| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-04 Medicare Claims Processing | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 2611** | **Date: December 14, 2012** |
| | **Change Request 8141** |

**SUBJECT: January 2013 Update of the Hospital Outpatient Prospective Payment System (OPPS)**

**I. SUMMARY OF CHANGES:** This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the January 2013 OPPS update. The January 2013 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this Change Request (CR).

The January 2013 revisions to I/OCE data files, instructions, and specifications are provided in the upcoming January 2013 I/OCE CR.

**EFFECTIVE DATE: January 1, 2013**
**IMPLEMENTATION DATE: January 7, 2013**

***Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.***

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 4/Table of Contents |
| R | 4/10.2.1 - Composite APCs |
| R | 4/10.6.3.1 - Payment Adjustment for Certain Cancer Hospitals for CY 2012 and CY 2013 |
| N | 4/61.5 - Billing for Intracoronary Stent Placement |
| R | 4/200.9 - Billing for “Sometimes Therapy” Services that May be Paid as Non-Therapy Services for Hospital Outpatients |
| R | 4/260.1 - Special Partial Hospitalization Billing Requirements for Hospitals, Community Mental Health Centers, and Critical Access Hospitals |
| R | 4/260.1.1 - Bill Review for Partial Hospitalization Services Provided in Community Mental Health Centers (CMHC) |

**III. FUNDING:**
**For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):**
No additional funding will be provided by CMS; Contractors activities are to be carried out with their

operating budgets

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

**IV. ATTACHMENTS:**
**Business Requirements**
**Manual Instruction**
**Unless otherwise specified, the effective date is the date of service.*

# Attachment - Recurring Update Notification

| Pub. 100-04 | Transmittal: 2611 | Date: December 14, 2012 | Change Request: 8141 |
|---|---|---|---|

**SUBJECT: January 2013 Update of the Hospital Outpatient Prospective Payment System (OPPS)**

**EFFECTIVE DATE: January 1, 2013**
**IMPLEMENTATION DATE: January 7, 2013**

## I. GENERAL INFORMATION

**A. Background:** This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the January 2013 OPPS update. The January 2013 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this Change Request (CR).

The January 2013 revisions to I/OCE data files, instructions, and specifications are provided in the upcoming Janury 2013 I/OCE CR.

**B. Policy:**

**1. Changes to Device Edits for January 2013**

The most current list of device edits can be found under "Device, Radiolabeled Product, and Procedure Edits" at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/. Failure to pass these edits will result in the claim being returned to the provider.

**2. Intracoronary Stent Placement Procedure Codes**

Effective January 1, 2013, the AMA's CPT Editorial Panel is deleting CPT codes 92980 (Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel) and 92981 (Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel), which are used to describe nondrug-eluting intracoronary stent placement procedures and replacing them with new CPT codes.

The creation of new CPT codes involving intracoronary stent placement procedures for CY 2013 requires us to create nine new HCPCS C-codes and to delete two existing HCPCS G-codes in order to maintain existing OPPS policy of differentiating payment for intracoronary stent placement procedures involving nondrug-eluting and drug-eluting stents for CY 2013.

CMS is updating Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, Section 61.5, to reflect these changes to the intracoronary stent placement HCPCS codes and reporting guidelines.

**3. Outpatient payment for Composite APC 8000** (Cardiac Electrophysiologic Evaluation and Ablation Composite)

CMS is modifying Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, Section 10.2.1, to account for coding changes to cardiac electrophysiologic evaluation and ablation codes by the AMA's CPT Editorial Panel. The CPT Editorial Panel deleted CPT codes 93651 and 93652, effective 1/1/2013 and created new CPT codes 93653, 93654, and 93656, effective 1/1/2013.

**4. New 'Sometimes Therapy' Services that May Be Paid as Non-Therapy Services for Hospital Outpatients**

Effective January 1, 2013, CMS is adding two HCPCS codes that are new for CY 2013 to the list of PT/SLP/OT "sometimes therapy" services that may be paid under certain circumstances to a facility under the OPPS. They are: G0456, Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters; and G0457, Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters. The limited set of sometimes therapy services listed in the manual are paid under the OPPS when they are not furnished as therapy, meaning they are not furnished under a certified therapy plan of care. When a hospital furnishes these services to a hospital outpatient as non-therapy, the hospital may submit a claim for facility payment for the services to the OPPS.

**5. Coding Changes for PHP Services**

In Pub. 100-04, Medicare Claims Processing Manual, chapter 4, sections 260.1 and 260.1.1, several revisions are being made to the PHP billing code set. Effective January 1, 2013, the AMA's CPT Editorial Panel deleted 28 psychiatric CPT codes, including those related to PHP services, and replaced them with 12 new CPT codes. As a result of the AMA's CPT coding changes to the psychiatric CPT codes, CMS is making corresponding changes to the PHP code set that is used for billing and documenting PHP services.

