12390.MPFS.CYXX.ANES.V1023

250.4 - CAH Outpatient Services Part B Deductible and Coinsurance

(Rev. 1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)

Payment for outpatient services of a CAH is subject to applicable Medicare Part B deductible and coinsurance amounts unless waived based on statute.

For information on the application of deductible and coinsurance for screening and preventive services, see chapter 18 of Pub. 100-04, Medicare Claims Processing Manual.

Payments for clinical diagnostic laboratory tests furnished to CAH outpatients on or after November 29, 1999, are made on a reasonable cost basis with no beneficiary cost-sharing – no coinsurance, deductible, copayment, or any other cost-sharing.

250.5 - Medicare Payment for Ambulance Services Furnished by Certain CAHs

(Rev. 2291, Issued: 08-26-11, Effective: 10-01-11, Implementation: 10-03-11)

Medically necessary ambulance services furnished for dates of service on or after December 21, 2000 and prior to January 1, 2004, by a CAH or by an entity that is owned and operated by the CAH are paid based on 100 percent of the reasonable costs if the 35 mile rule for reasonable cost-based payment is met.

For dates of service on or after January 1, 2004, medically necessary ambulance services furnished by a CAH or by an entity that is owned and operated by the CAH are paid based on 101 percent of the reasonable costs if the 35 mile rule for reasonable cost-based payment is met.

For dates of service on or after December 21, 2000 and prior to October 1, 2011, in order for the 35 mile rule to be met, the CAH or the entity that is owned and operated by the CAH, must be the only provider or supplier of ambulance services located within a 35 mile drive of the CAH or the entity.

For dates of service on or after October 1, 2011, in order for the 35 mile rule to be met, the CAH or the entity that is owned and operated by the CAH, must be the only provider or supplier of ambulance services located within a 35 mile drive of the CAH. Additionally, if there is no provider or supplier of ambulance services located within a 35 mile drive of the CAH but there is an entity owned and operated by the CAH located more than a 35 mile drive from the CAH, that CAH-owned and operated entity can only be paid 101

percent of reasonable costs for its ambulance services if it is the closest provider or supplier of ambulance services to the CAH.

Section 205 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 exempts certain CAHs from the current Medicare ambulance cost per trip payment limit as well as from the ambulance fee schedule. Section 205(a) of BIPA states:

> The Secretary shall pay the reasonable costs incurred in furnishing ambulance services if such services are furnished (A) by a CAH (as defined in §1861(mm)(1)), or (B) by an entity that is owned and operated by a CAH, but only if the CAH or entity is the only provider or supplier of ambulance services that is located within a 35-mile drive of such CAH.

Those CAHs and CAH-owned and operated entities that meet the 35 mile rule for reasonable cost-based payment shall report condition code B2 (CAH ambulance attestation) on their bills.

When the 35 mile rule for reasonable cost-based payment is not met, the CAH ambulance service or the ambulance service furnished by the entity that is owned and operated by the CAH, is paid based on the ambulance fee schedule.

250.6 - Clinical Diagnostic Laboratory Tests Furnished by CAHs

(Rev. 1782; Issued: 07-30-09; Effective Date: 07-01-09; Implementation Date: 07-06-09)

Medicare beneficiaries are not liable for any coinsurance, deductible, copayment, or other cost sharing amount for clinical diagnostic laboratory services furnished as a CAH outpatient service.

For dates of service prior to July 1, 2009, payment for clinical diagnostic laboratory tests furnished by a CAH is made at 101 percent of reasonable cost only if the patient is an outpatient of the CAH and is physically present in the CAH at the time the specimen is collected - (Type of Bill (TOB), 85x).

For dates of service on or after July 1, 2009, an individual is no longer required to be physically present in a CAH at the time the specimen is collected. However, the individual must be an outpatient of the CAH, as defined at 42 CFR §410.2 and be receiving services directly from the CAH. In order for the individual to be receiving services directly from the CAH, the individual must either be receiving outpatient services in the CAH on the same day the specimen is collected, or the specimen must be collected by an employee of the CAH.

Tests for non-patients are billed on TOB 14x, and are paid under the lab fee schedule.

250.7 – Payment for Outpatient Services Furnished by an Indian Health Service (IHS) or Tribal CAH

(Rev. 231, Issued 07-23-04, Effective: 01-01-04/Implementation: 01-03-05)

The IHS or Tribal CAHs are paid for outpatient services based on a facility specific visit rate that is established on a yearly basis from prior year cost report information.

Payment for outpatient IHS or Tribal CAH services is paid at 80% of the facility specific outpatient visit rate for both facilities electing Standard Method (I) and Optional Method (II) billing. IHS or Tribal CAHs

will follow the billing methodology for the billing method that is chosen. Standard Method (I) is found in §250.1 and Optional Method (II) is found in §250.2 of this chapter. Facilities billing under the Optional Method (II) will follow the methodology for HPSA and Scarcity payments as outlined in §250.2 of this chapter. Outpatient services provided at IHS or Tribal CAHs should be billed on an 85X type of bill.

Effective for cost reporting periods beginning on or after January 1, 2004, payment for outpatient IHS or Tribal CAH outpatient services will be made at 101% of the facility specific outpatient visit rate less applicable Part B deductible and coinsurance amounts.

250.8 – Coding for Administering Drugs in a Method II CAH

(Rev. 803, Issued: 01-03-06, Effective: 04-03-06, Implementation: 04-03-06)

This section provides billing guidance and payment instructions for hospitals when providing drugs and drug administration services in a Method II CAH.

250.8.1 – Coding for Low Osmolar Contrast Material (LOCM)

(Rev. 803, Issued: 01-03-06, Effective: 04-03-06, Implementation: 04-03-06)

Method II CAHs bill the outpatient physician involvement (professional component) for the administration of Low Osmolar Contrast Material (LOCM) with revenue code 96X, 97X or 98X on type of bill (TOB) 85X. Bills must include an appropriate outpatient hospital visit CPT code for evaluation and management (E & M).

The technical component for LOCM may be billed by both Method I and Method II CAHs with revenue code 636 and one of the following HCPCS codes as appropriate:

Q9945	Low osmolar contrast material (up to 149 mg/ml iodine concentration, per	ml);
Q9946	Low osmolar contrast material (150 - 199 mg/ml iodine concentration, per	ml);
Q9947	Low osmolar contrast material (200 - 249 mg/ml iodine concentration, per	ml);
Q9948	Low osmolar contrast material (250 - 299 mg/ml iodine concentration, per	ml);
Q9949	Low osmolar contrast material (300 - 349 mg/ml iodine concentration, per	ml);
Q9950	Low osmolar contrast material (350 - 399 mg/ml iodine concentration, per	ml); and
Q9951	Low osmolar contrast material (400 or greater mg/ml iodine concentration, per ml).	

250.8.2 – Coding for the Administration of Other Drugs and Biologicals

(Rev. 803, Issued: 01-03-06, Effective: 04-03-06, Implementation: 04-03-06)

Outpatient physician involvement for hydration; therapeutic or diagnostic injections and intravenous (IV) infusions (other than hydration); and chemotherapy administration in a Method II CAH is included in the physicians evaluation and management (E & M) services. Bills must include an appropriate outpatient hospital visit E & M CPT code with revenue code 96X, 97X or 98X on TOB 85X.

See §250.2 for information on fee schedule payment for professional services.

250.9 – Coding Assistant at Surgery Services Rendered in a Method II CAH

(Rev. 1620; Issued: 10-24-08; Effective: 01-01-08; Implementation: 04-06-09)

An assistant at surgery is a physician or non-physician practitioner who actively assists the physician in charge of the case in performing a surgical procedure.

Medicare makes payment for an assistant at surgery when the procedure is authorized for an assistant and the person performing the service is a physician, physician assistant (PA), nurse practitioner (NP) or a clinical nurse specialist (CNS).

Assistant at surgery services rendered by a physician or non-physician practitioner that has reassigned their billing rights to a Method II CAH are payable by Medicare when the procedure is billed on type of bill 85X with revenue code (RC) 96X, 97X or 98X and an appropriate assistant at surgery modifier.

Under authority of 42 CFR 414.40, CMS establishes uniform national definitions of services, codes to represent services, and payment modifiers to the codes. This includes the use of payment modifiers for assistant at surgery services.

Modifier 80 (assistant surgeon), 81 (minimum assistant surgeon), or 82 (when qualified resident surgeon not available) is used to bill for assistant at surgery services. When billed without modifier AS (PA, NP or CNS services for assistant at surgery) the use of these modifiers indicate that a physician served as an assistant at surgery.

Modifier AS is billed to indicate that a PA, NP or CNS served as the assistant at surgery. Modifier 80, 81 or 82 must also be billed when modifier AS is billed. Claims submitted with modifier AS and without modifier 80, 81 or 82 are returned to the provider (RTPd).

250.9.1 – Use of Payment Policy Indicators for Determining Procedures Eligible for Payment of Assistants at Surgery

(Rev. 1620; Issued: 10-24-08; Effective: 01-01-08; Implementation: 04-06-09)

Medicare makes payment for an assistant at surgery when the procedure is authorized for an assistant and the person performing the service is a physician, PA, NP or a CNS.

Section 1862 of the Act stipulates that no payment can be made for care that is not reasonable and necessary. Specifically, Section 1862(15)(A) addresses services of an assistant at surgery and when those services are statutorily excluded.

Medicare uses the payment policy indicators on the Medicare Physician Fee Schedule Database (MPFSDB) to determine if assistant at surgery services are reasonable and necessary for a specific HCPCS/CPT code. The MPFSDB is located at http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp.

Since all of the information housed on the MPFSDB is not needed to process Method II CAH claims, the payment policy indicators that are needed are extracted on a quarterly basis for use in processing these claims and sent to the fiscal intermediaries on the Physician Fee Schedule Payment Policy Indicator File.

See the Physician Fee Schedule Payment Policy Record Layout in §250.2 for a description of the assistant at surgery payment policy indicators.

250.9.2 – Payment of Assistant at Surgery Services Rendered in a Method II CAH
(Rev. 1620; Issued: 10-24-08; Effective: 01-01-08; Implementation: 04-06-09)

Under Section 1834(g)(2)(B) of the Social Security Act (the Act) outpatient professional services performed in a Method II CAH are paid 115 percent of such amounts as would otherwise be paid under the Act if the services were not included in the outpatient CAH services.

Section 1848(i)(2)(B) of the Act stipulates that in the case of a surgical service furnished by a physician, if payment is made separately under the Act for the services of a physician serving as an assistant at surgery, payment shall not exceed 16 percent of the MPFS amount.

Payment for assistant at surgery services performed by a physician is calculated as follows:

> ((facility specific MPFS amount times assistant at surgery reduction % (16%)) minus (deductible and coinsurance)) times 115%

Section 1833(a)(1)(O)(ii) of the Act states that in the case of a PA, NP or CNS the amounts paid for serving as an assistant at surgery shall be the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery. The payment methodology for these services has been codified in regulations found at 42 CFR 414.52(d) and 414.56(c).

Payment for assistant at surgery services performed by a PA, NP, or CNS is calculated as follows:

> ((facility specific MPFS) amount times assistant at surgery reduction (16%) times non-physician practitioner reduction % (85%)) minus (deductible and coinsurance)) times 115%

250.9.3 – Assistant at Surgery Medicare Summary Notice (MSN) and Remittance Advice (RA) Messages
(Rev. 1620; Issued: 10-24-08; Effective: 01-01-08; Implementation: 04-06-09)

Contractors shall use the following MSN and RA messages when denying medically unnecessary assistant at surgery services for HCPCS/CPT codes with a payment policy indicator of ‘0’ or ‘2’ when an Advance Beneficiary Notice (ABN) was issued.

MSN Message:

36.1 Our records show that you were informed in writing, before receiving the service, that Medicare would not pay. You are liable for this charge. If you do not agree with this statement, you may ask for a review.

Spanish version:

36.1 Nuestros archivos indican que usted fue informado por escrito, antes de recibir el servicio, que Medicare no pagaría. Usted es responsable por esta cantidad. Si usted no está de acuerdo, usted puede pedir una revisión.

RA Remark Code

M38 The patient is liable for charges for this service as you informed the patient in writing before the service was furnished that we could not pay for it, and the patient agreed to pay.

RA Group Code
PR – Patient Responsibility

RA Claim Adjustment Reason Code
54 – Multiple physicians/assistants are not covered in this case.

The following MSN and RA messages are used when denying medically unnecessary assistant at surgery services for HCPCS/CPT codes with a payment policy indicator of '0' or '2' when an ABN was **not** issued.

MSN Message
36.2 It appears that you did not know that we would not pay for this service, so you are not liable. Do not pay your provider for this service. If you have paid your provider for this service, you should submit to this office 3 things: (1) a copy of this notice, (2) your provider's bill, and (3) a receipt or proof that you have paid the bill. You must file your written request for payment within 6 months of the date of this notice. Future services of this type provided to you will be your responsibility.

Spanish version:

36.2 Aparentemente, usted no sabia que nosotros no pagamos por este servicio, por lo tanto usted no es responsable. Si usted le pagó al proveedor por este servicio debe enviarnos lo siguiente: (1) Copia de esta notificación; (2) Factura del proveedor; (3) El recibo o prueba de que usted le pagó. Debe enviar su petición por escrito dentro de 6 meses de la fecha de esta notificación. Servicios de este tipo prestados en el futuro serán su responsabilidad.

RA Remark Code

M27 The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.

