CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1060	**Date: SEPTEMBER 18, 2006**
	Change Request 5304

Subject: October 2006 Update of the Hospital Outpatient Prospective Payment System (OPPS): Summary of Payment Policy Changes

I. SUMMARY OF CHANGES: This Recurring Update Notification describes changes to, and billing instructions for, various payment policies implemented in the October 2006 OPPS update. The October 2006 OPPS Outpatient Code Editor (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 notification.

New / Revised Material
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

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	4/70/Transitional Outpatient Payments (TOPs)
R	4/70.1/TOPs Calculation for CY 2000 and CY 2001
N	4/70.2/TOPs Calculation for CY 2002
N	4/70.3/TOPs Calculation for CY 2003
N	4/70.4/TOPs Calculation for CY 2004 and CY 2005
N	4/70.5/TOPs Calculation for CY 2006 - CY 2008
N	4/70.6/TOPs Overpayments
R	4/80.1/Background - Payment-to-Cost Ratios
R	4/80.3/Using the Newly Calculated PCR for Determining Interim TOPs

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Recurring Update Notification

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal:1060	Date: September 18, 2006	Change Request 5304

SUBJECT: October 2006 Update of the Hospital Outpatient Prospective Payment System (OPPS): Summary of Payment Policy Changes

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to, and billing instructions for, various payment policies implemented in the October 2006 OPPS update. The October 2006 OPPS Outpatient Code Editor (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 notification.

October 2006 revisions to OPPS OCE data files, instructions and specifications are provided in Change Request (CR) 5244, "October 2006 Outpatient Prospective Payment System Code Editor (OPPS OCE) Specifications Version 7.3."

B. Policy:

1. Device Edit Changes and Questions

a. Addition of C1820, Generator, Neurostimulator (Implantable), with Rechargeable Battery and Charging System as an Allowed Device for CPT Code 64590, Insertion or Replacement of Peripheral Neurostimulator Pulse Generator or Receiver, Direct or Inductive Coupling

The HCPCS code C1820 has been added as an allowed device for CPT code 64590, based on newly received information that the rechargeable neurostimulator can be implanted for the purpose of stimulating peripheral nerves. The change is effective for services furnished on and after January 1, 2006, the effective date of C1820.

b. Clarification Regarding Reporting Devices for Pacemakers

Claims containing CPT codes 33206, 33207, 33208, 33213 and 33214 for insertion of pacemakers and leads require both a device code for a pacemaker, (found in column A of the device edits) and a device code for pacemaker leads, (found in column B of the device edits) (C1779, Lead, pacemaker, transvenous VDD single pass, or C1898, Lead, pacemaker, other than transvenous VDD single pass). To pass the OCE device edit, a claim for these procedure codes must have at least two devices on the claim: a pacemaker from the column A list of allowed pacemakers for the procedure code being billed and either C1779 or C1898 from column B devices.

2. List of Device Category Codes for Present or Previous Pass-Through Payment and Related Definitions

We have posted on our OPPS web site a document that provides a complete list of the device category codes used presently or previously for pass-through payment, along with their expiration dates, and definitions we published for certain device category C-codes. We posted this list to facilitate the public's ability to track all present and previous categories for pass-through payment. This list is located at: http://www.cms.hhs.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage. **NOTE:** this list does not include all device codes reportable in the OPPS; there are additional HCPCS codes for devices that were not eligible for pass-through payment. The Medicare Claims Processing Manual, Pub 100-04, Chapter 4, §61, provides detailed information on requirements for reporting device codes and satisfying device to procedure edits in the OPPS.

3. New Services

The following new service is assigned for payment under the OPPS:

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Payment Rate	Minimum Unadjusted Copayment
C9727	10/01/06	S	1510	Insert palate implants	Insertion of implants into the soft palate; minimum of three implants	$850.00	$170.00

4. Drugs and Biologicals

a. Drugs and Biologicals with Payment Rates Based on Average Sales Price (ASP) Effective October 1, 2006

In the CY 2006 OPPS final rule (70 FR 68643), it was stated that payments for drugs and biologicals based on average sale prices (ASPs) will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary, CMS will incorporate changes to the payment rates in the October 2006 release of the OPPS PRICER. The updated payment rates effective October 1, 2006, will be included in the October 2006 update of the OPPS Addendum A and Addendum B, which will be posted at the end of September on the CMS Web site.

b. Newly-Approved Drug Eligible for Pass-Through Status

The following drug has been designated as eligible for pass-through status under the OPPS effective October 1, 2006. The payment rate for this item can be found in the October 2006 update of OPPS Addendum A and Addendum B, which will posted on the CMS Web site at the end of September.

