Medicare Claims Processing Manual

Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

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(Rev. 53, 12-22-03)

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10 - Hospital Outpatient Prospective Payment System (OPPS)

(Rev. 1, 10-03-03)

A-01-93

10.1 - Background

(Rev. 1, 10-03-03)

A-01-93, A-01-15

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

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

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

- Establish payments under OPPS in a budget neutral manner based on estimates of amounts payable in 1999 from the Part B Trust Fund and as beneficiary coinsurance under the system in effect prior to OPPS (Although the base rates were calculated using the 1999 amounts, these amounts are increased by the hospital inpatient market basket, minus one percent, to arrive at the amounts payable in the year 2000. See §10.3 for Benefits and Improvement Protection Act (BIPA) changes in market basket updates.);
- Extend the 5.8 percent reduction in operating costs and 10 percent reduction in capital costs (which had been due to sunset on December 31, 1999) through the first date the OPPS is implemented;
- Require annual updating of the OPPS payment weights, rates, payment adjustments and groups;

- Require annual consultation with an expert provider advisory panel in review and updating of payment groups;

- Establish budget neutral outlier adjustments based on the charges, adjusted to costs, for all OPPS services included on the submitted outpatient bill for services furnished before January 1, 2002, and thereafter based on the individual services billed;

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

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

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

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

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

- Accelerated reductions of beneficiary copayments;

- Increase in market basket update for 2001;

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

- Special transitional corridor treatment for children's hospitals.

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

centers exempt from inpatient PPS are included in this system, but are eligible for hold harmless payment under the Transitional Corridor provision.

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

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

10.2 - APC Payment Groups

(Rev. 1, 10-03-03)

A-01-93

Payment for service under the OPPS is calculated based on grouping outpatient services into ambulatory payment classification (APC) groups. Services within an APC are similar clinically and require similar resource use. The payment rate and coinsurance amount calculated for an APC apply to all of the services within the APC. APCs require no changes to the billing form; however, hospitals are required to include HCPCS codes for all services paid under OPPS. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting.

10.3 - Calculation of APC Payment Rates

(Rev. 1, 10-03-03)

A-01-93

- A group's relative weight is calculated based on the median cost (operating and capital) of the services included in the group;
- Median costs were developed from a database of CY 96 hospital outpatient claims using "the most recent" cost report data available;
- Hospital-specific, department-specific cost-to-charge ratios to convert billed charges to median costs for each group;
- Weights are converted to payment rates using a conversion factor which takes into account group weights, the volume of services for each group, and an expenditure target specified in the law; and

- Hospital outpatient payments that would have been effective in CY 99 were calculated, in a budget neutral basis, to equal projected 1999 payments to hospitals for services included under the OPPS.

The initial rates were the 1999 rates updated by the hospital market basket minus one percent. Section 401 of BIPA provides for a full market basket increase to the OPPS conversion factor in 2001, rather than an increase based on the hospital inpatient market basket percentage increase minus 1 percent as required under prior law. Payment rates for services furnished between January 1, 2001, and March 31, 2001, were not revised, but payment rates for services furnished on or after April 1, 2001, and before January 1, 2002, are based on the full market basket percentage increase. The payment rates in effect for services furnished from April 1 through December 31, 2001, were further increased by 0.32 percent to account for the timing delay in implementing the full market basket update for 2001.

10.4 - Packaging

(Rev. 1, 10-03-03)

A-01-93, A-01-133

Initial packaging rules for OPPS implementation are:

- Initially, only minimal packaging, i.e., payment for a procedure or medical visits does not include payment for the related ancillary services such as laboratory tests or x-rays;

- Payment for clinical diagnostic laboratory tests which are paid under the clinical diagnostic fee schedule and radiology and other diagnostic services paid under OPPS will be made in addition to the OPPS payment for a surgical procedure or medical visit performed on the same day; and

- APC payments will include certain packaged items, such as anesthesia, supplies, certain drugs and the use of recovery and observation rooms.

Under OPPS, packaged services are items and services that are considered to be an integral part of another service that is paid under the OPPS. No separate payment is made for packaged services, because the cost of these items is included in the APC payment for the service of which they are an integral part. For example, routine supplies, anesthesia, recovery room and most drugs are considered to be an integral part of a surgical procedure so payment for these items is packaged into the APC payment for the surgical procedure.

A - Claims Resulting in APC Payments

If a claim contains services that result in an APC payment but also contains packaged services, separate payment for the packaged services is not made since payment is

included in the APC. However, charges related to the packaged services are used for outlier and Transitional Corridor Payments (TOPs) as well as for future rate setting.

Claims Resulting in No APC Payments

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

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

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

During claims processing of bill types 12X, 13X, and 14X, cost reimbursement payments may not be made to hospital outpatient departments for any items or services except for corneal tissue and certain CRNA services, PPV, influenza vaccines and their administration, orphan drugs, and ESRD drugs and supplies not included in the composite rate.

10.5 - Discounting

(Rev. 1, 10-03-03)

A-01-93

- Multiple surgical procedures furnished during the same operative session are discounted;
- The full amount is paid for the surgical procedure with the highest weight;
- Fifty percent is paid for any other surgical procedure(s) performed at the same time;
- Similar discounting occurs now under the physician fee schedule and the payment system for ASCs;
- Surgical procedures terminated after a patient is prepared for surgery but before induction of anesthesia are paid at 50 percent of the APC payment; and
- When multiple surgical procedures are performed during the same operative session, beneficiary coinsurance is discounted in proportion to the APC payment.