RA Group Code
CO – Contractual Obligation

RA Claim Adjustment Reason Code
54 – Multiple physicians/assistants are not covered in this case.

Contractors shall use the following MSN and RA messages when denying assistant at surgery services for HCPCS/CPT codes with a payment policy indicator of '1'.

MSN Message
15.11 – Medicare does not pay for an assistant surgeon for this procedure/surgery.

Spanish version:

15.11 - Medicare no paga por el asistente del cirujano por este procedimiento/cirugía.

RA Remark Code
N425 – Statutorily Excluded Service

RA Group Code
PR – Patient Responsibility

RA Claim Adjustment Reason Code
54 – Multiple physicians/assistants are not covered in this case.

250.9.4 – Assistant at Surgery Services in a Method II CAH Teaching Hospital
(Rev. 1620; Issued: 10-24-08; Effective: 01-01-08; Implementation: 04-06-09)

Section 1842(b)(7)(D) stipulates that no payment shall be made for the services of assistant at surgery with respect to a surgical procedure if a hospital has a training program relating to the medical specialty required for the surgical procedure and a qualified individual on the staff of the hospital is available to provide such services.

Fiscal intermediaries (FIs) and A/B MACs process assistant at surgery claims for services furnished in a teaching hospital through the use of modifier 82 which indicates that a qualified resident was not available. Modifier 82 is for use only when the basis for payment is the unavailability of qualified residents.

Payment may be made for the services of assistants at surgery in teaching hospitals not withstanding the availability of a qualified resident to furnish the services. There may be exceptional medical circumstances (emergency, life threatening situations such as multiple traumatic injuries) which require immediate treatment. There may be situations in which the medical staff may find that exceptional medical circumstances justify the services of a physician assistant at surgery even though a qualified resident is available.

Payment may also be made for the services of assistants at surgery in teaching hospitals, if the primary surgeon has an across-the-board policy of never involving residents in the preoperative, operative, or postoperative care of his or her patients.

Claims submitted by a Method II CAH teaching hospital on type of bill 85X with RC 96X, 97X or 98X and modifier AS, 80 or 81 are suspended for review by the FIs or A/B MAC when the HCPCS/CPT code has a payment policy indicator of '0' or '2'.

NOTE: Teaching hospitals are identified by an intern to bed ratio greater than 0 (zero), this field is located on the Provider Specific File.

250.9.5 – Review of Supporting Documentation for Assistant at Surgery Services in a Method II CAH

(Rev. 1620; Issued: 10-24-08; Effective: 01-01-08; Implementation: 04-06-09)

Given the absence of national policy on this provision, FIs and A/B MACs have the authority to establish procedures to define the appropriate supporting documentation needed to establish medical necessity, the existence of exceptional medical circumstances or to determine if the primary surgeon has an across-the-board policy of never involving residents in the preoperative, operative or postoperative care of his patients for assistant at surgery services. The FIs and A/B MACs shall also determine if a clinician or non-clinician medical reviewer shall review assistant at surgery services.

250.10 – Coding Co-surgeon Services Rendered in a Method II CAH

(Rev. 1781, Issued: 07-29-09; Effective: 01-01-08; Implementation: 07-06-09)

Under some circumstances, the skills of two surgeons (each in a different specialty) are required to perform surgery on the same patient during the same operative session. This may be required because of the complex nature of the procedure(s) and/or the patient's condition.

Co-surgery refers to a single surgical procedure which requires the skill of two surgeons, each in a different specialty, performing parts of the same procedure simultaneously. It is not always co-surgery when two doctors perform surgery on the same patient during the same operative session. Co-surgery has been performed if the procedure(s) performed is part of and would be billed under a **single surgical procedure code**.

When two surgeons work together as primary surgeons performing distinct part(s) of a single reportable procedure, each surgeon shall report his/her distinct operative work by reporting the same surgical procedure code and the 62 modifier (two surgeons).

The potential exists that there may only be one line billed on a Method II CAH claim with modifier 62. This occurs when one of the co-surgeons reassigns their billing rights to the CAH and the other co-surgeon does not reassign their billing rights to the CAH. The claim for the co-surgeon that reassigned their billing rights would be processed by the fiscal intermediary (FI)/A/B Medicare Administrative Contractor (MAC). The claim for the co-surgeon that did not reassign their billing rights to the CAH would be processed by the carrier/A/B MAC. The fiscal intermediary standard system (FISS) will accept and process claims with one line with a surgical procedure code and modifier 62 or two lines with the same surgical procedure code, line item date of service (LIDOS) and modifier 62. The FISS shall deny line items without the 62 modifier on claims with the same surgical procedure code and LIDOS when only one line has the 62 modifier.

Co-surgeon services rendered by a physician that has reassigned their billing rights to a Method II CAH are payable by Medicare when the procedure is authorized for co-surgeons and is billed on type of bill 85X with revenue code (RC) 96X, 97X or 98X and the 62 modifier.

Under authority of 42 CFR 414.40, CMS establishes uniform national definitions of services, codes to represent services, and payment modifiers to the codes. This includes the use of payment modifiers for co-surgeon services.

250.10.1 – Use of Payment Policy Indicators for Determining Procedures Eligible for Payment of Co-surgeons

(Rev. 1781, Issued: 07-29-09; Effective: 01-01-08; Implementation: 07-06-09)

Section 1862 of the Social Security Act (the Act) stipulates that no payment can be made for care that is not reasonable and necessary for the diagnosis and treatment of illness or injury.

Medicare uses the payment policy indicators on the Medicare Physician Fee Schedule Database (MPFSDB) to determine if co-surgeon services are reasonable and necessary for a specific HCPCS/CPT code. The MPFSDB is located at http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp . The FIs and A/B MACs have access to the payment policy indicators via the Physician Fee Schedule Payment Policy Indicator File in the FISS.

See the Physician Fee Schedule Payment Policy Record Layout in §250.2 for a description of the co-surgeon payment policy indicators.

250.10.2 – Payment of Co-surgeon Services Rendered in a Method II CAH

(Rev. 1781, Issued: 07-29-09; Effective: 01-01-08; Implementation: 07-06-09)

Under Section 1834(g)(2)(B) of the Act outpatient professional services performed in a Method II CAH are paid 115 percent of such amounts as would otherwise be paid under the Act if the services were not included in the outpatient CAH services.

Payment for co-surgeon services performed by a physician is based on the lesser of the actual charges or the reduced fee schedule amount (62.5%) and is calculated as follows:
((facility specific MPFS amount times co-surgery reduction % (62.5%)) minus (deductible and coinsurance)) times 115%.

250.10.3 – Co-surgeon Services Medicare Summary Notice (MSN) and Remittance Advice (RA) Messages

(Rev. 1781, Issued: 07-29-09; Effective: 01-01-08; Implementation: 07-06-09)

Contractors shall use the following MSN and RA messages when denying co-surgeon services for HCPCS/CPT codes with a payment policy indicator of ‘0’.

MSN Messages:

15.12 – Medicare does not pay for two surgeons for this procedure.

Spanish version:

15.12 - Medicare no paga por dos cirujanos para este procedimiento.

RA Remark Code
N431 – Service is not covered with this procedure.

RA Group Code
PR – Patient Responsibility

RA Claim Adjustment Reason Code
54 – Multiple physicians/assistants are not covered in this case.

Contractors shall use the following MSN and RA messages when denying medically unnecessary co-surgeon services for HCPCS/CPT codes with a payment policy indicator of '1' when an Advance Beneficiary Notice (ABN) was issued.

MSN Message

36.1 - Our records show that you were informed in writing, before receiving the service, that Medicare would not pay. You are liable for this charge. If you do not agree with this statement, you may ask for a review.

Spanish version:

36.1 - Nuestros archivos indican que usted fue informado por escrito, antes de recibir el servicio, que Medicare no pagaría. Usted es responsable por esta cantidad. Si usted no está de acuerdo, usted puede pedir una revisión.

RA Remark Code

M38 - The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.

RA Group Code
PR – Patient Responsibility

RA Claim Adjustment Reason Code
54 – Multiple physicians/assistants are not covered in this case.

Contractors shall use the following MSN and RA messages when denying medically unnecessary co-surgeon services for HCPCS/CPT codes with a payment policy indicator of '1' when an Advance Beneficiary Notice (ABN) was **not** issued.

MSN Message

36.2 - It appears that you did not know that we would not pay for this service, so you are not liable. Do not pay your provider for this service. If you have paid your provider for this service, you should submit to this office three things: (1) a copy of this notice, (2) your provider's bill, and (3) a receipt or proof that you have paid the bill. You must file your written request for payment within 6 months of the date of this notice. Future services of this type provided to you will be your responsibility.
Spanish version:

36.2 - Aparentemente, usted no sabia que nosotros no pagamos por este servicio, por lo tanto usted no es responsable. Si usted le pagó al proveedor por este servicio debe enviarnos lo siguiente: (1) Copia de esta notificación; (2) Factura del proveedor; (3) El recibo o prueba de que usted le pagó. Debe enviar su petición por escrito dentro de 6 meses de la fecha de esta notificación. Servicios de este tipo prestados en el futuro serán su responsabilidad.

RA Remark Code

M27 - The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.

RA Group Code
CO – Contractual Obligation

RA Claim Adjustment Reason Code
54 – Multiple physicians/assistants are not covered in this case.

Contractors shall use the following MSN and RA messages when denying co-surgeon services for HCPCS/CPT codes with a payment policy indicator of '2' when the co-surgeons each have the same specialty.

MSN Message

21.21 – This service was denied because Medicare only covers this service under certain circumstances.

Spanish version:
21.21 - Este servicio fue denegado porque Medicare solamente lo cubre bajo ciertas circunstancias.

RA Remark Code
N95 – The provider type/provider specialty may not bill this service.

RA Group Code
PR – Patient Responsibility

RA Claim Adjustment Reason Code
54 – Multiple physicians/assistants are not covered in this case.

Contractors shall use the following MSN and RA messages when denying line items for co-surgeon services without the 62 modifier on claims with the same surgical procedure code and line item date of service on more than one line when only one line has the 62 modifier.

MSN Message
16.10 – Medicare does not pay for this item or service.
Spanish version:
Medicare no paga por este artículo o servicio.

RA Remark Code
N180 – This item or service does not meet the criteria for the category under which it was billed.

RA Group Code
CO – Contractual Obligation

RA Claim Adjustment Reason Code
4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.

250.10.4 – Review of Supporting Documentation for Co-surgeon Services in a Method II CAH

(Rev. 1781, Issued: 07-29-09; Effective: 01-01-08; Implementation: 07-06-09)

Given the absence of national policy on this provision, FIs and A/B MACs have the authority to establish procedures to define the appropriate supporting documentation needed to establish medical necessity. The FIs and A/B MACs shall also determine if a clinician or non-clinician medical reviewer shall review co-surgeon services.

250.11 – Coding Bilateral Procedures Performed in a Method II CAH

(Rev. 1777; Issued: 07-24-09; Effective Date: 01-01-08; Implementation Date: 01-04-10)

Under authority of 42 CFR 414.40, CMS establishes uniform national definitions of services, codes to represent services, and payment modifiers to the codes. This includes the use of payment modifiers for bilateral procedures.

Bilateral procedures rendered by a physician that has reassigned their billing rights to a Method II CAH are payable by Medicare when the procedure is authorized as a bilateral procedure and is billed on type of bill 85X with revenue code (RC) 96X, 97X or 98X and the 50 modifier (bilateral procedure).

Modifier 50 applies to a bilateral procedure performed on both sides of the body during the same operative session. When a procedure is identified by the terminology as bilateral or unilateral, the 50 modifier is not reported.

If a procedure is authorized for the 150 percent payment adjustment for bilateral procedures (payment policy indicator 1), the procedure shall be reported on a single line item with the 50 modifier and one service unit. Modifiers LT (left side) and RT (right side) shall not be reported when the 50 modifier applies. See §20.6 in this chapter for more information on the use of the 50, LT and RT modifiers. See the Physician Fee Schedule Payment Policy Record Layout in §250.2 for a description of the bilateral procedure payment policy indicators.

If a procedure can be billed as bilateral, but is not authorized for the 150 percent bilateral adjustment (payment policy indicator 3), the procedure shall be reported on a single line item with the 50 modifier and one service unit.

250.11.1 – Use of Payment Policy Indicators for Determining Bilateral Procedures Eligible for 150 Percent Payment Adjustment

(Rev. 1777; Issued: 07-24-09; Effective Date: 01-01-08; Implementation Date: 01-04-10)

Medicare uses the payment policy indicators on the Medicare Physician Fee Schedule Database (MPFSDB) to determine if a bilateral procedure is authorized for a specific HCPCS/CPT code. The MPFSDB is located at http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp . The FIs and A/B MACs have access to the payment policy indicators via the Physician Fee Schedule Payment Policy Indicator File in the fiscal intermediary standard system.

See the Physician Fee Schedule Payment Policy Record Layout in §250.2 for a description of the bilateral procedure payment policy indicators.

250.11.2 – Payment of Bilateral Procedures Rendered in a Method II CAH

(Rev. 1777; Issued: 07-24-09; Effective Date: 01-01-08; Implementation Date: 01-04-10)

Under Section 1834(g)(2)(B) of the Act, outpatient professional services performed in a Method II CAH are paid 115 percent of such amounts as would otherwise be paid under the Act if the services were not included in the outpatient CAH services.