HCPCS	APC	SI	Long Description
C9231	9231	G	Injection, decitabine, per 1 mg

c. Updated Payment Rate for HCPCS C9227, Injection, Micafungin Sodium, per 1mg, Effective April 1, 2006 through June 30, 2006

The payment rate for C9227 was incorrect in the April 2006 OPPS PRICER. The corrected payment rate listed below has been installed in the October 2006 OPPS PRICER, effective for services furnished on April 1, 2006, through implementation of the July 2006 update.

HCPCS	APC	Short Description	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9227	9227	Injection, micafungin sodium	$1.89	$0.38

d. Updated Payment Rate for HCPCS C9230, Injection, Abatacept, per 10mg, Effective July 1, 2006 through September 30, 2006

The payment rate for C9230 was incorrect in the July 2006 OPPS PRICER. The corrected payment rate listed below has been installed in the October 2006 OPPS PRICER, effective for services furnished on July 1, 2006, through implementation of the October 2006 update.

HCPCS	APC	Short Description	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9230	9230	Injection, abatacept	$19.08	$3.82

e. Payment Rate for CPT 90736, Zoster (Shingles) Vaccine, Live, for Subcutaneous Injection, Becomes Effective on its Date of FDA Approval

Currently, CPT 90736 is not payable under OPPS and is assigned to status indicator 'E'. The product described by this code was approved by the Food and Drug Administration on May 25, 2006. Therefore, in the October 2006 OCE update, the status indicator for CPT 90736 will be changed from 'E' to 'K' to become payable under OPPS effective May 25, 2006. CPT 90736 will map to APC 0745. The payment rate for APC 0745 can be found in the October 2006 update of OPPS Addendum A and Addendum B, which will posted on the CMS Web site at the end of September.

f. Correct Reporting of Units for Drugs

Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor. For example, if the description for the drug code is 50 mg, but 200 mg of the drug was administered to the patient, the units billed should be 4. Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg, and a 10 mg vial of the drug was administered to the patient, bill 10 units, even though only 1 vial was administered. HCPCS short descriptors are limited to 28 characters, which includes spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is **extremely** important to review the complete long descriptors for the applicable HCPCS codes.

The full descriptors for the Level II HCPCS codes can be found in the latest code books or from the latest Level II HCPCS file, which is available for downloading from the CMS Web site at: http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp#TopOfPage. Providers are reminded to check HCPCS descriptors for any changes to the units when HCPCS definitions or codes are changed.

5. Transitional Outpatient Payments

Effective January 1, 2005, CMS transitioned from metropolitan statistical areas (MSAs) to core based statistical areas (CBSAs). Transmittal 82, Change Request (CR) 3214 issued on May 14, 2004, instructed fiscal intermediaries (FIs) to refer to the Inpatient Provider Specific File to determine whether a hospital was rural for purposes of TOPs payments. It also instructed FIs to populate both the Geographic/Actual MSA field and Wage Index MSA field in the Outpatient Provider Specific File (OPSF) using data from the inpatient regulations that were effective on and after October 1, 2004. In the transmittal, we noted that changes to wage index classifications that apply to the Inpatient PPS, on or after October 1 of any year, do not apply to the OPPS until January 1 of the next year. We further instructed FIs to use the OPSF to determine whether a provider was eligible for the Transitional Outpatient Payments System (TOPs) payments, beginning January 1, 2005.

We have received several inquiries related to the transition from MSAs to CBSAs. We would like to clarify that we anticipated FIs would automatically transition from MSAs to CBSAs as of January 1, 2005. Therefore, effective January 1, 2005, a hospital is considered rural for purposes of TOPs payments if either the Geographic/Actual CBSA field or the Wage Index CBSA field is rural. A hospital that was rural under MSAs, but is urban under CBSAs is no longer eligible for TOPs payments as of January 1, 2005.

Interim TOPs Calculation: If mutually agreed upon by both the FI and the provider, the FI can pay less than the monthly interim TOP payment (85% of the full hold harmless amount) to that provider to avoid significant overpayments throughout the year that must be paid back to the FI at cost report settlement. The interim TOPs payments would be reconciled at cost report settlement, as usual.

6. 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 determine whether a drug, device, procedure, or service meets all program requirements for coverage. For example, that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5304.1	Medicare contractors shall install the October 2006 OPPS PRICER.	X	X			X				
5304.2	Medicare contractors shall adjust as appropriate claims brought to their attention that meet all of the following conditions: (1) Contain HCPCS C9227; (2) Were incorrectly paid for services furnished on or after April 1, 2006, through June 30, 2006; and 3) Were processed before the installation of the October 2006 OPPS PRICER with updated ASP payment rates.	X	X							
5304.3	Medicare contractors shall adjust as appropriate claims brought to their attention that meet all of the following conditions: (1) Contain HCPCS C9230; (2) Were incorrectly paid for services furnished on or after July 1, 2006, through September 30, 2006; and 3) Were processed before the installation of the October 2006 OPPS PRICER with updated	X	X							