**6. Drugs, Biologicals, and Radiopharmaceuticals**

**a. New CY 2013 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals**

For CY 2013, several new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. These new codes are listed in Table 1, in the attachment A..

**b. Other Changes to CY 2013 HCPCS and CPT Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals**

Many HCPCS and CPT codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS and CPT code descriptors that will be effective in CY 2013. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2012 and replaced with permanent HCPCS codes in CY 2013. Hospitals should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the active CY 2013 HCPCS and CPT codes.

Table 2, in the attachment A, notes those drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS/CPT code, their long descriptor, or both. Each product's CY 2012 HCPCS/CPT code and long descriptor are noted in the two left hand columns and the CY 2013 HCPCS/CPT code and long descriptor are noted in the adjacent right hand columns.

**c. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective January 1, 2013**

For CY 2013, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2013, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Effective January 1, 2013, payment rates for many drugs and biologicals have changed from the values published in the CY 2013 OPPS/ASC final rule with comment period as a

result of the new ASP calculations based on sales price submissions from the third quarter of CY 2012. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2013 release of the OPPS Pricer. CMS is not publishing the updated payment rates in this Change Request implementing the January 2013 update of the OPPS. However, the updated payment rates effective January 1, 2013 can be found in the January 2013 update of the OPPS Addendum A and Addendum B on the CMS Web site at http://www.cms.gov/HospitalOutpatientPPS/.

**d. Updated Payment Rate for a HCPCS Code Effective April 1, 2012 through June 30, 2012**

The payment rate for one HCPCS code was incorrect in the April 2012 OPPS Pricer. The corrected payment rate is listed in Table 3, in the attachment A, and has been installed in the January 2013 OPPS Pricer, effective for services furnished on April 1, 2012, through June 30, 2012.

**e. Updated Payment Rate for a HCPCS Code Effective July 1, 2012 through September 30, 2012**

The payment rate for one HCPCS code was incorrect in the July 2012 OPPS Pricer. The corrected payment rate is listed in Table 4, in the attachment A, and has been installed in the January 2013 OPPS Pricer, effective for services furnished on July 1, 2012, through September 30, 2012.

**7. CY 2013 OPPS Payment Adjustment for Certain Cancer Hospitals**

Consistent with Section 3138 of the Affordable Care Act, we adopted a policy beginning in CY 2012 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. We are updating Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, section 10.6.3.1 to reflect that the target PCR for CY 2013, for purposes of the cancer hospital payment adjustment, is 0.91 for outpatient services furnished on or after January 1, 2013 through December 31, 2013.

**8. Changes to OPPS Pricer Logic**

**a**. Rural sole community hospitals and essential access community hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in CY 2013. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with section 1833(t)(13)(B) of the Act, as added by section 411 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

**b**. New OPPS payment rates and copayment amounts will be effective January 1, 2013. All copayment amounts will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the CY 2013 inpatient deductible.

**c.** For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2013. This threshold of 1.75 is multiplied by the total line-item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount. The payment formula is (cost-(APC payment x 1.75))/2.

**d**. There will be no change in the fixed-dollar threshold in CY 2013. The estimated cost of a service must be greater than the APC payment amount plus $2,025 in order to qualify for outlier payments.

**e.** For outliers for Community Mental Health Centers (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2012. This threshold of 3.4 is multiplied by the total line-item APC payment for APC 0173 to determine eligibility for outlier payments. This multiple amount is also used to determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment

formula is (cost-(APC 0173 payment x 3.4))/2.

**f.** Effective January 1, 2013, 3 devices are eligible for pass-through payment in the OPPS Pricer logic. Category C1830 (Powered bone marrow biopsy needle), has an offset amount of $0, because CMS is not able to identify portions of the APC payment amounts associated with the cost of the device. Category C1840 (Lens, intraocular (implantable)) and C1886 (Catheter, extravascular tissue ablation, any modality (insertable)) have offset amounts included in the Pricer for CY 2013. Pass-through offset amounts are adjusted annually. For outlier purposes, when C1830, C1840, or C1886 are billed with a service included in APC 0003, APC 0234 or APC 0415, respectively, they will be associated with a specific HCPCS code in those APCs for outlier eligibility and payment.

**g.** Effective January 1, 2013, the OPPS Pricer will apply a reduced update ratio of 0.980 to the payment and copayment for hospitals that fail to meet their hospital outpatient quality data reporting requirements or that fail to meet CMS validation edits. The reduced payment amount will be used to calculate outlier payments.

**h.** Effective January 1, 2013, there will be one diagnostic radiopharmaceutical receiving pass-through payment in the OPPS Pricer logic. For APCs containing nuclear medicine procedures, Pricer will reduce the amount of the pass-through diagnostic radiopharmaceutical payment by the wage-adjusted offset for the APC with the highest offset amount when the radiopharmaceutical with pass-through appears on a claim with a nuclear procedure. The offset will cease to apply when the diagnostic radiopharmaceutical expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals are the "policy-packaged" portions of the CY 2013 APC payments for nuclear medicine procedures and may be found on the CMS Web site.