Payment for bilateral procedures with a payment policy indicator of ‘1’ and the 50 modifier is based on the lesser of the actual charges or the 150 percent payment adjustment for bilateral procedures and is calculated as follows:

> (facility specific MPFS amount times payment adjustment for bilateral procedures (150%) minus (deductible and coinsurance)) times 115%

Payment for bilateral procedures with the 50 modifier and a payment policy indicator of ‘3’ is based on the lesser of the actual charges or 100% of the MPFS for **each** side of the body (200%) and is calculated as follows:

(facility specific MPFS amount times 200% minus (deductible and coinsurance)) times 115%

250.12 - Primary Care Incentive Payment Program (PCIP) Payments to Critical Access Hospitals (CAHs) Paid Under the Optional Method

(Rev. 2169, Issued: 03-03-11, Effective: 04-01-11, Implementation: 04-04-11)

Section 5501(a) of the Affordable Care Act revises section 1833 of the Social Security Act by adding a new paragraph, (x), "Incentive Payments for Primary Care Services." Section 1833(x) of the Act states that in the case of primary care services furnished on or after January 1, 2011, and before January 1, 2016, there shall be a 10 percent incentive payment for such services under Part B when furnished by a primary care practitioner.

250.12.1 - Definition of Primary Care Practitioners and Primary Care Services

(Rev. 2169, Issued: 03-03-11, Effective: 04-01-11, Implementation: 04-04-11)

Primary care practitioners are defined as:

(1) A physician who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine for whom primary care services accounted for at least 60 percent of the allowed charges under the PFS (excluding hospital inpatient care and emergency department visits) for the practitioner in a prior period as determined appropriate by the Secretary; or

(2) A nurse practitioner, clinical nurse specialist, or physician assistant for whom primary care services accounted for at least 60 percent of the allowed charges under the PFS (excluding hospital inpatient care and emergency department visits) for the practitioner in a prior period as determined appropriate by the Secretary.

Primary care services are defined as CPT Codes:

(1) 99201 through 99215 for new and established patient office or outpatient evaluation and management (E/M) visits;

(2) 99304 through 99340 for initial, subsequent, discharge, and other nursing facility E/M services; new and established patient domiciliary, rest home or custodial care E/M services; and domiciliary, rest home or home care plan oversight services; and

(3) 99341 through 99350 for new and established patient home E/M visits.

250.12.2 - Identifying Primary Care Services Eligible for the PCIP

(Rev. 2403, Issued: 01-26-2012, Effective: 01-01-2012, Implementation: 07-02-2012)

CAHs paid under the optional method billing on TOB 85X for professional primary care services (revenue code 96X, 97X or 98X) furnished by primary care physicians and nonphysician practitioners who have reassigned their billing rights to the CAH are eligible for PCIP payments.

The National Provider Identifier (NPIs) of primary care practitioners eligible for PCIP payment in a given calendar year (CY) are posted on Medicare contractor web sites in the Primary Care Incentive Payment Program Eligibility File by January 31 of the applicable incentive payment CY. Eligible practitioners for PCIP payment in a given calendar year who were newly enrolled in Medicare in the year immediately

preceding the PCIP payment year will be identified later in the payment year and posted on their Medicare contractor's website at that point in time. CAHs paid under the optional method should contact their contractor with any questions regarding the eligibility of physician and nonphysician practitioners for PCIP payments.

Primary care practitioners furnishing primary care services will be identified on CAH claims by the NPI of the rendering practitioner as specified in the "rendering physician" field on the claim for the primary care service. If the claim for a primary care service is submitted by a CAH paid under the optional method, the rendering physician's NPI must be included in the "rendering physician" field on the claim for the primary care service specified by an eligible CPT code. In order for a primary care service to be eligible for PCIP payment, the CAH paid under the optional method must be billing for the professional services of physicians under their NPIs or of physician assistants, clinical nurse specialists, or nurse practitioners under their own NPIs because they are not furnishing services incident to physicians' services.

If the CAH claim for a single date of service includes more than one primary care professional service, the incentive payment for all primary care services for that date, shall be made to the CAH on behalf of the eligible primary care physician or nonphysician practitioner based on the NPI in the "rendering physician" field.

If primary care services are furnished on different dates of service to the same patient, the CAH should ensure that the primary care professional service furnished each day is on a separate CAH claim so the NPI in the "rendering physician" field reflects the NPI of the physician or non physician practitioner who rendered that primary care service. This permits correct attribution of the primary care service to an NPI, so contractors can then determine if that NPI is eligible for PICP payment and, if so, then the contractor would include the PCIP payment for that service in the quarterly incentive payment to the CAH.

See section 230.1 for more information on primary care practitioner identification.

250.12.3 - Coordination with Other Payments

(Rev. 2169, Issued: 03-03-11, Effective: 04-01-11, Implementation: 04-04-11)

Section 5501(a)(3) of the ACA authorizes payment under the PCIP as an additional payment amount for specified primary care services without regard to any additional payment for the service under Section 1833(m) of the Social Security Act, the established Health Professional Shortage Area (HPSA) Medicare physician bonus program. Therefore, a CAH paid under the optional method and billing for the professional services of an eligible primary care physician or nonphysician practitioner furnishing a primary care service in a health professional shortage area (HPSA) may receive both a HPSA physician bonus payment (as described in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 4, Section 250.2) under the HPSA physician bonus program and a PCIP incentive payment under the new program beginning in CY 2011.

250.12.4 - Claims Processing and Payment for Critical Access Hospitals Paid Under the Optional Method

(Rev. 2169, Issued: 03-03-11, Effective: 04-01-11, Implementation: 04-04-11)

A. General Overview

Incentive payments will be made on a quarterly basis and shall be equal to 10 percent of the amount paid for such services under the Medicare Physician Fee Schedule (PFS) times 1.15 percent for those services furnished during the incentive payment year. PCIP payments for newly enrolled practitioners may be delayed due to the lag in claims data processing. PCIP payments for services by a newly enrolled primary care practitioner will be paid in the quarter following eligibility determination, and then quarterly for all subsequent incentive payments. Retroactive payments will be provided from the beginning of the PCIP year once these primary care practitioners are deemed eligible.

On an annual basis Medicare contractors shall receive a Primary Care Incentive Payment Program Eligibility File that they shall post to their websites. The file will list the NPIs of all physicians and nonphysician practitioners who are eligible to receive PCIP payments for the upcoming CY. The NPIs of eligible newly enrolled primary care practitioners will be posted to the contractors' websites later in the payment year.

On an annual basis Medicare contractors shall receive a Physician/Practitioner Specialty File. This file it to be used by contractors to answer provider inquiries regarding eligibility for the PCIP.

The PCIP payments will be calculated by Medicare contractors and made quarterly to CAHs paid under the optional method on behalf of the eligible primary care physician or nonphysician practitioner for the primary care services furnished by the practitioner in that quarter. The PCIP payments will be based on 10 percent of 115 percent of the PFS amount that the CAH was paid for the professional service.

B. Method of Payment

- Calculate and pay a CAH paid under the optional method based on primary care services furnished by qualifying primary care physicians and nonphysician practitioners an additional 10 percent incentive payment;

- Calculate the payment based on 115 percent of the PFS amounts that were paid to the CAH for the services; not the Medicare approved amounts;

- Combine the PCIP incentive payments, when appropriate, with other incentive payments, including the physician HPSA bonus payment and the HPSA Surgical Incentive Payment Program (HSIP) payment;

- Provide a special remittance for CAHs form that is forwarded with the incentive payment so that CAHs paid under the optional method can identify which type of incentive payment was paid for which services.

- CAHs paid under the optional method should contact their contractor with any questions regarding PCIP payments.

C. Changes for Contractor Systems

The Fiscal Intermediary Standard System (FISS), Common Working File (CWF) and National Claims History (NCH) shall be modified to accept a new PCIP indicator on the claim line. Once the type of

incentive payment has been identified by the shared systems, the shared system shall modify their systems to set the indicator on the claim line as follows:

1 = HPSA
2 = PSA
3 = HPSA and PSA
4 = HSIP
5 = HPSA and HSIP
6 = PCIP
7 = HPSA and PCIP
Space = Not Applicable

The FISS shall send the HIGLAS 810 invoice for incentive payment invoices, including the new PCIP payment. The contractor shall also combine the CAH's HPSA bonus, physician scarcity (PSA) bonus (if it should become available at a later date), HSIP payment and/or PCIP payment invoice per CAH. The contractor shall receive the HIGLAS 835 payment file from HIGLAS showing a single incentive payment per CAH.

250.13 – Health Professional Shortage Areas (HPSA) Surgical Incentive Payment Program (HSIP) for Surgical Services Rendered in Critical Access Hospitals (CAHs) Paid under the Optional Method

(Rev. 2078, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

There are two methods of payment for outpatient services furnished by Critical Access Hospitals (CAHs). The amount of payment for outpatient services furnished by a CAH under the traditional method is equal to 101 percent of the reasonable cost of the facility service and payment to the physician/practitioner under the Physician Fee Schedule(PFS) for the professional service or a CAH may elect to receive amounts that are equal to 101 percent of the reasonable cost of the facility service plus, with respect to the professional service, 115 percent of the amount otherwise paid for the professional service under the PFS. This election is sometimes referred to as "method II" or "the optional method."

Section 5501(b) (2) of the ACA is a conforming amendment, which refers to payments to the CAH for professional services under the optional method. As such, section 5501(b)(2) requires that, under the optional method, the 115 percent adjusted payment to the CAH for professional services does apply to the incentive payment for major surgical services furnished by general surgeons in HPSAs.

For major surgical services furnished by general surgeons on or after January 1, 2011 and before January 1, 2016, the additional incentive amount specified is to be included in the determination of payment for professional services made to CAHs paid under the optional method, but will be provided as a separate incentive payment to the CAH, on behalf of the qualified general surgeon, when they furnish a 10 - or 90 – day global surgical procedure in an identified HPSA. Therefore, the 10 percent incentive payment will be made based on 115 percent of the amount that would be paid for the surgeon's professional services under the PFS.

250.13.1 Overview of the HSIP

(Rev. 2078, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

The incentive payment applies to major surgical procedures, defined as 10 - and 90 - day global procedures under the PFS and furnished on or after January 1, 2011 and before January 1, 2016, furnished by an 02-general surgeon in an area designated under section 332(a)(1)(A) of the Public Health Service Act as a HPSA.

To be consistent with the Medicare HPSA physician program (Publication 100-04, Chapter 12, Section 90.4), HSIP payments will be calculated by Medicare contractors on a quarterly basis, on behalf of the qualifying 02-general surgeon for the qualifying surgical procedures.

250.13.2 - HPSA Identification

(Rev. 2078, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

For HSIP payments to be applicable, the 10 - or 90 – day global surgical procedure must be furnished in an area designated by the Secretary as of December 31 of the prior year as a HPSA.

Each year, a list of ZIP codes eligible for automatic payment of the HPSA physician bonus is published. This list is also utilized for automatic payments of the incentive for eligible services furnished by general surgeons. Modifier AQ is used to identify circumstances when general surgeons furnish services in areas that are designated as HPSAs as of December 31 of the prior year, but that are not on the list of ZIP codes eligible for automatic payment. Modifier AQ should be appended to the major surgical procedure on claims submitted for payment for professional services furnished in a HPSA that is not recognized as such for the purpose of automatic payment.

250.13.3 - Coordination with Other Payments

(Rev. 2078, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

Section 5501(b)(4) of the ACA provides payment under the HSIP as an additional payment amount for specified surgical services without regard to any additional payment for the service under section 1833(m) of the Act. Therefore, a general surgeon may receive both a HPSA physician bonus payment under the established program and an HSIP payment under the new program beginning in CY 2011.

250.13.4 – General Surgeon and Surgical Procedure Identification for Professional Services Paid under the Physician Fee Schedule (PFS)

(Rev. 2078, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

Qualifying general surgeons will be identified on a claim for a 10 - or 90 – day global surgical procedure based on the NPI listed in the “operating provider” field on the claim and the associated primary enrolled specialty of the operating physician of 02 - general surgery.

Major surgical procedures are those procedures for which a 10 - or 90 - day global period is used for payment under the PFS. The specific procedure codes eligible for the HSIP are identified in column U (global period) of the Physician Fee Schedule Relative Value Update (RVU) file located at: http://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp?listpage=4, with a global period designation of 10 - or 90 day.

250.13.5 - Claims Processing and Payment
(Rev. 2078, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

A. General Overview

The HPSA physician bonus program guidelines are contained in Publication 100-04, Chapter 12, and Section 90.4. Refer to that manual for payment and claims processing guidance for the HPSA physician bonus program that was established in 2005.

The following guidelines pertain only to qualifying 02- general surgeons who have reassigned their billing rights to CAHs paid under the optional method, and who are eligible to receive the additional 10 percent HSIP payment for major surgical procedures furnished in HPSAs from January 1, 2011 through December 31, 2015.

Contractors shall only identify eligible services with a 10 - or 90 - day global period rendered in eligible zip code areas based on the HPSA physician bonus program ZIP code file for the appropriate date of service.

Providers may report modifier AQ when submitting claims for major surgical procedures that were furnished in approved HPSAs, where those HPSAs are not recognized for automatic payment. The modifier must be appended to the major surgical procedure HCPCS code in order for the CAH paid under the optional method to be paid the 10 percent additional incentive payment for the surgical procedure on behalf of the general surgeon.