10.6 - Payment Adjustments

(Rev. 1, 10-03-03)

A-01-93

Payments are adjusted to reflect geographic differences in labor-related costs. The Secretary may also establish other adjustments or special adjustments for certain classes of hospitals.

10.7 - Outlier Adjustments

(Rev. 1, 10-03-03)

A-02-026

Prior to April 1, 2002, Pricer calculated outlier payments on a claim basis. However, beginning April 1, 2002, the OPPS Pricer calculates outlier payments based on each individual OPPS (line item) service.

The outlier payment is determined by:

- Calculating the costs related to the OPPS services for the line item, including a pro rata portion of any bundled services on the claim, by multiplying the total charges for covered OPPS services by an outpatient cost to charge ratio;
- Determining whether these costs exceed 2.5 (effective April 1, 2002, the threshold is 3.5) times the OPPS payment; and
- If costs exceed 2.5 times (effective April 1, 2002, the threshold is 3.5) the OPPS payments, calculating the outlier payment as 75 percent (effective April 1, 2002, the percentage is 50 percent) of the amount by which the costs exceed 2.5 (effective April 1, 2002, the threshold is 3.5) times the OPPS payment.

No outlier payment is calculated for Status Indicators G, N, or H.

Billed charges are converted to costs using a single overall hospital-specific cost-to-charge ratio. Beginning April 1, 2002, the costs attributable to all packaged items and services that appear on a claim are allocated to all the OPPS services that appear on the claim. The amount allocated to each OPPS service is based on the percent the Ambulatory Payment Classification (APC) payment rate for that service bears to the total APC rates for all OPPS services on the claim.

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

The second OPPS service will be allocated $30 or 30 percent of the costs of packaged services and the third OPPS service will be allocated $50 or 50 percent of the cost of packaged services.

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

All bundled services with a status indicator of N on a claim are summed and divided proportionately to the payment rate for all status indicators of S, T, V, or X before determining the line-by-line outlier calculation.

10.8 - Geographic Adjustments

(Rev. 1, 10-03-03)

A-01-93

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

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

10.8.1 - Wage Index Changes

(Rev. 1, 10-03-03)

A-02-026 §XIII, A-01-144

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

10.9 - Updates

(Rev. 1, 10-03-03)

A-01-93, A-03-051

The CMS will annually review/update groups, relative weights, wage indexes, and other adjustments.

BBA requires rates to be updated annually based on the hospital market basket less one percent for the years 2000 through 2002, and based on the hospital market basket for subsequent years. See §10.3 for market basket updates as a result of BIPA legislation.

New outpatient procedures and services will be added to the payment system as needed and weights will be adjusted to reflect changes in outpatient care.

The July 2003 Update of the Hospital OPPS is located at:
http://cms.hhs.gov/manuals/pm_trans/A03051.pdf

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

(Rev. 1, 10-03-03)

A-01-32

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

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

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

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

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

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

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

10.11 - Process and Information Required to Determine Eligibility of Drugs and Biologicals for Transitional Pass-Through Payment Under the Hospital Outpatient Prospective Payment System (OPPS)

(Rev. 1, 10-03-03)

A-02-026, §XV

For process and information required to apply for assignment and payment for new technology APCs, go to http://cms.hhs.gov/regulations/hopps/finalnewtechapc11602.pdf

For process and information required to apply for transitional pass-through payment for additional device categories, go to:
http://cms.hhs.gov/regulations/hopps/newcatapp11602final1.pdf.

The CMS makes information used in the rate setting process under the OPPS available to the public for analysis. Applicants are advised that any information submitted, including commercial or financial data, is subject to disclosure for this purpose.

The CMS will accept transitional pass-through applications for drug and/or biologicals on an ongoing basis. The most recent information concerning applications and requirements for APC payments for new technologies, additional device categories and pass-through

payments for drugs and biologicals is located on the CMS Web site at http://cms.hhs.gov/medlearn/refopps.asp.

However, CMS must receive applications sufficiently in advance of the first calendar quarter in which transitional pass-through payment is sought to allow time for analysis, decision-making, and computer programming. Therefore, the following schedule applies:

Complete Application Must Be Received by No Later Than...	For Consideration for Implementation Beginning...
March 1	July 1
June 1	October 1
September 3	January 1

A longer evaluation period may be required if an application is incomplete or if further information is required upon which to base a determination of pass-through eligibility.

An application is not considered complete until:

- All required information has been submitted, AND
- All questions related to such information have been answered.

10.11.1 - Background

(Rev. 1, 10-03-03)

Section 1883(t)(6) of the Act provides for temporary additional payments or "transitional pass-through payments" for certain innovative devices, drugs, and biologicals. This provision requires that transitional pass-through payments be made for current orphan drugs, as designated under §526 of the Federal Food, Drug, and Cosmetic Act; current cancer therapy drugs and biologicals, and current radiopharmaceutical drugs and biological products. Transitional pass-through payments are also required for new drugs and biologicals that were not being paid for as a hospital outpatient service as of December 31, 1996, and whose cost is "not insignificant" in relation to the OPPS payment for the procedures or services associated with the new drug or biological. Under the statute, transitional pass-through payments are to be made for at least two years but not more than three years.