**i.** Pricer will update the payment rates for drugs, biologicals, therapeutic radiopharmaceuticals, and diagnostic radiopharmaceuticals with pass-through status when those payment rates are based on ASP on a quarterly basis.

**j.** Effective January 1, 2013, CMS is adopting the FY 2013 IPPS post-reclassification wage index values with application of out-commuting adjustment authorized by Section 505 of the MMA to non-IPPS hospitals discussed below.

**9. Update the Outpatient Provider Specific File (OPSF)**

For January 1, 2013, contractors shall maintain the accuracy of the provider records in the Outpatient Provider Specific File (OPSF) as changes occur in data element values.

**Update the OPSF for New Core-Based Statistical Area (CBSA) and Wage Indices for Non-IPPS Hospitals Eligible for the Out-Commuting Adjustment Authorized by Section 505 of the MMA**

This includes updating the CBSA in the provider records, as well as updating the "special wage index" value for those providers who qualify for the Section 505 adjustment as annotated in Table 5, in the attachment A.. CMS notes that reclassification wage index values under Section 508 of the MMA and their subsequent extensions expired on March 31, 2012. As always, the OPPS applies the IPPS fiscal year 2013 post-reclassification wage index values to all hospitals and community mental health centers participating in the OPPS for the 2013 calendar year.

Contractors shall do the following to update the OPSF (effective January 1, 2013):

1**.** Update the CBSA value for each provider in Table 5;

2. For non-IPPS providers who qualify for the 505 adjustment in CY 2013 (Table 5.);

a) Create a new provider record, effective January 1, 2013 and

b) Enter a value of “1” in the Special Payment Indicator field on the OPSF; and

c) Enter the final wage index value (given for the provider in Table 5.) in the Special Wage Index field in the OPSF.

3. For non-IPPS providers who received a special wage index in CY 2012, but no longer receive it in CY 2013;

a) Create a new provider record, effective January 1, 2013 and

b) Enter a blank in the Special Payment Indicator field; and

c) Enter zeroes in the special wage index field.

**NOTE:** Although the Section 505 adjustment is static for each qualifying county for 3 years, the special wage index will need to be updated (using the final wage index in Table 5) because the post-reclassification CBSA wage index has changed.

**NOTE:** Payment for Distinct Part Units (DPUs) located in an acute care hospital is based on the wage index for the labor market area where the hospital is located, even if the hospital has a reclassified wage index. If the DPU falls in a CBSA eligible to receive the section 505 out-commuting adjustment, the DPU’s final wage index should consist of the geographic wage index plus the appropriate out-commuting adjustment.

**a) Updating the OPSF for Expiration of Transitional Outpatient Payments (TOPs)**

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*, extended through December 31, 2012, the hold harmless provision for a rural hospital with 100 or fewer beds that is not an SCH (as defined in section 1886(d)(5)(D)(iii) of the Act). Section 308 of the Temporary Payroll Tax Cut Continuation Act of 2011 also extended the hold harmless provision to rural sole community hospitals with more than 100 beds. 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*, extended through December 31, 2012, the hold harmless provision for rural sole community hospitals with 100 beds or less.

**NOTE:** EACHs are considered SCHs for purposes of the TOPs adjustment.

Cancer and children's hospitals are permanently held harmless under section 1833(t)(7)(D)(ii) of the Social Security Act and continue to receive hold harmless TOPs permanently. For CY 2013, cancer hospitals will receive an additional payment adjustment.

Unless otherwise instructed, by December 31, 2012, contractors shall create an additional OPSF for all providers listed in the attachment with a January 1, 2013, effective date that does not contain a “Y” in the TOPs Indicator.

**b) Updating the OPSF for the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) Requirements**

Effective for OPPS services furnished on or after January 1, 2009, Subsection (d) hospitals that have failed to submit timely hospital outpatient quality data as required in Section 1833(t)(17)(A) of the Act will receive payment under the OPPS that reflects a 2 percentage point deduction from the annual OPPS update for failure to meet the HOP QDRP requirements. This reduction will not apply to hospitals not required to submit quality data or hospitals that are not paid under the OPPS.

For January 1, 2013, contractors shall maintain the accuracy of the provider records in the OPSF by updating the Hospital Quality Indicator field. CMS will release a Technical Direction Letter that lists Subsection (d) hospitals that are subject to and fail to meet the HOP QDRP requirements. Once this list is released, FIs/MACs will update the OPSF by removing the '1', (that is, ensure that the Hospital Quality Indicator field is blank) for all hospitals identified on the list and will ensure that the OPSF Hospital Quality Indicator field contains '1' for all hospitals that are not on the list. CMS notes that if these hospitals are later determined to have met the HOP QDRP requirements, FIs/MACs shall update the OPSF. For greater detail regarding updating the OPSF for the HOP QDRP requirements, see Transmittal 368, CR 6072, issued on August 15, 2008.