B. Method of Payment:

- Calculate and pay CAHs paid under the optional method on behalf of 02- general surgeons furnishing 10 - and 90 - day global surgical procedures in a recognized HPSA an additional 10 percent incentive payment based on 115 percent of the amount that would be paid for the surgeon's professional services under the PFS;

- Calculate the payment based on the amount actually paid for the service, not the Medicare approved amount;

- Combine the additional payment with the HPSA physician bonus payment;

- Accept and pay services submitted with modifier AQ and;

- Revise the "special incentive remittance for CAHs" that is forwarded with the incentive check so that physicians can identify which type of incentive payment (HPSA physician, HSIP, or PCIP) was paid for which service.

C. Changes for Contractor Systems

The Medicare Carrier System, (MCS), Common Working File (CWF,) and National Claims History (NCH) shall be modified to accept a new HSIP and a new PCIP indicator on the claim line.

Once the type of incentive payment has been identified by the shared systems, the shared system shall modify their systems to set the indicator on the claim line as follows:

1 = HPSA;
2 = PSA;
3 = HPSA and PSA;
4 = HSIP;
5 = HPSA and HSIP
6 = PCIP;
7 = HPSA and PCIP;
Space = Not Applicable.

The contractor shared system shall send the HIGLAS 810 invoice for incentive payment invoices, including the new HSIP payment. The contractor shall also combine the practitioner's HPSA physician bonus, Physician Scarcity (PSA) bonus (if it should become available at a later date), and HSIP payment invoice per practitioner. The contractor shall receive the HIGLAS 835 payment file from HIGLAS showing a single incentive payment per practitioner.

250.14 – Payment of Licensed Clinical Social Workers (LCSWs) in a Method II CAH

(Rev. 2202, Issued: 04-27-11, Effective: 10-01-11, Implementation: 10-03-11)

The services of a LCSW that has reassigned their billing rights to a Method II CAH are payable by Medicare when the procedure is billed on type of bill 85X with revenue code (RC) 96X, 97X, and/or 98X and the AJ modifier (clinical social worker).

Under Section 1834(g)(2)(B) of the Act, outpatient professional services performed in a Method II CAH are paid 115 percent of such amounts as would otherwise be paid under the Act if the services were not included in the outpatient CAH services.

Section 1833 (a)(1)(F) of the Act stipulates that payment for services performed by a LCSW shall be 80 percent of the lesser of the actual charges for the services or 75 percent of the amount determined for the payment of a psychologist.

Payment is calculated as follows:

((Facility specific MPFS amount times the LCSW reduction (75%)) minus (deductible and coinsurance)) times 115%.

250.15 – Coding and Payment of Multiple Surgeries Performed in a Method II CAH

(Rev. 2333, Issued: 10-28-11, Effective: 04-01-12, Implementation: 04-02-12)

Multiple surgeries rendered by a physician that has reassigned their billing rights to a Method II CAH are payable by Medicare when the procedures are eligible and billed on type of bill 85x with revenue code (RC) 096x, 097x and/or 098x.

Multiple surgeries are separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants-at-surgery may participate in performing multiple surgeries on the same patient on the same day.

Medicare pays for multiple surgeries by ranking from the highest MPFS amount to the lowest MPFS amount. When the same physician performs more than one surgical service at the same session, the allowed amount is 100% for the surgical code with the highest MPFS amount. The allowed amount for the subsequent surgical codes is based on 50% of the MPFS amount. In addition, special endoscopic pricing rules are applied prior to the multiple surgery rules, if applicable. CAH Method II providers may review the multiple surgery and special endoscopic pricing rules in Pub. 100-04, Chapter 12, Section 40.6. In addition, section 40.6.D addresses rare situations where the above payment rules may be bypassed using modifier 22. Providers shall be aware that CAH claims billed with Modifier 22 may be subject to medical review.

250.16 – Multiple Procedure Payment Reduction (MPPR) on Certain Diagnostic Imaging Procedures Rendered by Physicians

(Rev. 2395, Issued: 01-26-12, Effective: 01-01-12, Implementation: 07-02-12)

Diagnostic imaging procedures rendered by a physician that has reassigned their billing rights to a Method II CAH are payable by Medicare when the procedures are eligible and billed on type of bill 85x with revenue code (RC) 096x, 097x and/or 098x.

The MPPR on diagnostic imaging applies when multiple services are furnished by the same physician to the same patient in the same session on the same day. Full payment is made for each service with the highest payment under the MPFS and payment is made at 75 percent for each subsequent service.

260 - Outpatient Partial Hospitalization Services

(Rev. 1, 10-03-03)
A3-3661, A-01-93

Medicare Part B coverage is available for outpatient partial hospitalization services provided by hospitals, CAHs, and CMHCs.

260.1 - Special Partial Hospitalization Billing Requirements for Hospitals, Community Mental Health Centers, and Critical Access Hospitals

(Rev. 2141, Issued: 01-24-11, Effective: 01-01-11, Implementation: 01-03-11)

Medicare Part B coverage is available for hospital outpatient partial hospitalization services.

A. Billing Requirement

Section 1861 of the Act defines the services under the partial hospitalization benefit in a hospital.

Section 1866(e)(2) of the Act recognizes CMHCs as “providers of services” but only for furnishing partial hospitalization services. See §261.1.1 for CMHC partial hospitalization bill review directions.

Hospitals and CAHs report condition code 41 in FLs 18-28 (or electronic equivalent) to indicate the claim is for partial hospitalization services. They must also report a revenue code and the charge for each individual covered service furnished. In addition, hospital outpatient departments are required to report HCPCS codes. CAHs are not required to report HCPCS code for this benefit.

Under component billing, hospitals are required to report a revenue code and the charge for each individual covered service furnished under a partial hospitalization program. In addition, hospital outpatient departments are required to report HCPCS codes. Component billing assures that only those partial hospitalization services covered under §1861(ff) of the Act are paid by the Medicare program.

All hospitals are required to report condition code 41 in FLs 18-28 to indicate the claim is for partial hospitalization services. Hospitals use bill type 13X and CAHs use bill type 85X. The following special procedures apply.

Bills must contain an acceptable revenue code. They are as follows:

Revenue Code	Description
0250	Drugs and Biologicals
043X	Occupational Therapy
0900	Behavioral Health Treatment/Services
0904	Activity Therapy
0910	Psychiatric/Psychological Services (Dates of Service prior to October 16, 2003)
0914	Individual Therapy
0915	Group Therapy
0916	Family Therapy
0918	Testing
0942	Education Training

Hospitals other than CAHs are also required to report appropriate HCPCS codes as follows:

Revenue Code	Description	HCPCS Code
043X	Occupational Therapy	*G0129
0900	Behavioral Health Treatment/Services	90801 or 90802
0904	Activity Therapy (Partial Hospitalization)	**G0176
0910	Psychiatric General Services (Dates of Service prior to October 16, 2003)	90801, 90802, 90899
0914	Individual Psychotherapy	90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829

Revenue Code	Description	HCPCS Code
		90845, 90865, or 90880
0915	Group Therapy	G0410 or G0411
0916	Family Psychotherapy	90846 or 90847
0918	Psychiatric Testing	96101, 96102, 96103, 96116, 96118, 96119, or 96120
0942	Education Training	***G0177

The FI will edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. The FI will not edit for matching the revenue code to HCPCS.

*The definition of code G0129 is as follows:

> Occupational therapy services requiring skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per session (45 minutes or more).

**The definition of code G0176 is as follows:

> Activity therapy, such as music, dance, art or play therapies not for recreation, related to care and treatment of patient's disabling mental problems, per session (45 minutes or more).

***The definition of code G0177 is as follows:

> Training and educational services related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more).

Codes G0129 and G0176 are used only for partial hospitalization programs.

Code G0177 may be used in both partial hospitalization program and outpatient mental health settings.

Revenue code 250 does not require HCPCS coding. However, Medicare does not cover drugs that can be self-administered.

Edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. Do not edit for the matching of revenue code to HCPCS.

B. Professional Services

The professional services listed below when provided in all hospital outpatient departments are separately covered and paid as the professional services of physicians and other practitioners. These professional services are unbundled and these practitioners (other than physician assistants (PA) bill the Medicare Part B carrier directly for the professional services furnished to hospital outpatient partial hospitalization patients. The hospital can also serve as a billing agent for these professionals by billing the Part B carrier on their behalf under their billing number for their professional services. The professional services of a PA can be

billed to the carrier only by the PAs employer. The employer of a PA may be such entities or individuals as a physician, medical group, professional corporation, hospital, SNF, or nursing facility. For example, if a physician is the employer of the PA and the PA renders services in the hospital, the physician and not the hospital would be responsible for billing the carrier on Form CMS-1500 for the services of the PA. The following direct professional services are unbundled and not paid as partial hospitalization services.

- Physician services that meet the criteria of 42 CFR 415.102, for payment on a fee schedule basis;
- Physician assistant (PA) services as defined in §1861(s)(2)(K)(i) of the Act;
- Nurse practitioner and clinical nurse specialist services, as defined in §1861(s)(2)(K)(ii) of the Act; and
- Clinical psychologist services as defined in §1861(ii) of the Act.

The services of other practitioners (including clinical social workers and occupational therapists), are bundled when furnished to hospital patients, including partial hospitalization patients. The hospital must bill the contractor for such nonphysician practitioner services as partial hospitalization services. Make payment for the services to the hospital.

C. Outpatient Mental Health Treatment Limitation

The outpatient mental health treatment limitation may apply to services to treat mental, psychoneurotic, and personality disorders when furnished by physicians, clinical psychologists, NPs, CNSs, and PAs to partial hospitalization patients. However, the outpatient mental health treatment limitation does not apply to such mental health treatment services billed to the intermediary by a CMHC or hospital outpatient department as partial hospitalization services.

D. Reporting of Service Units

Hospitals report the number of times the service or procedure, as defined by the HCPCS code, was performed. CAHs report the number of times the revenue code visit was performed.

NOTE: Service units are not required to be reported for drugs and biologicals (Revenue Code 250).

E. Line Item Date of Service Reporting

Hospitals other than CAHs are required to report line item dates of service per revenue code line for partial hospitalization claims. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are reported in FL 45 “Service Date” (MMDDYY). See §260.5 for a detailed explanation.

F. Payment

Beginning with services provided on or after August 1, 2000, for hospital outpatient departments and CMHCs, make payment under the hospital outpatient prospective payment system for partial hospitalization

services. Effective January 1, 2011, there are four separate APC payment rates for PHP: two for CMHCs (for Level 1 and Level II services based on only CMHC data) and two for hospital-based PHPs (for Level I and Level II services based on only hospital-based data). The following chart displays the CMHC and hospital-based PHP APCs:

Community Mental Health Center PHP APCs

APC	Group Title
0172	Level I Partial Hospitalization (3 services) for CMHCs
0173	Level II Partial Hospitalization (4 or more services) for CMHCs

Hospital-based PHP APCs

APC	Group Title
0175	Level I Partial Hospitalization (3 services) for hospital-based PHPs
0176	Level II Partial Hospitalization (4 or more services) for hospital-based PHPs

Apply Part B deductible, if any, and coinsurance.

G. Data for CWF and PS&R

Include revenue codes, HCPCS/CPT codes, units, and covered charges in the financial data section (fields 65a - 65j), as appropriate. Report the billed charges in field 65h, "Charges," of the CWF record.

Include in the financial data portion of the PS&R UNIBILL, revenue codes, HCPCS/CPT codes, units, and charges, as appropriate.

Future updates will be issued in a Recurring Update Notification.

260.1.1 - Bill Review for Partial Hospitalization Services Provided in Community Mental Health Centers (CMHC)

(Rev. 2141, Issued: 01-24-11, Effective: 01-01-11, Implementation: 01-03-11)

A. General

Medicare Part B coverage for partial hospitalization services provided by CMHCs is available effective for services provided on or after October 1, 1991.

B. Special Requirements

Section 1866(e)(2) of the Act recognizes CMHCs as “providers of services” but only for furnishing partial hospitalization services. Applicable provider ranges are 1400-1499, 4600-4799, and 4900-4999.

C. Billing Requirements

The CMHCs bill for partial hospitalization services on Form CMS-1450 or electronic equivalent under bill type 76X. The FIs follow bill review instructions in chapter 25 of this manual, except for those listed below.

The acceptable revenue codes are as follows:

Code	Description
0250	Drugs and Biologicals
043X	Occupational Therapy
0900	Behavioral Health Treatments/Services
0904	Activity Therapy
0910	Psychiatric/Psychological Services (Dates of Service prior to October 16, 2003)
0914	Individual Therapy
0915	Group Therapy
0916	Family Therapy
0918	Testing
0942	Education Training

The CMHCs are also required to report appropriate HCPCS codes as follows:

Revenue Codes	Description	HCPCS Code
043X	Occupational Therapy (Partial Hospitalization)	*G0129
0900	Behavioral Health Treatments/Services	90801 or 90802
0904	Activity Therapy (Partial Hospitalization)	**G0176
0910	Psychiatric General Services (Dates of Service prior to October 16, 2003)	90801, 90802, 90899

Revenue Codes	Description	HCPCS Code
0914	Individual Psychotherapy	90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829, 90845, 90865, or 90880
0915	Group Psychotherapy	G0410 or G0411
0916	Family Psychotherapy	90846 or 90847
0918	Psychiatric Testing	96101, 96102, 96103, 96116, 96118, 96119, or 96120
0942	Education Training	***G0177

The FIs edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. They do not edit for the matching of revenue codes to HCPCS.

*The definition of code G0129 is as follows:

> Occupational therapy services requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, - per session (45 minutes or more).