10.11.2 - Required Information

(Rev. 1, 10-03-03)

The information in **items 1-10** below, is required in **every application** for pass-through payment for a drug or biological, including radiopharmaceutical drugs and biological

products and contrast agents. **In addition**, the applicant must provide the information in **either item 11A or 11B**, whichever is applicable. An application that does not include the following information is considered incomplete and cannot be acted upon:

1. The trade name and generic name of the product.

2. A detailed description of the clinical application of the product:

    a. What it is and what it does.

    b. The form in which it is supplied (i.e., solution, tablet, etc.).

    c. Method of administration (intramuscularly, intravenously, orally, subcutaneously, sublingually, etc.).

    d. Manner of packaging (indicate dosages/concentrations per ml, per tablet, per mCi, etc.).

    e. The usual minimum dosage per day for one patient.

    f. The usual maximum dosage per day for one patient.

    g. The Healthcare Common Procedure Coding System (HCPCS) code(s), if any, used to identify the product. Specifically, which code(s) is/are used to report the use of this drug or biologic to third party payers? **(NOTE: Approval of a drug or biological for a transitional pass-through payment under the OPPS is not contingent on prior assignment of a national HCPCS code.)**

3. A copy of the most recently published average wholesale price (AWP), including the date of publication.

4. The current cost of the drug, biological, or radiopharmaceutical to hospitals, that is, the actual cost paid by hospitals net of all discounts, rebates, and incentives in cash or in kind. In other words, the applicant must submit the best and latest information available that provides evidence of the actual cost to hospitals for a specific drug, biological, or radiopharmaceutical specified in terms of dosage and concentration.

5. The date of sale of first unit.

6. Usage by site of service (i.e., inpatient, outpatient, physician office, etc.).

7. A copy of the Food and Drug Administration (FDA) approval/clearance letter for the product.

8. A copy of the package insert.

9. Name(s), address(es), e-mail addresses and telephone number(s) of the party or parties making the request and responsible for the information contained in the application. If different from the requester, give the name, address, e-mail address,

and telephone number of the person that CMS should contact for any additional information that may be needed to evaluate the application.

10. Other information as CMS may require to evaluate a specific request or that the applicant believes CMS may need to evaluate the application.

IN ADDITION, the applicant must answer 11A. or 11B., whichever is applicable.

11A. For drugs and biologicals OTHER THAN contrast agents or radiopharmaceutical products, specify how dosages are measured, i.e., in milligrams, micrograms, etc.

11B. For radiopharmaceutical drugs and biological products and for contrast agents, specify the following information:

a. Indicate whether the product is available in milligrams (mg), millicuries (mCi), or microcuries (uCi), including concentration before and after reconstitution.

b. If the AWP is stated "per vial" or "per ampule," indicate how many doses can be administered from one vial or one ampule.

c. If the AWP is stated "per dose," "per vial," or "per ampule," but the item is administered in milligrams (mg), millicuries (mCi), or microcuries (uCi), indicate how many mg, mCi, or uCi are in one dose, one vial and/or one ampule.

Note that a separate application is required for each distinct drug or biological included in a request. For example, if an applicant requests transitional pass-through status for five new drugs, the required information listed above must be completed for each of the five drugs.

10.11.3 - Where to Send Applications

(Rev. 1, 10-03-03)

Because of staffing and resource limitations, CMS cannot accept applications by facsimile (FAX) transmission or by e-mail. Mail **one** copy of each completed application to the following address:

Centers for Medicare & Medicaid Services
OPPS Pass-Through Applications
Division of Outpatient Care
Mail Stop C4-05-17
7500 Security Boulevard
Baltimore, MD 21244-1850

10.12 - Process and Information Required to Apply for Additional Device Categories for Transitional Pass-Through Payment Status Under the Hospital Outpatient Prospective Payment System

(Rev. 1, 10-03-03)

http://www.cms.hhs.gov/regulations/hopps/newcatapp11602final1.pdf

This describes in detail the process and information required for applications requesting additional categories for medical devices that may be eligible for transitional pass-through payment under the Medicare hospital outpatient prospective payment system (OPPS). This applies solely to requests for **additional categories of medical devices.**

The CMS makes information used in the rate setting process under the OPPS available to the public for analysis. Any information submitted, including commercial or financial data, is subject to disclosure for this purpose.

The CMS accepts category applications on an ongoing basis. However, CMS must receive applications sufficiently in advance of the calendar quarter in which a category would be established to allow time for analysis, decision-making, and computer programming. Therefore, the following schedule applies:

Complete Application Must Be Received by No Later Than...	For Consideration for Implementation Beginning...
December 3	March 1
March 1	July 1
June 1	October 1
September 3	January 1

A longer evaluation period may be required if an application is incomplete or if further information is required upon which to base a determination of eligibility.

An application is not considered complete until:

- All required information has been submitted; **and**
- All questions related to such information have been answered.

Applicants submitting amended requests to establish a new medical device category should attach a statement indicating that the amended application is intended to replace or to supplement a previous filing. The applicant should also submit a copy of the previous filing. We can act only on applications that fully address the criteria and requirements set forth in this announcement.

Device manufacturers, hospitals, or other interested parties may apply for a new device category for transitional pass-through payments. The law requires that:

- New categories be established in such a way that no medical device is described by more than one category; and
- The average cost of devices included in a new category be "not insignificant" relative to the payment amount for the procedure(s) or service(s) with which the device is associated. The definition of "not insignificant" cost is described below.