**c) Updating the OPSF for the Outpatient Cost to Charge Ratio (CCR)**

As stated in Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, Section 50.1, contractors must maintain the accuracy of the data and update the OPSF as changes occur in data element values, including changes to provider cost–to-charge ratios. The file of OPPS hospital upper limit CCRs and the file of Statewide CCRs are located on the CMS Web site at www.cms.gov/HospitalOutpatientPPS/ under "*Annual Policy Files*."

**10. Coverage Determinations**

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Fiscal Intermediaries (FIs)/Medicare Administrative Contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, FIs/MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

## II. BUSINESS REQUIREMENTS TABLE

*Use "Shall" to denote a mandatory requirement.*

| Number | Requirement | Responsibility | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | Other |
| | | Part A | Part B | | | | | FISS | MCS | VMS | CWF | |
| 8141.1 | Medicare contractors shall install the January 2013 OPPS Pricer. | X | | | X | | X | X | | | | COBC |
| 8141.2 | Medicare contactors shall manually add CPT code 81161 listed in the upcoming January 2013 I/OCE CR to their systems effective January 1 2013.<br><br>**Note:** 81161 will be included with the January 2013 I/OCE update. Status and payment indicator for this CPT code will be listed in the January 2013 update of the OPPS Addendum B on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html | X | | | X | | X | X | | | | COBC |

| Number | Requirement | Responsibility | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | Other |
| | | Part A | Part B | | | | | FISS | MCS | VMS | CWF | |
| | | | | | | | | | | | | |
| 8141.3 | Medicare contractors shall adjust as appropriate claims brought to their attention that:<br><br>1. Have dates of service that fall on or after April 1, 2012, but prior to July 1, 2012;<br>2. Contain HCPCS code Q4112; and<br>3. Were originally processed prior to the installation of the January 2013 OPPS Pricer. | X | | | X | | X | | | | | COBC |
| 8141.4 | Medicare contractors shall adjust as appropriate claims brought to their attention that:<br><br>4. Have dates of service that fall on or after July 1, 2012, but prior to October 1, 2012;<br>5. Contain HCPCS code Q4112; and<br>6. Were originally processed prior to the installation of the January 2013 OPPS Pricer. | X | | | X | | X | | | | | COBC |
| 8141.5 | Medicare contractors shall calculate interim cancer hospital payment adjustment amounts for outpatient services furnished on or after January 1, 2013 through December 31, 2013. | X | | | X | | | | | | | |
| 8141.6 | As specified in chapter 4, section 50.1, Medicare contractors shall maintain the accuracy of the data and update the OPSF file as changes occur in data element values. For CY 2013, this includes all changes to the OPSF identified in Section 9 of this Change Request. | X | | | X | | X | | | | | COBC |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | DME MAC | FI | CARRIER | RHHI | Other |
| | | Part A | Part B | | | | | |

| Number | Requirement | Responsibility | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | DME MAC | FI | CARRIER | RHHI | Other |
| | | Part A | Part B | | | | | |
| 8141.7 | MLN Article : A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly. | X | | | X | | X | |

## IV. SUPPORTING INFORMATION

**Section A: Recommendations and supporting information associated with listed requirements: N/A**
*Use "Should" to denote a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|

**Section B: All other recommendations and supporting information: N/A**

## V. CONTACTS

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

**Post-Implementation Contact(s):** Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

## VI. FUNDING

**Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):**
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

**Section B: For Medicare Administrative Contractors (MACs):**
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically

authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

## 10.2.1 - Composite APCs

*(Rev.2611, Issued: 12-14-12, Effective: 01-01-13, Implementation, 01-07-13)*

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 on the same date of service*; or, at least one unit of CPT codes 93653, 93654, or 93656 (no additional concurrent service codes required)*. |
| 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--<br>• On the same day as HCPCS code G0379*; or<br>• On the same day or the day after CPT codes 99205 or 99215; and<br>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<br>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 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. |

| Composite APC | Composite APC Title | Criteria for Composite Payment |
|---|---|---|
| 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.

## 10.6.3.1 - Payment Adjustment for Certain Cancer Hospitals for CY 2012 *and CY 2013*

***(Rev.2611, Issued: 12-14-12, Effective: 01-01-13, Implementation, 01-07-13)***

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, *2013*.