**The definition of code G0176 is as follows:

> Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more).

***The definition of code G0177 is as follows:

> Training and educational services related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more).

Codes G0129 and G0176 are used only for partial hospitalization programs.

Code G0177 may be used in both partial hospitalization program and outpatient mental health settings.

Revenue code 0250 does not require HCPCS coding. However, drugs that can be self-administered are not covered by Medicare.

HCPCS includes CPT-4 codes. CMHCs report HCPCS codes in FL44, "HCPCS/Rates." HCPCS code reporting is effective for claims with dates of service on or after April 1, 2000.

The FIs are to advise their CMHCs of these requirements. CMHCs should complete the remaining items on Form CMS-1450 in accordance with the bill completion instructions in chapter 25 of this manual.

The professional services listed below are separately covered and are paid as the professional services of physicians and other practitioners. These professional services are unbundled and these practitioners (other than physician assistants (PAs)) bill the Medicare Part B carrier directly for the professional services furnished to CMHC partial hospitalization patients. The CMHC can also serve as a billing agent for these professionals by billing the Part B carrier on their behalf for their professional services. The professional services of a PA can be billed to the carrier only by the PAs employer. The employer of a PA may be such entities or individuals as a physician, medical group, professional corporation, hospital, SNF, or nursing facility. For example, if a physician is the employer of the PA and the PA renders services in the CMHC, the physician and not the CMHC would be responsible for billing the carrier on Form CMS-1500 for the services of the PA.

The following professional services are unbundled and not paid as partial hospitalization services:

- Physician services that meet the criteria of 42 CFR 415.102, for payment on a fee schedule basis;
- PA services, as defined in §1861(s)(2)(K)(i) of the Act;
- Nurse practitioner and clinical nurse specialist services, as defined in §1861(s)(2)(K)(ii) of the Act; and,
- Clinical psychologist services, as defined in §1861(ii) of the Act.

The services of other practitioners (including clinical social workers and occupational therapists) are bundled when furnished to CMHC patients. The CMHC must bill the FI for such nonphysician practitioner services as partial hospitalization services. The FI makes payment for the services to the CMHC.

D. Outpatient Mental Health Treatment Limitation

The outpatient mental health treatment limitation **may apply** to services to treat mental, psychoneurotic, and personality disorders when furnished by physicians, clinical psychologists, NPs, CNSs, and PAs to partial hospitalization patients. However, the outpatient mental health treatment limitation **does not** apply to such mental health treatment services billed to the FI as partial hospitalization services.

E. Reporting of Service Units

Visits should no longer be reported as units. Instead, CMHCs report in the field, “Service Units,” the number of times the service or procedure, as defined by the HCPCS code, was performed when billing for partial hospitalization services identified by revenue code in subsection C.

EXAMPLE: A beneficiary received psychological testing (HCPCS code 96100, which is defined in 1 hour intervals) for a total of 3 hours during one day. The CMHC reports revenue code 0918, HCPCS code 96100, and “3”.

When reporting service units for HCPCS codes where the definition of the procedure does not include any reference to time (either minutes, hours or days), CMHCs should not bill for sessions of less than 45 minutes.

The CMHC need not report service units for drugs and biologicals (Revenue Code 0250)

NOTE: Information regarding the claim form locators that correspond with these fields and a table to crosswalk the CMS-1450 form locators to the 837 transaction is found in chapter 25 of this manual.

F. Line Item Date of Service Reporting

Dates of service per revenue code line for partial hospitalization claims that span two or more dates. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are reported in "Service Date". See examples below of reporting line item dates of service. These examples are for group therapy services provided twice during a billing period.

For claims, report as follows:

Revenue Code	HCPCS	Dates of Service	Units	Total Charges
0915	G0176	20090505	1	$80
0915	G0176	20090529	2	$160

NOTE: Information regarding the claim form locators that correspond with these fields and a table to crosswalk the CMS-1450 form locators to the 837 transaction is found in chapter 25 of this manual.

The FIs return to provider claims that span two or more dates if a line item date of service is not entered for each HCPCS code reported or if the line item dates of service reported are outside of the statement covers period. Line item date of service reporting is effective for claims with dates of service on or after June 5, 2000.

G. Payment

Section 1833(a)(2)(B) of the Act provides the statutory authority governing payment for partial hospitalization services provided by a CMHC. FIs made payment on a reasonable cost basis until OPPS was implemented. The Part B deductible and coinsurance applied.

Payment principles applicable to partial hospitalization services furnished in CMHCs are contained in §2400 of the Medicare Provider Reimbursement Manual.

The FIs make payment on a per diem basis under the hospital outpatient prospective payment system for partial hospitalization services. CMHCs must continue to maintain documentation to support medical necessity of each service provided, including the beginning and ending time.

Effective January 1, 2011, there are four separate APC payment rates for PHP: two for CMHCs (for Level I and Level II services based on only CMHC data) and two for hospital-based PHPs (for Level I and Level II services based on only hospital-based PHP data). The following chart displays the CMHC APCs:

Community Mental Health Center PHP APCs

APC	Group Title
0172	Level I Partial Hospitalization (3 services) for CMHCs
0173	Level II Partial Hospitalization (4 or more services) for CMHCs

NOTE: Occupational therapy services provided to partial hospitalization patients are not subject to the prospective payment system for outpatient rehabilitation services, and therefore the financial limitation required under §4541 of the Balanced Budget Act (BBA) does not apply.

H. Medical Review

The FIs follow medical review guidelines in Pub. 100-08, Medicare Program Integrity Manual.

I. Coordination With CWF

See chapter 27 of this manual. All edits for bill type 74X apply, except provider number ranges 4600-4799 are acceptable only for services provided on or after October 1, 1991.

260.2 - Professional Services Related to Partial Hospitalization

(Rev. 1, 10-03-03)
A3-3661

The professional services listed below when provided in a hospital or CAH outpatient department are separately covered and paid as the professional services of physicians and other practitioners. These professional services are unbundled and these practitioners (other than physician assistants (PA)) bill the Medicare Part B carrier directly for the professional services furnished to hospital outpatient partial hospitalization patients. The hospitals or CAHs can also serve as a billing agent for these professionals by billing the Part B carrier on their behalf under their billing number for their professional services. Only a PA's employer can bill the carrier for professional services of a PA.

The following direct professional services are unbundled and not paid as partial hospitalization services:

- Physician services that meet the criteria of 42 CFR 415.102, for payment on a fee schedule basis;
- Physician assistant (PA) services as defined in §1861(s)(2)(K)(i) of the Act;
- Nurse practitioner and clinical nurse specialist services, as defined in §1861(s)(2)(K)(ii) of the Act; and

- Clinical psychologist services as defined in §1861(ii) of the Act.

The services of other practitioners (including clinical social workers and occupational therapists), are bundled when furnished to hospital or CAH patients, including partial hospitalization patients. The hospital or CAH must bill their FI for such nonphysician practitioner services as partial hospitalization services. Payment is made to the provider for these services.

Only the actual employer of the PA can bill for these services. The employer of a PA may be such entities or individuals such as a physician, medical group, professional corporation, hospital, SNF, or nursing facility. For example, if a physician is the employer of the PA and the PA renders services in the hospital or CAH, the physician and not the hospital or CAH is responsible for billing the carrier on the Form CMS-1500 for the services of the PA.

260.3 - Outpatient Mental Health Treatment Limitation for Partial Hospitalization Services

(Rev. 1, 10-03-03)
A-01-93

The outpatient mental health treatment limitation applies to services to partial hospitalization patients to treat mental, psychoneurotic, and personality disorders when furnished by physicians, clinical psychologists, NPs, CAHs, and PAs. It does not apply to such mental health treatment services billed to the FI by a CMHC, hospital or CAH as partial hospitalization services.

260.4 - Reporting Service Units for Partial Hospitalization

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

Hospitals report number of times the service or procedure, as defined by the HCPCS code, was performed. CAHs report the number of times the revenue code visit was performed.

EXAMPLE: A beneficiary received psychological testing (HCPCS code 96100 which is defined in one-hour intervals) for a total of three hours during one day. The hospital reports revenue code 0918 in FL 42, HCPCS code 96100 in FL 44, and three units in FL 46. The CAH would report revenue code 0918, leave HCPCS blanks, and report 1 unit in FL 46.

When reporting service units for HCPCS codes where the definition of the procedure does not include any reference to time (either in minutes, hours, or days), hospital outpatient departments do not bill for sessions of less than 45 minutes.

The FI must return to the provider claims other than CAH claims that do not contain service units for each HCPCS code.

NOTE: Service units do not need to be reported for drugs and biologicals (Revenue Code 0250).

Hospitals must retain documentation to support the medical necessity of each service provided, including beginning and ending time.

260.5 - Line Item Date of Service Reporting for Partial Hospitalization

(Rev. 1657, Issued: 12-31-08, Effective: 01-01-09, Implementation: 01-05-09)

Hospitals other than CAHs are required to report line item dates of service per revenue code line for partial hospitalization claims. Where services are provided on more than one day included in the billing period, the date of service must be identified. Each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. See examples below of reporting line item dates of service. These examples are for group therapy services provided twice during a billing period.

For the claims, report as follows:

Revenue Code	HCPCS	Dates of Service	Units	Total Charges
0915	G0176	20090505	1	$80.00
0915	G0176	20090529	2	$160.00

NOTE: Information regarding the claim form locators that correspond with these fields and a table to crosswalk the CMS-1450 form locators to the 837 transaction is found in Chapter 25.

The FI must return to the hospital (RTP) claims where a line item date of service is not entered for each HCPCS code reported, or if the line item dates of service reported are outside of the statement covers period. Line item date of service reporting is effective for claims with dates of service on or after June 5, 2000.

260.6 - Payment for Partial Hospitalization Services

(Rev. 1, 10-03-03)

A3-3661

For hospital outpatient departments, the FI makes payments on a reasonable cost basis until August 1, 2000 for partial hospitalization services. The Part B deductible and coinsurance apply. During the year, the FI will make payment at an interim rate based on a percentage of the billed charges. At the end of the year, the hospital will be paid at the reasonable cost incurred in furnishing partial hospitalization services, based upon the Medicare cost report filed with the FI.

Beginning with services provided on or after August 1, 2000, payment is made under the hospital outpatient prospective payment system for partial hospitalization services.

For CAHs, payment is made on a reasonable cost basis regardless of the date of service.

The Part B deductible, if any, and coinsurance apply.

270 - Billing for Hospital Outpatient Services Furnished by Clinical Social Workers (CSW)

(Rev. 1, 10-03-03)

A3-3662

Payment may be made for covered diagnostic and therapeutic services furnished by CSWs in a hospital outpatient setting. CSW services furnished under a partial hospitalization program are included in the partial hospitalization rate. Other CSW services must be billed to the carrier on Form CMS-1500 or the electronic equivalent.

See chapters 13 and 15, of the Medicare Benefit Policy Manual, for a discussion of the coverage requirements for CSW.

270.1 - Fee Schedule to be Used for Payment for CSW Services

(Rev. 1, 10-03-03)

The fee schedule for CSW services is set at 75 percent of the fee schedule for comparable services furnished by clinical psychologists, except for services under a CAH partial hospitalization program. These are paid on a reasonable cost basis.

270.2 - Outpatient Mental Health Payment Limitation for CSW Services

(Rev. 1, 10-03-03)

The CSW services are subject to the outpatient mental health services limitation in §1833 of the Act. The imitation of 62.5 percent is applied to the lesser of the actual charge or fee schedule amount. Diagnostic services are not subject to the limitation.

270.3 - Coinsurance and Deductible for CSW Services

(Rev. 1, 10-03-03)

The annual Part B deductible and the 20 percent coinsurance apply to CSW services.

280 - Hospital-Based Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Billing for Non RHC/FQHC Services

(Rev. 1, 10-03-03)

A-01-93, A-03-066

Hospitals sometimes operate hospital based RHCs or FQHCs. Prior to implementation of outpatient PPS, hospital based RHCs/FQHCc were permitted to include both RHC/FQHC and non-RHC/FQHC services on the same claim, under the RHC/FQHC bill type, with appropriate revenue codes.

Beginning with the implementation of OPPS, non-RHC/FQHC services provided by the hospital based RHC/FQHC, including RHCs/FQHCs that are parts of CAHs or other exempted or excluded (from OPPS) hospitals, must be billed under the host hospital's provider number, using hospital billing procedures and bill types. These services are not covered or paid as RHC/FQHC services but instead may be covered hospital outpatient services and paid under the applicable methodology for the hospital.

The RHC/FQHC services remain subject to the encounter rate payment methodology and are billed using the RHC/FQHC provider number, bill type and revenue codes.

See the Medicare Benefit Policy Manual for a description of covered RHC/FQHC services.

See chapter 9, in this manual for billing instructions for provider based and independent RHC/FQHC services.

290 - Outpatient Observation Services
(Rev. 1, 10-03-03)
A3-3663, A3-3112.8.D, A-01-91

290.1 - Observation Services Overview
(Rev. 1760, Issued: 06-23-09; Effective Date: 07-01-09; Implementation Date: 07-06-09)

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services.

Observation services must also be reasonable and necessary to be covered by Medicare. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

290.2 - General Billing Requirements for Observation Services
(Rev. 787, Issued: 12-16-05, Effective: 01-01-06, Implementation: 01-03-06)

290.2.1 - Revenue Code Reporting
(Rev. 1760, Issued: 06-23-09; Effective Date: 07-01-09; Implementation Date: 07-06-09)

Hospitals are required to report observation charges under the following revenue codes:

Revenue Code	Subcategory
0760	General Classification category
0762	Observation Room

Other ancillary services performed while the patient receives observation services are reported using appropriate revenue codes and HCPCS codes as applicable.