To be included in a category a device must meet all applicable criteria that were previously established for a device eligible for transitional pass-through payments. Those criteria are the following:

1. If required by the FDA, the device must have received FDA approval or clearance. (This requirement is met if a device has received an FDA investigational device exemption (IDE) and has been classified as a Category B device by the FDA in accordance with 405.203 through 405.207 and 405.211 through 405.215 of Title 42 of the Code of Federal Regulations or has received another appropriate FDA exemption.)

2. The device is determined to be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part (as required by §1862(a)(1)(A) of the Act.) Note that neither assignment of a HCPCS code nor approval of a device for transitional pass-through payment assures coverage of the specific item or service in a given case. To receive transitional pass-through payments, qualified devices must be considered reasonable and necessary; each use of a qualified device is subject to medical review for determination of whether its use was reasonable and necessary.

3. The device must:

    a. Be an integral and subordinate part of the service furnished;

    b. Be used for one patient only;

    c. Come in contact with human tissue; and

    d. Be surgically implanted or inserted whether or not the device remains with the patient when the patient is released from the hospital.

4. The device is not any of the following:

    a. Equipment, an instrument, apparatus, implement, or item of this type for which depreciation and financing expenses are recovered as depreciable assets as defined in Chapter 1 of the Medicare Provider Reimbursement Manual (CMS Pub. 15-1);

b. A material or supply furnished incident to a service (for example, a suture, customized surgical kit, scalpel, or clip, other than radiological site marker); and

c. A material that may be used to replace human skin (for example, a biological or synthetic material).

10.12.1 - The Criteria That CMS Uses to Establish a New Category

(Rev. 1, 10-03-03)

1. A device to be included in the category is not described by any of the existing or previously existing categories established for transitional pass-through payments. A device for which a brand-specific application was made before December 1, 2000 that was determined to be eligible for transitional pass-through payment is not eligible to be placed in a new category. Such devices were placed in one of the initial categories that were effective April 1, 2001 and are already being paid as pass-through devices.

2. A device to be included in the category was not being paid for as an outpatient service as of December 31, 1996.

3. "Substantial Clinical Improvement Criterion": CMS determines that a device to be included in the category has demonstrated that it will substantially improve the diagnosis or treatment of an illness or injury or improve the functioning of a malformed body part compared to the benefits of a device or devices in a previously established category or other available treatment. "Substantial clinical improvement" is measured by one or more of the following:

    a. The device offers a treatment option for a patient population unresponsive to, or ineligible for, currently available treatments.

    b. The device offers the ability to diagnose a medical condition in a patient population where that medical condition is currently undetectable or offers the ability to diagnose a medical condition earlier in a patient population than is currently possible. There must also be evidence that use of the device to make a diagnosis affects the management of the patient.

    c. Use of the device significantly improves clinical outcomes for a patient population as compared to currently available treatments. Some examples of outcomes that are frequently evaluated in studies of medical devices are the following:

        - Reduced mortality rate with use of the device;

        - Reduced rate of device-related complications;

- Decreased rate of subsequent diagnostic or therapeutic interventions (e.g., due to reduced rate of recurrence of the disease process);
- Decreased number of future hospitalizations or physician visits;
- More rapid beneficial resolution of the disease process treated because of the use of the device;
- Decreased pain, bleeding, or other quantifiable symptom; and
- Reduced recovery time.

A - "Not Insignificant" Cost Requirement

The CMS considers the average cost of devices that would be included in an additional category and that are being marketed at the time the category is established to be "not insignificant" if the following conditions are met:

1. The estimated average reasonable cost of devices in the category exceeds 25 percent of the applicable APC payment amount for the service associated with the category of devices;

2. The estimated average reasonable cost of the devices in the category exceeds the cost of the device-related portion of the APC payment amount for the service associated with the category of devices by at least 25 percent; and

3. The difference between the estimated average reasonable cost of the devices in the category and the portion of the APC payment amount determined to be associated with the device in the associated APC exceeds 10 percent of the total APC payment.

Exemptions From "Not Insignificant" Cost Requirements

The following medical devices are exempt from the "not insignificant" cost requirements if payment for the device was being made as an outpatient service on August 1, 2000:

1. A device of brachytherapy.

2. A device of temperature-monitored cryoablation.

B - Length of Time That a New Category is Eligible for a Pass-Through Payment

A new device category is eligible for a pass-through payment for at least two years, but not more than three years, beginning on the date that CMS establishes the category.

10.12.2 - Contents of Application for Additional Transitional Pass-Through Category for New Medical Devices

(Rev. 1, 10-03-03)

To enable CMS to make an appropriate determination that the criteria for an additional category of new medical devices are met, applications for an additional device category **must** include all of the information listed below. A separate application is required for each distinct additional category that is being requested. An application that does not include all of the following information is considered incomplete and cannot be acted upon. Those requesting the establishment of an additional category of medical devices for transitional pass-through payment under the OPPS must supply the following information:

A. Proposed name or description for the additional category

B. Trade/brand names of any known devices fitting the proposed additional category

Applications must include the name and description of at least one marketed medical device, or device with a Category B investigational device exemption, that would be placed in the proposed additional category.

C. A list of all existing or previously existing categories that describe related or similar devices

For each existing or previously existing category, the applicant must provide a detailed explanation as to why that category does not encompass the nominated device(s).