## *61.5 - Billing for Intracoronary Stent Placement*

***(Rev.2611, Issued: 12-14-12, Effective: 01-01-13, Implementation, 01-07-13)***

*Since CY 2003, under the OPPS, we assign coronary stent placement procedures to separate APCs based on the use of nondrug-eluting or drug-eluting stents (APC 0104 (Transcatheter Placement of Intracoronary Stents) or APC 0656 (Transcatheter Placement of Intracoronary Drug-Eluting Stents), respectively). In order to effectuate this policy, we created HCPCS G-codes G0290 (Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel) and G0291 (Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel) for drug-eluting intracoronary stent placement procedures that parallel existing CPT codes 92980 (Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel) and 92981 (Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel), which are used to describe nondrug-eluting intracoronary stent placement procedures. For CY 2012 and years prior, CPT codes 92980*

*and 92981 have been assigned to APC 0104, while HCPCS codes G0290 and G0291 have been assigned to APC 0656.*

*Effective January 1, 2013, the AMA's CPT Editorial Panel is deleting CPT codes 92980 and 92981 and replacing them with the following new CPT codes:*

- *CPT code 92928 (Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch)*
- *CPT code 92929 (Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure));*
- *CPT code 92933 (Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch);*
- *CPT code 92934 (Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure));*
- *CPT code 92937 (Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel);*
- *CPT code 92938 (Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (List separately in addition to code for primary procedure));*
- *CPT code 92941 (Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel);*
- *CPT code 92943 (Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel); and*
- *CPT code 92944 (Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (List separately in addition to code for primary procedure)).*

*In order to maintain the existing policy of differentiating payment for intracoronary stent placement procedures involving nondrug-eluting and drug-eluting stents, we are deleting HCPCS codes G0290 and G0291 and replacing them with the following new HCPCS C-codes to parallel the new CPT codes:*

- *HCPCS code C9600 (Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch);*
- *HCPCS code C9601 (Percutaneous transcatheter placement of drug-eluting intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure));*
- *HCPCS code C9602 (Percutaneous transluminal coronary atherectomy, with drug eluting intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch);*
- *HCPCS code C9603 (Percutaneous transluminal coronary atherectomy, with drug-eluting intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure));*
- *HCPCS code C9604 (Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel);*
- *HCPCS code C9605 (Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (List separately in addition to code for primary procedure));*
- *HCPCS code C9606 (Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any*

*combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel);*

- *HCPCS code C9607 (Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; single vessel); and*
- *HCPCS code C9608 (Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (List separately in addition to code for primary procedure)).*

*CPT codes 92928, 92933, 92929, 92934, 92937, 92938, 92941, 92943, and 92944 should be used to describe nondrug-eluting intracoronary stent placement procedures and are assigned to APC 0104. HCPCS codes C9600, C9601, C9602, C9603, C9604, C9605, C9606, C9607, and C9608 are assigned to APC 0656.*

## 200.9 - Billing for "Sometimes Therapy" Services that May be Paid as Non-Therapy Services for Hospital Outpatients

***(Rev.2611, Issued: 12-14-12, Effective: 01-01-13, Implementation, 01-07-13)***

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.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html. 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 |
| ***G0456*** | *Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters* |
| ***G0457*** | *Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters* |

## 260.1 - Special Partial Hospitalization Billing Requirements for Hospitals, Community Mental Health Centers, and Critical Access Hospitals

***(Rev.2611, Issued: 12-14-12, Effective: 01-01-13, Implementation, 01-07-13)***

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 | *****90791 or***** 90792* |
| 0904 | Activity Therapy (Partial Hospitalization) | **G0176 |
| 0914 | Individual Psychotherapy | *90785, 90832, 90833, 90834, 90836, 90837, 90838,* 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).

*****The definition of code 90791 is as follows:*

*Psychiatric diagnostic evaluation (no medical services) completed by a non-physician.*

******The definition of code 90792 is as follows:*

*Psychiatric diagnostic evaluation (with medical services) completed by a physician.*

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.2611, Issued: 12-14-12, Effective: 01-01-13, Implementation, 01-07-13)*

### 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 | *****90791 or***** 90792* |
| 0904 | Activity Therapy (Partial Hospitalization) | **G0176 |
| 0914 | Individual Psychotherapy | *90785, 90832, 90833, 90834, 90836, 90837, 90838,* 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).

*****The definition of code 90791 is as follows:*

*Psychiatric diagnostic evaluation (no medical services) completed by a non-physician.*

******The definition of code 90792 is as follows:*

*Psychiatric diagnostic evaluation (with medical services) completed by a physician.*

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.

# Attachment A – Tables for the Policy Section

**Table 1 – New CY 2013 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals**

| CY 2013 HCPCS Code | CY 2013 Long Descriptor | CY 2013 SI | CY 2013 APC |
|---|---|---|---|
| C9294 | Injection, taliglucerase alfa, 10 units | G | 9294 |
| C9295 | Injection, carfilzomib, 1 mg | G | 9295 |
| C9296 | Injection, ziv-aflibercept, 1 mg | G | 9296 |
| J1744 | Injection, icatibant, 1 mg | K | 1443 |
| J2212 | Injection, methylnaltrexone, 0.1 mg | K | 1445 |
| J7315 | Mitomycin, ophthalmic, 0.2 mg | N | |
| Q4134 | Hmatrix, per square centimeter | E | |
| Q4135 | Mediskin, per square centimeter | E | |
| Q4136 | Ez-derm, per square centimeter | E | |
| Q9969 | Tc-99m from non highly-enriched uranium source, full cost recovery add-on, per study dose | K | 1442 |