290.2.2 - Reporting Hours of Observation
(Rev. 2234, Issued: 05-27-11, Effective: 07-01-11, Implementation: 07-05-11)

Observation time begins at the clock time documented in the patient's medical record, which coincides with the time that observation care is initiated in accordance with a physician's order. Hospitals should round to

the nearest hour. For example, a patient who began receiving observation services at 3:03 p.m. according to the nurses' notes and was discharged to home at 9:45 p.m. when observation care and other outpatient services were completed, should have a "7" placed in the units field of the reported observation HCPCS code.

General standing orders for observation services following all outpatient surgery are not recognized. Hospitals should not report as observation care, services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours), which should be billed as recovery room services. Similarly, in the case of patients who undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished prior to the testing and recovery afterwards are included in the payments for those diagnostic services.

Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy). In situations where such a procedure interrupts observation services, hospitals may determine the most appropriate way to account for this time. For example, a hospital may record for each period of observation services the beginning and ending times during the hospital outpatient encounter and add the length of time for the periods of observation services together to reach the total number of units reported on the claim for the hourly observation services HCPCS code G0378 (Hospital observation service, per hour). A hospital may also deduct the average length of time of the interrupting procedure, from the total duration of time that the patient receives observation services.

Observation time ends when all medically necessary services related to observation care are completed. For example, this could be before discharge when the need for observation has ended, but other medically necessary services not meeting the definition of observation care are provided (in which case, the additional medically necessary services would be billed separately or included as part of the emergency department or clinic visit). Alternatively, the end time of observation services may coincide with the time the patient is actually discharged from the hospital or admitted as an inpatient. Observation time may include medically necessary services and follow-up care provided after the time that the physician writes the discharge order, but before the patient is discharged. However, reported observation time would not include the time patients remain in the hospital after treatment is finished for reasons such as waiting for transportation home.

If a period of observation spans more than 1 calendar day, all of the hours for the entire period of observation must be included on a single line and the date of service for that line is the date that observation care begins.

290.3 - Reserved

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

290.4 - Billing and Payment for Observation Services Furnished Between January 1, 2006 and December 31, 2007

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

290.4.1 - Billing and Payment for All Hospital Observation Services Furnished Between January 1, 2006 and December 31, 2007

(Rev. 1760, Issued: 06-23-09; Effective Date: 07-01-09; Implementation Date: 07-06-09)

Since January 1, 2006, two G-codes have been used to report observation services and direct referral for observation care. For claims for dates of service January 1, 2006 through December 31, 2007, the Integrated Outpatient Code Editor (I/OCE) determines whether the observation care or direct referral services are packaged or separately payable. Thus, hospitals provide consistent coding and billing under all circumstances in which they deliver observation care.

Beginning January 1, 2006, hospitals should not report CPT codes 99217-99220 or 99234-99236 for observation services. In addition, the following HCPCS codes were discontinued as of January 1, 2006: G0244 (Observation care by facility to patient), G0263 (Direct Admission with congestive heart failure, chest pain or asthma), and G0264 (Assessment other than congestive heart failure, chest pain, or asthma).

The three discontinued G-codes and the CPT codes that were no longer recognized were replaced by two new G-codes to be used by hospitals to report all observation services, whether separately payable or packaged, and direct referral for observation care, whether separately payable or packaged:

- G0378- Hospital observation service, per hour; and
- G0379- Direct admission of patient for hospital observation care.

The I/OCE determines whether observation services billed as units of G0378 are separately payable under APC 0339 (Observation) or whether payment for observation services will be packaged into the payment for other services provided by the hospital in the same encounter. Therefore, hospitals should bill HCPCS code G0378 when observation services are ordered and provided to any patient regardless of the patient's condition. The units of service should equal the number of hours the patient receives observation services.

Hospitals should report G0379 when observation services are the result of a direct referral for observation care without an associated emergency room visit, hospital outpatient clinic visit, critical care service, or hospital outpatient surgical procedure (status indicator T procedure) on the day of initiation of observation services. Hospitals should only report HCPCS code G0379 when a patient is referred directly for observation care after being seen by a physician in the community (see §290.4.2 below)

Some non-repetitive OPPS services provided on the same day by a hospital may be billed on different claims, provided that all charges associated with each procedure or service being reported are billed on the same claim with the HCPCS code which describes that service. See chapter 1, section 50.2.2 of this manual. It is vitally important that all of the charges that pertain to a non-repetitive, separately paid procedure or service be reported on the same claim with that procedure or service. It should also be emphasized that this relaxation of same day billing requirements for some non-repetitive services does not apply to non-repetitive services provided on the same day as either direct referral to observation care or observation services because the OCE claim-by-claim logic cannot function properly unless all services related to the episode of observation care, including diagnostic tests, lab services, hospital clinic visits, emergency department visits, critical care services, and status indicator T procedures, are reported on the same claim. Additional guidance can be found in chapter 1, section 50.2.2 of this manual.

290.4.2 - Separate and Packaged Payment for Direct Referral for Observation Services Furnished Between January 1, 2006 and December 31, 2007

(Rev. 1760, Issued: 06-23-09; Effective Date: 07-01-09; Implementation Date: 07-06-09)

In order to receive separate payment for a direct referral for observation care (APC 0604), the claim must show:

1. Both HCPCS codes G0378 (Hourly Observation) and G0379 (Direct Admit to Observation) with the same date of service;

2. That no services with a status indicator T or V or
Critical care (APC 0617) were provided on the same day of service as HCPCS code G0379; and

3. The observation care does not qualify for separate payment under APC 0339.

Only a direct referral for observation services billed on a 13X bill type may be considered for a separate APC payment.

Separate payment is not allowed for HCPCS code G0379, direct admission to observation care, when billed with the same date of service as a hospital clinic visit, emergency room visit, critical care service, or "T" status procedure.

If a bill for the direct referral for observation services does not meet the three requirements listed above, then payment for the direct referral service will be packaged into payments for other separately payable services provided to the beneficiary in the same encounter.

290.4.3 - Separate and Packaged Payment for Observation Services Furnished Between January 1, 2006 and December 31, 2007

(Rev. 1760, Issued: 06-23-09; Effective Date: 07-01-09; Implementation Date: 07-06-09)

Separate payment may be made for observation services provided to a patient with congestive heart failure, chest pain, or asthma. The list of ICD-9-CM diagnosis codes eligible for separate payment is reviewed annually. Any changes in applicable ICD-9-CM diagnosis codes are included in the October quarterly update of the OPPS and also published in the annual OPPS Final Rule. The list of qualifying ICD-9-CM diagnosis codes is also published on the OPPS Web page.

All of the following requirements must be met in order for a hospital to receive a separate APC payment for observation services through APC 0339:

1. Diagnosis Requirements

   a. The beneficiary must have one of three medical conditions: congestive heart failure, chest pain, or asthma.

   b. Qualifying ICD-9-CM diagnosis codes must be reported in Form Locator (FL) 76, Patient Reason for Visit, or FL 67, principal diagnosis, or both in order for the hospital to receive separate payment for APC 0339. If a qualifying ICD-9-CM diagnosis code(s) is reported in the secondary diagnosis

field, but is not reported in either the Patient Reason for Visit field (FL 76) or in the principal diagnosis field (FL 67), separate payment for APC 0339 is not allowed.

2. Observation Time

   a. Observation time must be documented in the medical record.

   b. Hospital billing for observation services begins at the clock time documented in the patient's medical record, which coincides with the time that observation services are initiated in accordance with a physician's order for observation services.

   c. A beneficiary's time receiving observation services (and hospital billing) ends when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.

   d. The number of units reported with HCPCS code G0378 must equal or exceed 8 hours.

3. Additional Hospital Services

   a. The claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line item date of service on the same day or the day before the date reported for observation:

      - An emergency department visit (APC 0609, 0613, 0614, 0615, 0616) or
      - A clinic visit (APC 0604, 0605, 0606, 0607, 0608); or
      - Critical care (APC 0617); or
      - Direct referral for observation care reported with HCPCS code G0379 (APC 0604); must be reported on the same date of service as the date reported for observation services.

   b. No procedure with a T status indicator can be reported on the same day or day before observation care is provided.

4. Physician Evaluation

   a. The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by outpatient registration, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.

   b. The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

Only observation services that are billed on a 13X bill type may be considered for a separate APC payment.

Hospitals should bill all of the other services associated with the observation care, including direct referral for observation, hospital clinic visits, emergency room visits, critical care services, and T status procedures, on the same claim so that the claims processing logic may appropriately determine the payment status (either packaged or separately payable) of HCPCS codes G0378 and G0379.

If a bill for observation care does not meet all of the requirements listed above, then payment for the observation care will be packaged into payments for other separately payable services provided to the beneficiary in the same encounter.

290.5 - Billing and Payment for Observation Services Furnished on or After January 1, 2008

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

290.5.1 - Billing and Payment for Observation Services Beginning January 1, 2008

(Rev. 1760, Issued: 06-23-09; Effective Date: 07-01-09; Implementation Date: 07-06-09)

Observation services are reported using HCPCS code G0378 (Hospital observation service, per hour). Beginning January 1, 2008, HCPCS code G0378 for hourly observation services is assigned status indicator N, signifying that its payment is always packaged. No separate payment is made for observation services reported with HCPCS code G0378, and APC 0339 is deleted as of January 1, 2008. In most circumstances, observation services are supportive and ancillary to the other services provided to a patient. In certain circumstances when observation care is billed in conjunction with a high level clinic visit (Level 5), high level Type A emergency department visit (Level 4 or 5), high level Type B emergency department visit (Level 5), critical care services, or a direct referral as an integral part of a patient's extended encounter of care, payment may be made for the entire extended care encounter through one of two composite APCs when certain criteria are met. For information about payment for extended assessment and management composite APCs, see §10.2.1 (Composite APCs) of this chapter.

APC 8002 (Level I Extended Assessment and Management Composite) describes an encounter for care provided to a patient that includes a high level (Level 5) clinic visit or direct referral for observation in conjunction with observation services of substantial duration (8 or more hours). APC 8003 (Level II Extended Assessment and Management Composite) describes an encounter for care provided to a patient that includes a high level (Level 4 or 5) emergency department visit or critical care services in conjunction with observation services of substantial duration. Beginning January 1, 2009, APC 8003 also includes high level (Level 5) Type B emergency department visits. There is no limitation on diagnosis for payment of these composite APCs; however, composite APC payment will not be made when observation services are reported in association with a surgical procedure (T status procedure) or the hours of observation care reported are less than 8. The I/OCE evaluates every claim received to determine if payment through a composite APC is appropriate. If payment through a composite APC is inappropriate, the I/OCE, in conjunction with the Pricer, determines the appropriate status indicator, APC, and payment for every code on a claim.

All of the following requirements must be met in order for a hospital to receive an APC payment for an extended assessment and management composite APC:

1. Observation Time

a. Observation time must be documented in the medical record.

b. Hospital billing for observation services begins at the clock time documented in the patient's medical record, which coincides with the time that observation services are initiated in accordance with a physician's order for observation services.

c. A beneficiary's time receiving observation services (and hospital billing) ends when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.

d. The number of units reported with HCPCS code G0378 must equal or exceed 8 hours.

2. Additional Hospital Services

a. The claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line item date of service on the same day or the day before the date reported for observation:

- A Type A or B emergency department visit (CPT codes 99284 or 99285 or HCPCS code G0384); or
- A clinic visit (CPT code 99205 or 99215); or
- Critical care (CPT code 99291); or
- Direct referral for observation care reported with HCPCS code G0379 (APC 0604) must be reported on the same date of service as the date reported for observation services.

b. No procedure with a T status indicator can be reported on the same day or day before observation care is provided.

3. Physician Evaluation

a. The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by outpatient registration, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.

b. The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

Criteria 1 and 3 related to observation care beginning and ending time and physician evaluation apply regardless of whether the hospital believes that the criteria will be met for payment of the extended encounter through extended assessment and management composite payment.

Only visits, critical care and observation services that are billed on a 13X bill type may be considered for a composite APC payment.

Non-repetitive services provided on the same day as either direct referral for observation care or observation services must be reported on the same claim because the OCE claim-by-claim logic cannot function properly unless all services related to the episode of observation care, including hospital clinic visits, emergency department visits, critical care services, and T status procedures, are reported on the same claim. Additional guidance can be found in chapter 1, section 50.2.2 of this manual.

If a claim for services provided during an extended assessment and management encounter including observation care does not meet all of the requirements listed above, then the usual APC logic will apply to separately payable items and services on the claim; the special logic for direct admission will apply, and payment for the observation care will be packaged into payments for other separately payable services provided to the beneficiary in the same encounter.

290.5.2 - Billing and Payment for Direct Referral for Observation Care Furnished Beginning January 1, 2008

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

Direct referral for observation is reported using HCPCS code G0379 (Direct referral for hospital observation care). Note: Prior to January 1, 2010, the code descriptor for HCPCS code G0379 was (Direct admission of patient for hospital observation care). Hospitals should report G0379 when observation services are the result of a direct referral for observation care without an associated emergency room visit, hospital outpatient clinic visit, or critical care service on the day of initiation of observation services. Hospitals should only report HCPCS code G0379 when a patient is referred directly to observation care after being seen by a physician in the community.