D. Detailed description of the clinical use(s) of each nominated device requiring an additional category

1. The applicant must describe each nominated device fully:

    a. What is it? Provide a complete physical description of the device including its components, e.g., hardware, software, reservoir, tubing, its composition, coating, or covering.

    b. What does it do?

    c. How is it used?

    d. What makes it different from similar devices of the same type?

    e. What are its clinical characteristics, e.g., is it used for diagnosis or treatment, what is its life span, what are the complications associated with its use, for what disease processes and patient populations is it used?

f. Submit relevant booklets, pamphlets, brochures, product catalogues, price lists, and/or package inserts that further describe and illuminate the nature of the nominated device.

2. Using Healthcare Common Procedure Coding System (HCPCS) Level I and/or Level II code(s), the applicant must list all of the specific procedure(s) and/or services with which the nominated device is used. (HCPCS Level I is the American Medical Association's "Current Procedural Terminology" (CPT); HCPCS Level II, National Codes are alpha-numeric codes that describe medical services and supplies not contained in CPT.)

3. If a device replaces or improves upon an existing device, the applicant must identify the trade/brand name of the existing device and any HCPCS Level I and/or Level II code(s) used to identify the existing device.

4. The applicant must identify by name and manufacturer similar devices that would also become eligible for transitional pass-through payment under the proposed additional category, insofar as this information is known to the applicant.

E - Substantial Clinical Improvement

The applicant must provide a full discussion of the reasons why the device for which an additional category is requested meets the **substantial clinical improvement** criterion that CMS uses to establish an additional category. This discussion must include evidence to demonstrate that the device under consideration satisfies one or more of the measures of "substantial clinical improvement" that are listed both in these instructions and in the November 2, 2001, interim final rule. This evidence can include copies of published peer-review literature and other materials to demonstrate substantial clinical improvement.

F - Sales and Marketing

The applicant must provide the following information for the device(s) for which an additional category is proposed:

1. Date(s) the device for which an additional category is requested was first marketed:

    a. In the United States;

    b. Outside the United States;

2. Date of sale of first unit of the device nominated for an additional category:

    a. In the United States;

    b. Outside the United States;

3. Number of device(s) nominated for an additional category that have been sold up to the date of the application.

4. Number of facilities currently using the nominated device.

5. Projected total annual utilization for both the nominated device and for the proposed device category as a whole.

6. The annual projected utilization of the nominated device in connection with each HCPCS code with which it is used. For example, projected utilization in connection with CPT code xxxxx equals 300 cases using 1 device per case; utilization in connection with CPT code yyyyy equals 1500 cases using 3 devices per case; utilization in connection with HCPCS code zzzzz equals 50 cases with 6 devices required per case.

7. For each CPT code associated with a device, an estimate of annual utilization by site of service, that is, for HCPCS code xxxxx, projected utilization is 40 percent hospital outpatient, 30 percent ambulatory surgical center, 10 percent hospital inpatient, 20 percent physician office.

G - Cost

The applicant must indicate the current cost of the device to hospitals, that is, the actual cost paid by hospitals for the device net of all discounts, rebates, and incentives in cash or in kind. In other words, the applicant submits the best and latest information available that provides evidence of the hospitals' actual cost for the nominated device.

H - FDA Approval

1. If the device requires approval or clearance by the Food and Drug Administration (FDA), the applicant must provide a copy of the FDA approval/clearance letter.

2. If the device has an investigational device exemption (IDE), the applicant must provide a copy of the FDA approval letter and must indicate whether it is a "Category B" IDE.

3. If the device is covered by a guidance document or is exempt from FDA approval or clearance, the applicant must provide the complete citation of the guidance level regulation or exemption from approval or clearance.

4. If a new category of devices is exempt from FDA approval or clearance, or the FDA has chosen an alternate regulatory scheme (e.g., guidance documentation during a defined period of time), then the applicant should so state, along with supporting references and citations.

I - Contact Information: Name(s), address(es), e-mail addresses and telephone number(s) of the party or parties making the request and responsible for the information contained in the application.

If this is different from the requester, the applicant must give the name, address, e-mail address, and telephone number of the person that CMS should contact for any additional information that may be needed to evaluate the application.

The applicant mails one copy of each completed application to the following address:

Centers for Medicare and Medicaid Services
OPPS Additional Pass-Through Category of Device
Division of Outpatient Care
Mail Stop C4-05-17
7500 Security Boulevard
Baltimore, MD 21244-1850

The CMS does not accept applications by facsimile (FAX) transmission or by e-mail.

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

(Rev. 1, 10-03-03)

A3-3626.4, HO-442.6

20.1 - General

(Rev. 1, 10-03-03)

HO-442.6

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

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

Hospital-based and independent ESRD facilities must use HCPCS to bill for blood and blood products, and to bill for drugs and clinical laboratory services paid outside the

composite rate. In addition, the hospital is required to report modifiers as applicable and as described in §20.6.

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

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

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

20.2 - Applicability of OPPS to Specific HCPCS Codes

(Rev. 1, 10-03-03)

Tables describing the treatment of HCPCS codes for OPPS are published in the Federal Register annually.

20.3 - Line Item Dates of Service

(Rev. 1, 10-03-03)

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

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

20.4 - Reporting of Service Units

(Rev. 1, 10-03-03)

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

EXAMPLES

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

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

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

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

The beginning and ending time of the treatment should be recorded in the patient's medical record along with the note describing the treatment. (The total length of the treatment to the minute could be recorded instead.) If more than one CPT code is billed during a calendar day, then the total number of units that can be billed is constrained by the total treatment time. For example, if 24 minutes of code 97112 and 23 minutes of code 97110 were furnished, then the total treatment time was 47 minutes; so only 3 units can be billed for the treatment. The correct coding is two units of code 97112 and one unit of code 97110, assigning more units to the service that took more time.