**Table 2 – Other CY 2013 HCPCS and CPT Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals**

| CY 2012 HCPCS/ CPT code | CY 2012 Long Descriptor | CY 2013 HCPCS/ CPT Code | CY 2013 Long Descriptor |
|---|---|---|---|
| C9279 | Injection, ibuprofen, 100 mg | J1741 | Injection, ibuprofen, 100 mg |
| C9286 | Injection, belatacept, 1 mg | J0485 | Injection, belataccept, 1 mg |
| C9287 | Injection, brentuximab vedotin, 1 mg | J9042 | Injection, brentuximab vedotin, 1 mg |
| C9288 | Injection, centruroides (scorpion) immune f(ab)2 (equine), 1 vial | J0716 | Injection, centruroides immune f(ab)2, up to 120 milligrams |
| C9289 | Injection, asparaginase erwinia chrysanthemi, 1,000 international units (i.u.) | J9019 | Injection, asparaginase (Erwinaze), 1,000 IU |
| C9366 | EpiFix, per square centimeter | Q4131 | Epifix, per square centimeter |
| C9368 | Grafix core, per square centimeter | Q4132 | Grafix core, per square centimeter |
| C9369 | Grafix prime, per square centimeter | Q4133 | Grafix prime, per square centimeter |
| J1051 | Injection, medroxyprogesterone acetate, 50 mg | J1050 | Injection, medroxyprogesterone acetate, 1 mg |
| J8561 | Everolimus, oral, 0.25 mg | J7527 | Everolimus, oral, 0.25 mg |
| J9020 | Injection, asparaginase, 10,000 units | J9020 | Injection, Asparaginase, Not Otherwise Specified, 10,000 Units |
| J9280 | Mitomycin, 5 mg | J9280 | Injection, mitomycin, 5 mg |
| Q2045* | Injection, human fibrinogen concentrate, 1 mg | J7178 | Injection, human fibrinogen concentrate, 1 mg |
| Q2046* | Injection, aflibercept, 1 mg | J0178 | Injection, aflibercept, 1 mg |
| Q2047 | Injection, peginesatide, 0.1 mg (for esrd on dialysis) | J0890 | Injection, peginesatide, 0.1 mg (for esrd on dialysis) |
| Q2048* | Injection, doxorubicin hydrochloride, liposomal, doxil, 10 mg | J9002 | Injection, doxorubicin hydrochloride, liposomal, doxil, 10 mg |

| CY 2012 HCPCS/ CPT code | CY 2012 Long Descriptor | CY 2013 HCPCS/ CPT Code | CY 2013 Long Descriptor |
|---|---|---|---|
| Q4119 | Matristem wound matrix, per square centimeter | Q4119 | Matristem wound matrix, psmx, rs, or psm, per square centimeter |
| Q4126 | Memoderm, per square centimeter | Q4126 | Memoderm, dermaspan, tranzgraft or integuply, per square centimeter |
| Q4128 | Flexhd or allopatch hd, per square centimeter | Q4128 | Flex hd, allopatch hd, or matrix hd, per square centimeter |

*HCPCS code J1680 was replaced with HCPCS code Q2045 effective July 1, 2012. HCPCS code Q2045 was subsequently replaced with HCPCS code J7178, effective January 1, 2013.
*HCPCS code C9291 was replaced with HCPCS code Q2046 effective July 1, 2012. HCPCS code Q2046 was subsequently replaced with HCPCS code J0178, effective January 1, 2013.
*HCPCS code J9001 was replaced with HCPCS code Q2048 effective July 1, 2012. HCPCS code Q2048 was subsequently replaced with HCPCS code J9002, effective January 1, 2013.

**Table 3 – Updated payment Rates for Certain HCPCS Codes Effective April 1, 2012 through June 30, 2012**

| HCPCS Code | Status Indicator | APC | Short Descriptor | Corrected Payment Rate | Corrected Minimum Unadjusted Copayment |
|---|---|---|---|---|---|
| Q4112 | K | 1250 | Cymetra allograft | $271.12 | $54.22 |

**Table 4 – Updated payment Rates for Certain HCPCS Codes Effective July 1, 2012 through September 30, 2012**

| HCPCS Code | Status Indicator | APC | Short Descriptor | Corrected Payment Rate | Corrected Minimum Unadjusted Copayment |
|---|---|---|---|---|---|
| Q4112 | K | 1250 | Cymetra allograft | $323.65 | $64.73 |