Payment for direct referral for observation care will be made either separately as a low level hospital clinic visit under APC 0604 or packaged into payment for composite APC 8002 (Level I Prolonged Assessment and Management Composite) or packaged into the payment for other separately payable services provided in the same encounter. For information about payment for extended assessment and management composite APCs, see, §10.2.1 (Composite APCs) of this chapter.

The criteria for payment of HCPCS code G0379 under either APC 0604 or APC 8002 include:

1. Both HCPCS codes G0378 (Hospital observation services, per hr.) and G0379 (Direct referral for hospital observation care) are reported with the same date of service.

2. No service with a status indicator of T or V or Critical Care (APC 0617) is provided on the same day of service as HCPCS code G0379.

If either of the above criteria is not met, HCPCS code G0379 will be assigned status indicator N and will be packaged into payment for other separately payable services provided in the same encounter.

Only a direct referral for observation services billed on a 13X bill type may be considered for a composite APC payment.

290.6 - Services Not Covered as Observation Services

(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

Hospitals must not bill beneficiaries directly for reasonable and necessary observation services for which the OPPS packages payment for observation as part of the payment for the separately payable items and services on the claim. Hospitals should not confuse packaged payment with non-coverage or nonpayment. See the Medicare Benefit Policy Manual, Pub 100-02, chapter 6, section 20.6 for further explanation of non-covered services and notification of the beneficiary in relation to observation care.

300 - Medical Nutrition Therapy (MNT) Services

(Rev. 2127, Issued: 12-29-10, Effective: 01-01-2002, Implementation: 03-29-11)

Section 105 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) permits Medicare coverage of Medical Nutrition Therapy (MNT) services when furnished by a registered dietitian or nutrition professional meeting certain requirements. The benefit is available for beneficiaries with diabetes or renal disease, when referral is made by a physician as defined in §1861(r)(l) of the Act. It also allows registered dietitians and nutrition professionals to receive direct Medicare reimbursement for the first time. The effective date of this provision is January 1, 2002.

The benefit consists of an initial visit for an assessment; follow-up visits for interventions; and reassessments as necessary during the 12-month period beginning with the initial assessment ("episode of care") to assure compliance with the dietary plan. Effective October 1, 2002, basic coverage of MNT for the first year a beneficiary receives MNT with either a diagnosis of renal disease or diabetes as defined at 42 CFR, 410.130 is 3 hours. Also effective October 1, 2002, basic coverage in subsequent years for renal disease is 2 hours.

For the purposes of this benefit, renal disease means chronic renal insufficiency or the medical condition of a beneficiary who has been discharged from the hospital after a successful renal transplant within the last 36 months. Chronic renal insufficiency means a reduction in renal function not severe enough to require dialysis or transplantation (glomerular filtration rate (GFR) 13-50 ml/min/1.73m^2). Effective January 1, 2004, CMS updated the definition of diabetes to be as follows: Diabetes is defined as diabetes mellitus, a condition of abnormal glucose metabolism diagnosed using the following criteria: a fasting blood sugar greater than or equal to 126 mg/dL on two different occasions; a 2 hour post-glucose challenge greater than or equal to 200 mg/dL on 2 different occasions; or a random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

The MNT benefit is a completely separate benefit from the diabetes self-management training (DSMT) benefit. CMS had originally planned to limit how much of both benefits a beneficiary might receive in the same time period. However, the national coverage decision, published May 1, 2002, allows a beneficiary to receive the full amount of both benefits in the same period. Therefore, a beneficiary can receive the full 10 hours of initial DSMT and the full 3 hours of MNT. However, providers are not allowed to bill for both DSMT and MNT on the same date of service for the same beneficiary.

300.1 - General Conditions and Limitations on Coverage

(Rev. 673, Issued: 09-09-05, Effective: N/A, Implementation: N/A)

A. General Conditions on Coverage

The following are the general conditions of coverage:

- The treating physician must make a referral and indicate a diagnosis of diabetes or renal disease. As described above, a treating physician means the primary care physician or specialist coordinating care for beneficiary with diabetes or renal disease.
- The number of hours covered in an episode of care may not be exceeded unless a second referral is received from the treating physician;
- Services may be provided either on an individual or group basis without restrictions and;
- For a beneficiary with a diagnosis of diabetes, Diabetes Self Management Training (DSMT) and MNT services can be provided within the same time period, and the maximum number of hours allowed under each benefit are covered. The only exception is that DSMT and MNT may not be provided on the same day to the same beneficiary. For a beneficiary with a diagnosis of diabetes who has received DSMT and is also diagnosed with renal disease in the same episode of care, the beneficiary may receive MNT services based on a change in medical condition, diagnosis or treatment as stated in 42 CFR 410.132(b)(5).

B. Limitations on Coverage

The following limitations apply:

- MNT services are not covered for beneficiaries receiving maintenance dialysis for which payment is made under Section 1881 of the Act.
- A beneficiary may not receive MNT and DSMT on the same day.

300.2 - Referrals for MNT Services

(Rev. 673, Issued: 09-09-05, Effective: N/A, Implementation: N/A)

Medicare covers 3 hours of MNT in the beneficiary' s initial calendar year. No initial hours can be carried over to the next calendar year. For example, if a physician gives a referral to a beneficiary for 3 hours of MNT but a beneficiary only uses 2 hours in November, the calendar year ends in December and if the third hour is not used, it cannot be carried over into the following year. The following year a beneficiary is eligible for 2 follow-up hours (with a physician referral). Every calendar year a beneficiary must have a new referral for follow-up hours.

Referral may only be made by the treating physician when the beneficiary has been diagnosed with diabetes or renal disease.

Documentation must be maintained by the referring physician in the beneficiary's medical record. Referrals must be made for each episode of care and reassessments prescribed during an episode of care as a result of a change in medical condition or diagnosis. The UPIN number of the referring physician must be on the Form CMS-1500 claim submitted by a registered dietitian or nutrition professional. The Carrier or FI shall return claims that do not contain the referring UPIN of the referring physician.

NOTE: Additional covered hours of MNT services may be covered beyond the number of hours typically covered under an episode of care when the treating physician determines there is a change of diagnosis or medical condition within such episode of care that makes a change in diet necessary. Appropriate medical review for this provision should only be done on a post payment basis. Outliers may be judged against nationally accepted dietary or nutritional protocols in accordance with 42 CFR 410.132 (a).

300.3 - Dietitians and Nutritionists Performing MNT Services

(Rev. 673, Issued: 09-09-05, Effective: N/A, Implementation: N/A)

A Professional Standards for Dietitians and Nutritionists

For Medicare Part B coverage of MNT, only a registered dietitian or nutrition professional may provide the services. "Registered dietitian or nutrition professional" means a dietitian or nutritionist licensed or certified in a State as of December 21, 2000 (they are not required to meet any other requirements); or an individual whom, on or after December 22, 2000:

- Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics, as accredited by an appropriate national accreditation organization recognized for this purpose. The academic requirements of a nutrition or dietetics program may be completed after the completion of the degree;

- Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. Documentation of the supervised dietetics practice may be in the form of a signed document by the professional/facility that supervised the individual; and

- Is licensed or certified as a dietitian or nutrition professional by the state in which the services are performed. In a state that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements stated above.

B Enrollment of Dietitians and Nutritionists

- In order to file claims for MNT, a registered dietitian/nutrition professional must be enrolled as a provider in the Medicare program and meet the requirements outlined above. MNT services can be billed with the effective date of the provider's license and the establishment of the practice location.

- The carrier shall establish a permanent UPIN for any new registered dietitian or nutrition professional who is applying to become a Medicare provider for MNT.

- Registered dietitians and nutrition professionals must accept assignment. Since these new providers must accept assignment, the limiting charge does not apply.

300.4 - Payment for MNT Services

(Rev. 673, Issued: 09-09-05, Effective: N/A, Implementation: N/A)

The contractor shall pay for MNT services under the physician fee schedule for dates of service on or after January 1, 2002, to a registered dietitian or nutrition professional that meets the above requirements. Deductible and coinsurance apply. As with the diabetes self management training (DSMT) benefit, payment is only made for MNT services actually attended by the beneficiary and documented by the provider, and for beneficiaries that are not inpatients of a hospital or skilled nursing facility.

The contractor shall pay the lesser of the actual charge, or 85 percent of the physician fee schedule amount when rendered by a registered dietitian or nutrition professional. Coinsurance is based on 20 percent of the lesser of these two amounts. As required by statute, use this same methodology for services provided in the hospital outpatient department.

A Payable Codes for MNT with Applicable Instructions

- 97802 – Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes. (**NOTE:** This HCPCS code must only be used for the initial visit.)

  - This code is to be used only once for the initial assessment of a new patient. The provider shall bill all subsequent individual visits (including reassessments and interventions) as 97803. The provider shall bill all subsequent group visits as 97804.

- 97803 – Re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes

  - The provider shall bill this code for all reassessments and all interventions after the initial visit (see 97802). This code should also be used when there is a change in the patient's medical condition that affects the nutritional status of the patient (see the heading, Additional Covered Hours for Reassessments and Interventions).

- 97804 – Group (2 or more individual(s)), each 30 minutes

The provider shall bill this code for group visits, initial and subsequent. This code can also be used when there is a change in a patient's condition that affects the nutritional status of the patient and the patient is attending in a group.

NOTE: The above codes can be paid if submitted by a registered dietitian or nutrition professional who meet the specified requirements; or a hospital that has received reassigned benefits from a registered dietitian or nutritionist. These services cannot be paid "incident to" physician services.

B HCPCS Codes for MNT When There is a Change in the Beneficiaries Condition (for services effective on or after January 1, 2003)

The following HCPCS codes shall be used when there is a change in the beneficiary's condition:

- G0270 – Medical Nutrition Therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes.

- G0271 – Medical Nutrition Therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease) group (2 or more individuals), each 30 minutes.

NOTE: These G codes should be used when additional hours of MNT services are performed beyond the number of hours typically covered, (3 hours in the initial calendar year, and 2 follow-up hours in subsequent years with a physician referral) when the treating physician determines there is a change of diagnosis or medical condition that makes a change in diet necessary. Appropriate medical review for this provision should only be done on a post payment basis. Outliers may be judged against nationally accepted dietary or nutritional protocols in accordance with 42 CFR 410.132(a).

300.5 - General Claims Processing Information

(Rev. 673, Issued: 09-09-05, Effective: N/A, Implementation: N/A)

This benefit is payable for beneficiaries who have diabetes or renal disease. Contractors are urged to perform data analysis of these services in your jurisdiction. If you determine that a potential problem exists, you should verify the cause of the potential error by conducting an error validation review as described in the Program Integrity Manual (PIM), Chapter 3, Section 2A. Where errors are verified, initiate appropriate

corrective actions found in the PIM, Chapter 3, Sections 3 through 6. If no diagnosis is on the claim, return the claim as unprocessable. If the claim does not contain a diagnosis of diabetes or renal disease, then deny the claim under Section 1862(a)(1)(A) of the Act.

A. Special Requirements for Carriers

- Registered dietitians and nutrition professionals can be part of a group practice in which case the provider identification number of the registered dietitian or nutrition professional that performed the service must be entered in on the claim form.

  - The specialty code for "dietitians/nutritionists" is 71.

B. Medicare Summary Notices (MSNs)

- Use the following MNT messages where appropriate. If you locate a more appropriate message, then you should use it.

  - If a claim for MNT is submitted with dates of service before January 1, 2002, use MSN 21.11 (This service was not covered by Medicare at the time you received it). The Spanish version is 'Este servicio no estaba cubierto por Medicare cuando usted lo recibio.'

  - If a claim for MNT is submitted by a provider that does not meet the criteria use MSN 21.18 (This item or service is not covered when performed or ordered by this provider). The Spanish version is 'Este servicio no esta cubierto cuando es ordenado o rendido por este proveedor.'

C. FI Special Billing Instructions

MNT Services can be billed to FIs when performed in an outpatient hospital setting. The Hospital outpatient departments can bill for the MNT services through the local FI if the nutritionists or registered dietitians reassign their benefits to the hospital. If the hospitals do not get the reassignments the nutritionists and the registered dietitians will have to bill the local Medicare carrier under their own provider number or the hospital will have to bill the local Medicare carrier.

NOTE: Nutritionists and registered dietitians must obtain a Medicare provider number before they can reassign their benefits.

The only applicable bill types are 13X, 14X, 23X, 32X, and 85X.

300.5.1 - RHCs/FQHCs Special Billing Instructions

(Rev. 1719, Issued: 04-24-09, Effective: 10-01-09, Implementation: 10-05-09)

Detailed billing instructions for Medical Nutrition Therapy (MNT) services provided in RHCs and FQHCs can be found in Chapter 9, section 182 of this manual.

300.6 - Common Working File (CWF) Edits

(Rev. 1846; Issued: 11-06-09; Effective Date: 04-01-10; Implementation Date: 04-05-10)

The CWF edit will allow 3 hours of therapy for MNT in the initial calendar year. The edit will allow more than 3 hours of therapy if there is a change in the beneficiary's medical condition, diagnosis, or treatment regimen and this change must be documented in the beneficiary's medical record. Two new G codes have been created for use when a beneficiary receives a second referral in a calendar year that allows the

beneficiary to receive more than 3 hours of therapy. Another edit will allow 2 hours of follow up MNT with another referral in subsequent years.

Advance Beneficiary Notice (ABN)

The beneficiary is liable for services denied over the limited number of hours with referrals for MNT. An ABN should be issued in these situations. In absence of evidence of a valid ABN, the provider will be held liable.