20.5 - HCPCS/Revenue Code Chart

(Rev. 1, 10-03-03)

A-01-93, A-01-50, A-03-066

The following chart reflects HCPCS coding to be reported under OPPS by hospital outpatient departments. This chart is intended only as a guide to be used by hospitals to assist them in reporting services rendered. Hospitals that are currently utilizing different revenue/HCPCS reporting may continue to do so. They are not required to change the way they currently report their services to agree with this chart. Note that this chart does not represent all HCPCS coding subject to OPPS**.**

Revenue Code	HCPCS Code	Description
*	10040-69990	Surgical Procedure
*	92950-92961	Cardiovascular
*	96570, 96571	Photodynamic Therapy
*	99170, 99185, 99186	Other Services and Procedures
*	99291-99292	Critical Care
*	99440	Newborn Care
*	90782-90799	Therapeutic or Diagnostic Injections
*	D0150, D0240-D0274 D0277, D0460, D0472-D0999, D1510-D1550 D2970, D2999, D3460 D3999, D4260-D4264, D4270-D4273, D4355-D4381, D5911-D5912, D5983-D5985, D5987,D6920, D7110-D7260, D7291, D7940, D9630,	Dental Services

Revenue Code	HCPCS Code	Description
	D9930,D9940, D9950-D9952	
*	92502-92596, 92599	Otorhinolaryngologic Services (ENT)
0278	E0749, E0782, E0783, E0785	Implanted Durable Medical Equipment
0278	E0751, E0753, L8600, L8603, L8610, L8612, L8613, L8614, L8630, L8641, L8642, L8658, L8670, L8699	Implanted Prosthetic Devices
0302	86485-86586	Immunology
0305	85060-85102, 86077-86079	Hematology
031X	80500-80502	Pathology - Lab
0310	88300-88365, 88399	Surgical Pathology
0311	88104-88125, 88160-88199	Cytopathology
032X	70010-76092, 76094-76999	Diagnostic Radiology
0333	77261-77799	Radiation Oncology
034X	78000-79999	Nuclear Medicine
037X	99141-99142	Anesthesia
045X	99281-99285, 99291	Emergency
046X	94010-94799	Pulmonary Function
0480	93600-93790, 93799, G0166	Intra Electrophysiological Procedures and Other Vascular Studies
0481	93501-93572	Cardiac Catheterization
0482	93015-93024	Stress Test
0483	93303-93350	Echocardiography

Revenue Code	HCPCS Code	Description
051X	92002-92499	Ophthalmological Services
051X	99201-99215, 99241-99245, 99271-99275	Clinic Visit
0510, 0517, 0519	95144-95149, 95165, 95170, 95180, 95199	Allergen Immunotherapy
0519	95805-95811	Sleep Testing
0530	98925-98929	Osteopathic Manipulative Procedures
0636	A4642, A9500, A9605	Radionucleides
0636	90476-90665, 90675-90749	Vaccines, Toxiods
0636	90296-90379, 90385, 90389-90396	Immune Globulins
073X	G0004-G0006, G0015	Event Recording ECG
0730	93005-93009, 93011-93013, 93040-93224, 93278	Electrocardiograms (ECGs)
0731	93225-93272	Holter Monitor
074X	95812-95827, 95950-95962	Electroencephalogram (EEG)
0771	G0008-G0010	Vaccine Administration
088X	90935-90999	Non-ESRD Dialysis
0901	90870, 90871	Psychiatry
0903	90910, 90911, 90812-90815, 90823, 90824, 90826-90829	Psychiatry
0909	90880	Psychiatry
0910	90801, 90802, 90865,90899	Psychiatry
0914	90804-90809, 90816-90819, 90821, 90822, 90845, 90862	Psychiatry
0915	90853, 90857	Psychiatry

Revenue Code	HCPCS Code	Description
0916	90846,90847, 90849	Psychiatry
0917	90901-90911	Biofeedback
0918	96100-96117	Central Nervous System Assessments/Tests
092X	95829-95857, 95900-95937, 95970-95999	Miscellaneous Neurological Procedures
0920, 0929	93875-93990	Non Invasive Vascular Diagnosis Studies
0922	95858-95875	Electromyography (EMG)
0924	95004-95078	Allergy Test
0940	96900-96999	Special Dermatological Procedures
0940	98940-98942	Chiropractic Manipulative Treatment
0940	99195	Other Services and Procedures
0943	93797-93798	Cardiac Rehabilitation

*Revenue codes have not been identified for these procedures, as they can be performed in a number of revenue centers within a hospital, such as emergency room (0450), operating room (0360), or clinic (0510). Hospitals are to report these HCPCS codes under the revenue center where they were performed.

NOTE: The listing of HCPCS codes contained in the above chart does not assure coverage on the specific service. Current coverage criteria apply. FIs are not to install additional edits for matching of revenue codes and HCPCS codes.

20.5.1 – Appropriate Revenue Codes to Report Medical Devices That Have Been Granted Pass-Through Status

A-03-035

FIs shall instruct their hospitals to use an appropriate HCPCS code and one of the following revenue codes:

> 0272, 0275, 0276, 0278, 0279, 0280, 0289 or 0624 to bill implantable devices that have been granted pass-through status under the OPPS. Devices eligible for pass-through payment, as designated by payment

status indicator "H," should not be reported utilizing any other revenue code series or subcategories.