**Table 5 – Wage Index by CBSA for Non-IPPS Hospitals that are Eligible for the Section 505 Out-Commuting Adjustment**

| Provider | CBSA | Section 505 Out Commuting Adjustment | Final Wage Index for Calendar Year 2013 |
|---|---|---|---|
| 012011 | 11500 | YES | 0.7485 |
| 013027 | 01 | YES | 0.7224 |
| 013032 | 23460 | YES | 0.7634 |
| 014006 | 23460 | YES | 0.7634 |
| 014016 | 01 | YES | 0.7291 |
| 042007 | 38220 | YES | 0.8079 |
| 042011 | 04 | YES | 0.7621 |
| 052034 | 36084 | YES | 1.6145 |
| 052035 | 42044 | YES | 1.2313 |
| 052039 | 42044 | YES | 1.2313 |
| 052053 | 42044 | YES | 1.2313 |
| 053034 | 42044 | YES | 1.2313 |
| 053301 | 36084 | YES | 1.6145 |

| Provider | CBSA | Section 505 Out Commuting Adjustment | Final Wage Index for Calendar Year 2013 |
|---|---|---|---|
| 053304 | 42044 | YES | 1.2313 |
| 053306 | 42044 | YES | 1.2313 |
| 053308 | 42044 | YES | 1.2313 |
| 054074 | 46700 | YES | 1.5648 |
| 054110 | 36084 | YES | 1.6145 |
| 054122 | 34900 | YES | 1.5752 |
| 054135 | 42044 | YES | 1.2313 |
| 054141 | 46700 | YES | 1.5648 |
| 054146 | 36084 | YES | 1.6145 |
| 063033 | 24540 | YES | 1.0071 |
| 064007 | 14500 | YES | 1.0367 |
| 074003 | 25540 | YES | 1.1830 |
| 074007 | 25540 | YES | 1.1830 |
| 114018 | 11 | YES | 0.7737 |
| 132001 | 17660 | YES | 0.9423 |
| 134010 | 13 | YES | 0.8746 |
| 153040 | 15 | YES | 0.8625 |
| 154014 | 15 | YES | 0.8540 |
| 154035 | 15 | YES | 0.8422 |
| 154047 | 15 | YES | 0.8625 |
| 183028 | 21060 | YES | 0.8199 |
| 184012 | 21060 | YES | 0.8199 |
| 192022 | 19 | YES | 0.7895 |
| 192026 | 19 | YES | 0.8119 |
| 192034 | 19 | YES | 0.7997 |
| 192036 | 19 | YES | 0.8078 |
| 192040 | 19 | YES | 0.8078 |
| 192050 | 19 | YES | 0.8056 |
| 193036 | 19 | YES | 0.7997 |
| 193044 | 19 | YES | 0.8078 |
| 193047 | 19 | YES | 0.7997 |
| 193049 | 19 | YES | 0.7997 |
| 193055 | 19 | YES | 0.7890 |
| 193058 | 19 | YES | 0.7915 |
| 193063 | 19 | YES | 0.8078 |
| 193067 | 19 | YES | 0.7948 |
| 193068 | 19 | YES | 0.8078 |
| 193069 | 19 | YES | 0.7915 |
| 193073 | 19 | YES | 0.7997 |
| 193079 | 19 | YES | 0.8078 |
| 193081 | 19 | YES | 0.8056 |
| 193088 | 19 | YES | 0.8056 |
| 193091 | 19 | YES | 0.7911 |
| 194047 | 19 | YES | 0.8119 |
| 194075 | 19 | YES | 0.7948 |

| Provider | CBSA | Section 505 Out Commuting Adjustment | Final Wage Index for Calendar Year 2013 |
|---|---|---|---|
| 194077 | 19 | YES | 0.7895 |
| 194081 | 19 | YES | 0.7897 |
| 194082 | 19 | YES | 0.7948 |
| 194083 | 19 | YES | 0.7915 |
| 194085 | 19 | YES | 0.8056 |
| 194087 | 19 | YES | 0.7895 |
| 194091 | 19 | YES | 0.8078 |
| 194092 | 19 | YES | 0.7871 |
| 194095 | 19 | YES | 0.7997 |
| 194097 | 19 | YES | 0.8056 |
| 212002 | 25180 | YES | 0.9536 |
| 214001 | 12580 | YES | 1.0032 |
| 214003 | 25180 | YES | 0.9536 |
| 222000 | 15764 | YES | 1.3439 |
| 222003 | 15764 | YES | 1.3439 |
| 222026 | 37764 | YES | 1.3308 |
| 222044 | 37764 | YES | 1.3308 |
| 222047 | 37764 | YES | 1.3308 |
| 223026 | 15764 | YES | 1.3439 |
| 223028 | 37764 | YES | 1.3308 |
| 224007 | 15764 | YES | 1.3439 |
| 224033 | 37764 | YES | 1.3308 |
| 224038 | 15764 | YES | 1.3439 |
| 224039 | 37764 | YES | 1.3308 |
| 232019 | 19804 | YES | 0.9427 |
| 232023 | 47644 | YES | 0.9628 |
| 232025 | 35660 | YES | 0.8456 |
| 232027 | 19804 | YES | 0.9427 |
| 232028 | 12980 | YES | 0.9754 |
| 232030 | 47644 | YES | 0.9631 |
| 232031 | 19804 | YES | 0.9427 |
| 232032 | 19804 | YES | 0.9427 |
| 232035 | 12980 | YES | 0.9754 |
| 232036 | 27100 | YES | 0.8760 |
| 232038 | 19804 | YES | 0.9427 |
| 233025 | 12980 | YES | 0.9754 |
| 233027 | 19804 | YES | 0.9427 |
| 233028 | 47644 | YES | 0.9631 |
| 233300 | 19804 | YES | 0.9427 |
| 234011 | 47644 | YES | 0.9631 |
| 234021 | 47644 | YES | 0.9628 |
| 234023 | 47644 | YES | 0.9631 |
| 234028 | 19804 | YES | 0.9427 |
| 234034 | 19804 | YES | 0.9427 |
| 234035 | 19804 | YES | 0.9427 |