An ABN should not be issued for Medicare-covered services such as those provided by hospital dietitians or nutrition professionals who are qualified to render the service in their state but who have not obtained Medicare provider numbers.

Duplicate Edits

Although beneficiaries are allowed to receive training and therapy during the same time period Diabetes Self-Management and Training (DSMT) and Medical Nutrition Therapy (MNT) services may not be provided on the same day to the same beneficiary. Effective April 1, 2010 CWF shall implement a new duplicate crossover edit to identify and prevent claims for DSMT/MNT services from being billed with the same dates of services for the same beneficiaries submitted from institutional providers and from a professional provider.

310 - Lung Volume Reduction Surgery

(Rev. 768, Issued: 12-01-05; Effective: 11-17-05; Implementation: 03-02 06)

Lung Volume Reduction Surgery (LVRS) (also known as reduction pneumoplasty, lung shaving, or lung contouring) is an invasive surgical procedure to reduce the volume of a hyperinflated lung in order to allow the underlying compressed lung to expand, and thus, establish improved respiratory function.

Effective for 'from' dates of service on or after January 1, 2004, Medicare will cover LVRS under certain conditions as described in §240 of the Pub. 100-03, “National Coverage Determinations”.

LVRS can only be performed in the facilities listed on the following website: www.cms.hhs.gov/coverage/lvrsfacility.pdf

LVRS is an inpatient procedure. However pre- and post- operative services are performed on an outpatient basis and must be performed at one of the facilities certified to do so. These procedures are paid under the Outpatient Prospective Payment System (OPPS), except for hospitals located in Maryland.

Medicare previously only covered LVRS as part of the National Emphysema Treatment Trial (NETT). The study was limited to 18 hospitals, and patients were randomized into two arms, either medical management and LVRS or medical management. The study was conducted by The National Heart, Lung, and Blood Institute of the National Institutes of Health and coordinated by Johns Hopkins University (JHU). Hospital claims for patients in the NETT were identified by the presence of Condition Code EY. The JHU instructed hospitals of the correct billing procedures for billing claims under the NETT.

320 – Outpatient Intravenous Insulin Treatment (OIVIT)

(Rev. 1930, Issued: 03-09-10, Effective Date: 12-23-09; Implementation Date: 04-05-10)

Effective for claims with dates of service on and after December 23, 2009, the Centers for Medicare and Medicaid Services (CMS) determines that the evidence does not support a conclusion that OIVIT improves health outcomes in Medicare beneficiaries. Therefore, CMS has determined that OIVIT is not reasonable and necessary for any indication under section 1862(a)(1)(A) of the Social Security Act. Services comprising an OIVIT regimen are nationally non-covered under Medicare when furnished pursuant to an OIVIT regimen.

See Pub. 100-03, Medicare National Coverage Determinations Manual, Section 40.7, Outpatient Intravenous Insulin Treatment (Effective December 23, 2009), for general information and coverage indications.

320.1 – HCPCS Coding for OIVIT

(Rev. 1930, Issued: 03-09-10, Effective Date: 12-23-09; Implementation Date: 04-05-10)

HCPCS code G9147, effective with the April IOCE and MPFSDB updates, is to be used on claims with dates of service on and after December 23, 2009, billing for non-covered OIVIT and any services comprising an OIVIT regimen.

NOTE: HCPCS codes 99199 or 94681(with or without diabetes related conditions 250.00-250.93) are not to be used on claims billing for non-covered OIVIT and any services comprising an OIVIT regimen when furnished pursuant to an OIVIT regimen. Claims billing for HCPCS codes 99199 and 94681 for non-covered OIVIT are to be returned to provider/returned as unprocessable.

320.2 – Medicare Summary Notices (MSN), Reason Codes, and Remark Codes

(Rev. 1930, Issued: 03-09-10, Effective Date: 12-23-09; Implementation Date: 04-05-10)

When returning non-covered OIVIT claims billed with HCPCS 99199 to provider/returning as unprocessable, contractors shall use:

Claims Adjustment Reason Code (CARC) 189: NOS or unlisted procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service,

Remittance Advice Remark Code (RARC) N56: The procedure code billed is not correct/valid for the services billed or the date of service billed, and,

RARC MA66: Missing/incomplete/invalid principal procedure code.

When returning non-covered OIVIT claims billed with HCPCS 94681 with or without diabetes-related conditions 250-00-250.93 to provider/returning as unprocessable, contractors shall use:

CARC 11: The diagnosis is inconsistent with the procedure,

RARC N56: The procedure code billed is not correct/valid for the services billed or the date of service billed, and,

RARC MA66: Missing/incomplete/invalid principal procedure code.

When denying claims for non-covered OIVIT and any services comprising an OIVIT regimen billed with HCPCS code G9147, contractors shall use:

MSN 16.10 - Medicare does not pay for these item(s) or service(s),

CARC 96: Non-covered charge(s),

CARC M51: Missing/Incomplete /Invalid Procedure Code(s), and,

RARC N386: This decision was based on an NCD. An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at http://www.cms.hhs.gov/mcd/search.asp. If you do not have Web access, you may contact the contractor to request a copy of the NCD.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R2531CP	08/24/2012	October 2012 Update of the Hospital Outpatient Prospective Payment System (OPPS)	10/01/2012	803
R2483CP	06/08/2012	July 2012 Update of the Hospital Outpatient Prospective Payment System (OPPS)	07/02/2012	784
R2455CP	04/26/2012	Hospital Dialysis Services for Patients With and Without End Stage Renal Disease (ESRD)	10/01/2012	776
R2452CP	04/26/2012	Anesthesiologist Services With a Modifier GC in a Method II Critical Access Hospital (CAH)	10/01/2012	776
R2453CP	04/26/2012	CY 2012 OPPS Payment Adjustment for Certain Cancer Hospitals	05/29/2012	778
R2418CP	03/02/2012	April 2012 Update of the Hospital Outpatient Prospective Payment System (OPPS)	04/02/2012	774
R2403CP	01/26/2012	Medicare System Update to Include a Rendering Provider Field to Allow Correct Physician National Provider Identifier (NPI) Reporting for the Primary Care Incentive Program (PCIP) for Critical Access Hospitals (CAHs) Reimbursed Under the Optional Method	07/02/2012	768
R2395CP	01/26/2012	Multiple Procedure Payment Reduction (MPPR)for Physician Services for Certain Diagnostic Imaging Procedures in Critical Access Hospitals (CAH)	07/02/2012	768
R2386CP	01/13/2012	January 2012 Update of the Hospital Outpatient Prospective Payment System (OPPS)	01/03/2012	767
R2376CP	12/29/2011	January 2012 Update of the Hospital Outpatient Prospective Payment System (OPPS) – Rescinded and replaced by Transmittal 2386	01/03/2012	767
R2361CP	11/25/2011	Clarification and Revisions for Claims Submitted for End Stage Renal Disease (ESRD) Patients	04/02/2012	759
R2335CP	10/28/2011	Clarification and Revisions for Claims Submitted for End Stage Renal Disease (ESRD) Patients – Rescinded and replaced by Transmittal 2361	04/02/2012	759

Rev #	Issue Date	Subject	Impl Date	CR#
R2333CP	10/28/2011	Payment for Multiple Surgeries in a Method II Critical Access Hospital (CAH)	04/02/2012	758
R2311CP	09/23/2011	Implementation of the MIPPA 153c End Stage Renal Disease (ESRD) Quality Incentive Program (QIP) and Other Requirements for ESRD Claims	01/03/2012	746
R2296CP	09/02/2011	October 2011 Update of the Hospital Outpatient Prospective Payment System (OPPS)	10/03/2011	754
R2291CP	08/26/2011	Fiscal Year (FY) 2012 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH) PPS, and Critical Access Hospital (CAH) Changes	10/03/2011	750
R2268CP	08/01/2011	Anesthesiologist Services in a Method II Critical Access Hospital (CAH)	01/03/2012	746
R2262CP	07/29/2011	Implementation of the MIPPA 153c End Stage Renal Disease (ESRD) Quality Incentive Program (QIP) and Other Requirements for ESRD Claims – Rescinded and replaced by Transmittal 2311	01/03/2012	746
R2242CP	6/17/2011	Revision to Formula to Compute the Time Value of Money under the Inpatient Prospective Payment System (IPPS), Outpatient Prospective Payment System (OPPS), Inpatient Rehabilitation Facility (IRF PPS), Inpatient Psychiatric Facility (IPF PPS) and Long Term Care Hospital (LTCH PPS)	07/01/2011	746
R2234CP	05/27/2011	July 2011 Update of the Hospital Outpatient Prospective Payment System (OPPS)	07/05/2011	744
R2232CP	05/27/2011	Critical Access Hospital (CAH) Optional Method Election for Outpatient Services	10/03/2011	740
R2202CP	04/27/2011	Section 1833(a)(1)(F) of the Social Security Act-Payment of Licensed Clinical Social Workers (LCSW) in a Method II Critical Access Hospital (CAH)	10/03/2011	736
R2201CP	04/22/2011	Section 1833(a)(1)(F) of the Social Security Act-Payment of Licensed Clinical Social Workers (LCSW) in a Method II Critical Access Hospital (CAH) – Rescinded and replaced by Transmittal 2202	10/03/2011	736
R2169CP	03/03/2011	Incentive Payment Program for Primary Care Services, Section 5501(a) of the Patient Protection and	04/04/2011	711

Rev #	Issue Date	Subject	Impl Date	CR#
		Affordable Care Act (the ACA), Payment to a CAH Paid Under the Optional Method		
R2141CP	01/24/2011	January 2011 Update of the Hospital Outpatient Prospective Payment System (OPPS)	01/03/2011	727
R2137CP	01/21/2011	Certified Registered Nurse Anesthetist (CRNA) Services n a Method II Critical Access Hospital (CAH) Without a CRNA Pass-Through Exemption	07/05/2011	720
R2130CP	12/30/2010	January 2011 Update of the Hospital Outpatient Prospective Payment System (OPPS) – Rescinded and replaced by Transmittal 2141	01/03/2011	727
R2127CP	12/29/2010	Medical Nutrition Therapy (MNT) Manual Correction	03/29/2011	726
R2117CP	12/10/2010	Revisions to the Medicare Code Editor (MCE) and Integrated Outpatient Code Editor(IOCE) Reporting Requirements	01/12/2011	724
R2111CP	12/03/2010	Outlier Reconciliation and other Outlier Manual Updates for the Inpatient Prospective Payment System (IPPS), Outpatient Prospective Payment System (OPPS), Inpatient Rehabilitation Facility (IRF) PPS, Inpatient Psychiatric Facility (IPF) PPS and Long Term Care Hospital (LTCH) PPS	04/04/2011	719
R2102CP	11/19/2010	Systems Changes Necessary to Implement “Technical Correction Related to Critical Access Hospital Services”, Section 3128 of the Affordable Care Act, Pub. 118-148	04/04/2011	721
R2081CP	12/03/2010	Incentive Payment Program for Primary Care Services, Section 5501(a) of the Patient Protection and Affordable Care Act (the ACA), Payment to a CAH Paid Under the Optional Method – Rescinded and replaced by Transmittal 2169	04/04/2011	711
R2078CP	10/28/2010	Incentive Payment Program for Major Surgical Procedures Furnished in Health Professional Shortage Areas, Section 5501(b) of the Patient Protection and Affordable Care Act (the ACA), and Payments to a Critical Access Hospital (CAH) Paid under the Optional Method	04/04/2011	714

Rev #	Issue Date	Subject	Impl Date	CR#
R2061CP	10/01/2010	October 2010 Update of the Hospital Outpatient Prospective Payment System (OPPS)	10/04/2010	711
R2050CP	09/17/2010	October 2010 Update of the Hospital Outpatient Prospective Payment System (OPPS) – Rescinded and replaced by Transmittal 2061	10/04/2010	711
R2024CP	08/06/2010	Payment for Certified Nurse-Midwife Services	01/03/2011	700
R1980CP	06/04/2010	July 2010 Update of the Hospital Outpatient Prospective Payment System (OPPS)	07/06/2010	699
R1976CP	05/28/2010	July 2010 Update of the Hospital Outpatient Prospective Payment System (OPPS) – Rescinded and replaced by Transmittal 1980	07/06/2010	699
R1930CP	03/09/2010	Outpatient Intravenous Insulin Treatment (Therapy)	04/05/2010	677
R1924CP	02/26/2010	April 2010 Update of the Hospital Outpatient Prospective Payment System (OPPS)	04/05/2010	685
R1923CP	02/22/2010	Outpatient Intravenous Insulin Treatment (Therapy) – Rescinded and replaced by Transmittal 1930	03/08/2010	677
R1921CP	02/19/2010	Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs)	04/05/2010	656
R1913CP	02/05/2010	Outpatient Intravenous Insulin Treatment (Therapy) – Rescinded and replaced by Transmittal 1923	03/08/2010	677
R1894CP	01/15/2010	Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs) – Rescinded and replaced by Transmittal 1921	04/05/2010	656
R1882CP	12/21/2009	January 2010 Update of the Hospital Outpatient Prospective Payment System (OPPS)	01/04/2010	675
R1871CP	12/11/2009	January 2010 Update of the Hospital Outpatient Prospective Payment System (OPPS) - Rescinded and replaced by Transmittal 1882	01/04/2010	675
R1846CP	11/06/2009	Implementation of Common Working File (CWF) Editing for Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT)	04/05/2010	655

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