FIs shall instruct their hospitals to report implantable orthotic and prosthetic devices and implantable durable medical equipment (DME) under another revenue code such as 0278- *other implants*. Hospitals are not to use revenue codes 0274 or 0290 to report implantable orthotic and prosthetic devices or implantable DME. Similar requirements apply to reporting revenue codes for non-pass-through devices.

20.5.1.1 - Packaged Revenue Codes

(Rev. 36, 11-28-03)

A-01-50, A-03-035

The following revenue codes when billed under OPPS without HCPCS codes are packaged services for which no separate payment is made. However, the cost of these services is included in the transitional outpatient payment (TOP) and outlier calculations. The revenue codes for packaged services are: 0250, 0251, 0252, 0254, 0255, 0257, 0258, 0259, 0260, 0262, 0263, 0264, 0269, 0270, 0271, 0272, 0275, 0276, 0278, 0279, 0280, 0289, 0370, 0371, 0372, 0379, 0390, 0399, 0560, 0569, 0621, 0622, 0624, 0630, 0631, 0632, 0633, 0637, *0681, 0682, 0683, 0684, 0689,* 0700, 0709, 0710, 0719, 0720, 0721, 0762, 0810, 0819, and 0942.

Any other revenue codes that are billable on a hospital outpatient claim must contain a HCPCS code in order to assure payment under OPPS. FIs should return to provider (RTP), claims which contain revenue codes that require HCPCS when no HCPCS is shown on the line.

See Business Requirements at http://www.medicaid.com/manuals/pm_trans/R36CP.pdf

20.5.1.2 – Clarification Regarding Revenue Codes 0274 and 0290

(Rev. 1, 10-03-03)

A-03-035

As stated above, revenue codes 0274 and 0290 are no longer acceptable revenue codes for reporting implantable orthotic and prosthetic devices and implantable DME furnished in the hospital outpatient setting by a hospital that is subject to the OPPS. When furnished by an OPPS hospital, implantable orthotic and prosthetic devices and implantable DME are subject to the OPPS and must be reported under another revenue code such as 0278-*other implants.*

Non-implantable orthotic and prosthetic devices furnished by an OPPS hospital or any other hospital are billed and paid under the Durable Medical Equipment, Prosthetic Orthotic and Supply (DMEPOS) fee schedule, and reported under revenue code 0274 with the appropriate HCPCS code.

Non-implantable DME furnished by an OPPS hospital or any other hospital is billed to the DME regional carrier (DMERC) on Form CMS-1500 and paid under the DMEPOS fee schedule.

20.5.1.3 - Clarification of HCPCS Code to Revenue Code Reporting

(Rev. 1, 10-03-03)

A-03-035

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

20.5.2 - HCPCS/Revenue Code Edits

(Rev. 1, 10-03-03)

FIs are prohibited from editing to match revenue codes to HCPCS for services payable under OPPS with the exception of editing for revenue codes required to be billed with pass-through medical devices as described above.

20.6 - Use of Modifiers

(Rev. 1, 10-03-03)

A-01-080, A-02-026 §XII

The following is a list of all modifiers that are reported under OPPS as of April 1, 2002. Definitions may be found in the current CPT guide or the HCPCS Guide.

Modifiers Used for Outpatient Prospective Payment System

Level I (CPT) Modifiers				Level II (HCPCS) Modifiers							
-25	-50	-73	-91	-CA	-E1	-FA	-GA	-LC	-QL	-RC	-TA
-27	-52	-74			-E2	-F1	-GG	-LD	-QM	-RT	-T1
	-58	-76			-E3	-F2	-GH	-LT			-T2
	-59	-77			-E4	-F3	-GY				-T3
		-78				-F4	-GZ				-T4
		-79				-F5					-T5

Level I (CPT) Modifiers				Level II (HCPCS) Modifiers							
						-F6					-T6
						-F7					-T7
						-F8					-T8
						-F9					-T9

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

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

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

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

EXAMPLES

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

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

EXAMPLES

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

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

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

Modifiers -50 (bilateral) and -52 (when used to indicate a discontinued procedure) apply to diagnostic, radiology, and surgical procedures, and should be used to report bi-lateral surgical procedures.

Modifiers -53, -73, and -74 apply only to surgical procedures.

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

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

EXAMPLE

Cataract surgery on the right or left eye.

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

EXAMPLES

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

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

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

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

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

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

EXAMPLE:

Codes Q0081 (Infusion therapy, using other than chemotherapeutic drugs, per visit) and 36000 (Introduction of needle or intra catheter, vein): If procedure 36000 was performed for a reason other than as part of the IV infusion, modifier -59 would be appropriate.

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

(Rev. 1, 10-03-03)

Modifiers are reported on the hardcopy UB-92 (Form CMS-1450) in FL 44 next to the HCPCS code. There is space for two modifiers on the hardcopy form (4 of the 9 positions). On the UB-92 flat file, providers use record type 61, field numbers 6 and 7. There is space for two modifiers, one in field 6 and one in field 7.

On the HIPAA X12N 837 data elements SV202-3 and SV202-4 are used to report the two modifiers.

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

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

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

(Rev. 1, 10-03-03)

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

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

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

Modifier -50 may not be used:

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

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

20.6.3 - Modifiers -LT and -RT

(Rev. 1, 10-03-03)

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

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

These modifiers are required whenever they are appropriate.