| Provider | CBSA | Section 505 Out Commuting Adjustment | Final Wage Index for Calendar Year 2013 |
|---|---|---|---|
| 234038 | 19804 | YES | 0.9427 |
| 234039 | 47644 | YES | 0.9628 |
| 234040 | 19804 | YES | 0.9427 |
| 252011 | 25 | YES | 0.7986 |
| 264005 | 26 | YES | 0.8023 |
| 303026 | 40484 | YES | 1.2045 |
| 304001 | 40484 | YES | 1.2045 |
| 312018 | 20764 | YES | 1.1233 |
| 312020 | 35084 | YES | 1.1366 |
| 313025 | 35084 | YES | 1.1427 |
| 313300 | 20764 | YES | 1.1233 |
| 314010 | 35084 | YES | 1.1427 |
| 314011 | 20764 | YES | 1.1233 |
| 314016 | 35084 | YES | 1.1366 |
| 314020 | 35084 | YES | 1.1427 |
| 334017 | 39100 | YES | 1.1742 |
| 334049 | 10580 | YES | 0.8681 |
| 334061 | 39100 | YES | 1.1742 |
| 342019 | 34 | YES | 0.8404 |
| 344001 | 39580 | YES | 0.9383 |
| 344011 | 39580 | YES | 0.9383 |
| 344014 | 39580 | YES | 0.9383 |
| 362016 | 15940 | YES | 0.8627 |
| 362032 | 15940 | YES | 0.8627 |
| 364031 | 15940 | YES | 0.8627 |
| 364040 | 44220 | YES | 0.9241 |
| 364042 | 36 | YES | 0.8470 |
| 364043 | 36 | YES | 0.8529 |
| 372017 | 37 | YES | 0.7848 |
| 372019 | 37 | YES | 0.8064 |
| 373032 | 37 | YES | 0.7848 |
| 392031 | 27780 | YES | 0.8329 |
| 392034 | 10900 | YES | 0.9258 |
| 393026 | 39740 | YES | 0.9246 |
| 393050 | 10900 | YES | 1.1235 |
| 394014 | 39740 | YES | 0.9246 |
| 394020 | 30140 | YES | 0.8589 |
| 394052 | 39740 | YES | 0.9246 |
| 422004 | 43900 | YES | 0.9012 |
| 423029 | 11340 | YES | 0.9070 |
| 424011 | 11340 | YES | 0.9070 |
| 424013 | 42 | YES | 0.8359 |
| 444008 | 44 | YES | 0.7920 |
| 444019 | 17300 | YES | 0.8360 |
| 452018 | 23104 | YES | 0.9489 |

| Provider | CBSA | Section 505 Out Commuting Adjustment | Final Wage Index for Calendar Year 2013 |
|---|---|---|---|
| 452019 | 23104 | YES | 0.9489 |
| 452028 | 23104 | YES | 0.9489 |
| 452088 | 23104 | YES | 0.9489 |
| 452099 | 23104 | YES | 0.9489 |
| 452110 | 23104 | YES | 0.9489 |
| 453040 | 23104 | YES | 0.9489 |
| 453041 | 23104 | YES | 0.9489 |
| 453042 | 23104 | YES | 0.9489 |
| 453089 | 45 | YES | 0.8103 |
| 453094 | 23104 | YES | 0.9489 |
| 453300 | 23104 | YES | 0.9489 |
| 454009 | 45 | YES | 0.8125 |
| 454012 | 23104 | YES | 0.9489 |
| 454101 | 45 | YES | 0.8211 |
| 454113 | 23104 | YES | 0.9489 |
| 462005 | 39340 | YES | 0.8986 |
| 464014 | 39340 | YES | 0.8986 |
| 493026 | 49 | YES | 0.8229 |
| 522005 | 39540 | YES | 0.9716 |
| 524025 | 22540 | YES | 0.9509 |
| 673035 | 23104 | YES | 0.9489 |
| 673044 | 23104 | YES | 0.9489 |
| 673048 | 23104 | YES | 0.9489 |