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	ASP payment rates.									
5304.4	Medicare contractors shall create a January 1, 2007, provider specific file record, as necessary, to update the Geographic/Actual CBSA field and the Wage Index CBSA field in the OPSF using data from the inpatient regulations that are effective on or after October 1, 2006.	X	X							
5304.4.1	Medicare contractors shall continue to update, as needed, future changes to the provider specific file information contained in these fields. NOTE: Change to wage index reclassifications that apply to the Inpatient PPS on October 1 of any year do not apply to the OPPS until January 1 of the next year.	X	X							
5304.5	Medicare contractors shall use a provider's bed size and urban/rural designation to determine a provider's TOPS eligibility.	X	X							
5304.5.1	Medicare contractors shall accurately update the TOPS Indicator field in the OPSF to indicate whether a particular hospital is eligible for TOPs payments.	X	X							
5304.6	If mutually agreed upon by both the FI and the provider, the FI shall pay less than the monthly interim TOP payment (85% of the full hold harmless amount) to that provider. The interim TOP payments would continue to be reconciled at cost report settlement	X	X							

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5304.7	A provider education article related to this instruction will be available at 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 site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. 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							

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: October 1, 2006 **Implementation Date:** October 2, 2006 **Pre-Implementation Contact(s):** Marina Kushnirova marina.kushnirova@cms.hhs.gov **Post-Implementation Contact(s):** Regional Office	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

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

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(Rev.1060, 09-18-06)

70 - Transitional *Outpatient* Payments

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

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) *and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) provide several provisions related to transitional outpatient payments (TOPs). The purpose of TOPs payments is to limit provider's losses under OPPS, for providers who would have received higher payments under the cost-based system that was in effect prior to OPPS. The initial TOPs payments were for 3 1/2 years for community mental health centers (CMHCs) and most hospitals, and were later extended for several groups of hospitals, as described below. Effective August 1, 2000, these additional payments are permanent for cancer and children's hospitals, which are excluded from the inpatient prospective payment system.*

Beginning September 1, 2000, and every month thereafter until further notice, the shared system maintainers must provide FIs with software that gathers all data required to calculate a TOP*s* amount for each hospital and CMHC. The software must calculate and pay the TOP*s* 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*s* amounts, and transfer to the PS&R system any necessary data. The TOP*s* amounts should be paid before the next month begins *or within the first 3 days of the new month,* and they are not subject to normal payment floor requirements.

The following items contained in the provider file and defined under the *OPSF* section above are needed to calculate the TOP amount for each hospital or CMHC. They are:

- The provider number;
- *Effective date;*
- The provider type;
- Actual geographic location – MSA *prior to 2004, CBSA after 2004;*
- Wage index location – MSA *prior to 2004, CBSA after 2004;*
- Bed size;
- Outpatient cost to charge ratio;
- *Outpatient payment to cost ratio; and*
- *Yes/No TOPs indicator.*

Pursuant to §403 of BIPA, the law was amended to provide that if a hospital or CMHC did not file a cost report for the cost reporting period ending in calendar year 1996, the payment-to-cost ratio used in calculating TOPs 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. The FIs were instructed to make a lump sum payment retroactive to August 1, 2000, for any estimated amounts due to the provider as a result of this provision. The FI was further instructed to continue monthly payments as necessary for future months.

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

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

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

Step 1 – Computer 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.1060, Issued: 09-18-06, Effective: 10-01-06, Implementation: 10-02-06)

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, FIs were instructed to revise the monthly interim TOP calculations to reflect the new calculation.

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

Step 1 – Computer 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 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.1060, Issued: 09-18-06, Effective: 10-01-06, Implementation: 10-02-06)

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, FIs were instructed to revise the monthly interim TOP calculations to reflect the new calculation.

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

Step 1 – Computer 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 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.1060, Issued: 09-18-06, Effective: 10-01-06, Implementation: 10-02-06)

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 FI identifies additional hospitals that are eligible for TOPs payments, the FI 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%, and will receive the additional 15% (to reach 100%) at cost report settlement.

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

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

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. 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% of the hold harmless amount during 2006, 90% of the hold harmless amount in 2007, and 85% of the hold harmless amount in 2008. Interim TOPs payments will continue at 85%, 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%, and will receive the additional 10% (to reach 95%) at cost report settlement. For 2007, providers

will receive the additional 5% (to reach 90%) 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 FIs are required to calculate are described below. This calculation is effective for services provided between January 1, 2006, and December 31, 2008.

Step 1 – Computer 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 that is not also a SCH 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--TOPs Overpayments

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

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 FI and the provider, the FI can pay less than 85% of the monthly TOP payment to that provider, to avoid significant overpayments throughout the year that must be paid back to the FI at cost report settlement.

The FIs 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).

80.1 - 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.

80.3 - 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.