20.6.4 - Use of Modifiers for Discontinued Services

(Rev. 1, 10-03-03)

A - General

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

Modifier -73 is used when a procedure is terminated after a patient has been prepared for surgery (including sedation when provided) and taken to the room where the procedure is to be performed, but **before** the induction of anesthesia (e.g. local, regional block(s), or general anesthesia). Prior to January 1, 1999, modifier -52 was used for reporting these discontinued services.

Modifier -74 is used when a procedure started, but is terminated **after** the induction of anesthesia (e.g. local, regional block(s), or general anesthesia), or after the procedure was started (incision made, intubation started, scope inserted) due to extenuating circumstances or circumstances that threatened the well being of the patient. To recognize the costs incurred by the hospital to prepare the patient for surgery and the resources expended in the operating room and recovery room, the hospital will receive full payment for a procedure that was started but discontinued after the induction of anesthesia or after the procedure was started. Prior to January 1, 1999, modifier -53 was used for reporting these discontinued services.

The elective cancellation of a procedure should not be reported.

Modifiers -73 and -74 are used to indicate discontinued surgical and certain diagnostic procedures only. They are **not** used to indicate discontinued radiology procedures.

B - Affect on Payment

If modifier -73 is reported, payment is 50 percent of the facility rate. If modifier -74 is reported, there is no payment reduction. This is because the resources of the facility are consumed in essentially the same manner and to same extent as they would have been had the procedure been completed.

C - Termination Where Multiple Procedures Planned

When one or more of the procedures planned is completed, the completed procedures are reported as usual.

The other(s) that were planned, and not started, are not reported. When none of the procedures that were planned are completed, the first procedure that was planned to be done is reported with modifier -73 or modifier -74 as appropriate. The others are not reported.

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

20.6.5 - Modifiers for Repeat Procedures

(Rev. 1, 10-03-03)

Two repeat procedure modifiers are applicable for hospital use:

- Modifier -76 is used to indicate that the same physician repeated a procedure or service in a separate operative session on the same day.
- Modifier -77 is used to indicate that another physician repeated a procedure or service in a separate operative session on the same day.

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

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

20.6.6 - Modifiers for Radiology Services

(Rev. 1, 10-03-03)

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

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

EXAMPLE

Code 71020 (Radiologic examination, chest, two views, frontal and lateral) is ordered. Only one view is performed. Code 71010 (Radiologic examination, chest: single view, frontal) is reported. Code 71020-52 is not reported.

Payment is not reduced for radiology services reported with modifier - 52 (Reduced Services).

20.6.7 - CA Modifier

(Rev. 1, 10-03-03)

Definition:

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

20.6.8 - HCPCS Level II Modifiers

(Rev. 1, 10-03-03)

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

They may be appended to CPT codes.

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

EXAMPLE

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

26010FA

26010F1

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

30 - OPPS Coinsurance

(Rev. 1, 10-03-03)

A-01-15

OPPS freezes coinsurance for outpatient hospital at 20 percent of the national median charge for the services within each APC (wage adjusted for the provider's geographic

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

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

The OPPS Pricer reflects the lower copayment amounts for services furnished on or after April 1, 2001.

For screening colonoscopies and sigmoidoscopies, the coinsurance amount is 25 percent of the payment rate. The APC payment rate is limited to the lower of the hospital outpatient rate or the ASC payment rate. The payment rate for screening barium enemas is the same as that for diagnostic barium enemas. The coinsurance amount for screening barium enemas is 20 percent of the APC payment rate.

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

See §30.2 below for more detail.

30.1 - Coinsurance Election

(Rev. 1, 10-03-03)

PM A-02-26, A-03-066

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

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

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

The lesser amount elected:

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

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

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

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

Provider number	876543		
Provider name	XYZ Hospital	Effective from	8/1/2000 - 12/31/2000
Provider contact	Joe Smith	Phone #	123-456-7890
Contact e-mail	Jsmith@XYZ.ORG	Fax #	123-456-7891

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

APC____ Coinsurance___.__ APC____ Coinsurance___.__

APC____ Coinsurance___.__ APC____ Coinsurance___.__

APC____ Coinsurance___.__ APC____ Coinsurance___.__

APC____ Coinsurance___.__ APC____ Coinsurance___.__

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APC____ Coinsurance___.__ APC____ Coinsurance___.__

APC____ Coinsurance___.__ APC____ Coinsurance___.__

APC____ Coinsurance___.__ APC____ Coinsurance___.__

Return to:

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

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

30.2 - Calculating the Medicare Payment Amount and Coinsurance

(Rev. 1, 10-03-03)

A-02-026

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

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

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

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

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

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

EXAMPLE 1

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

A. Adjusted APC payment rate: $300.

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

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

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

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

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

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

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

A. Adjusted APC payment rate: $300.

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

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

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

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

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

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

EXAMPLE 2

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

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

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

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

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

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

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

For calendar year 2002, the national unadjusted copayment amount for an ambulatory payment classification (APC) is limited to 55 percent of the APC payment rate established for a procedure or service. In addition the wage-adjusted copayment amount for a procedure or service cannot exceed the inpatient hospital deductible amount for 2002 of $812. These changes were implemented by changes to the OPPS Pricer effective for services furnished on or after January 1, 2002.

40 - Outpatient Code Editor (OCE)

(Rev. 53, 12-22-03)

HO-440.1, A-01-21, A-01-01, A-01-36, A-01-66, A-02-025, A-02-052, A-02-082, A-03-003, A-03-026, A-03-028, A-03-048, A-03-050, A-03-069

The CMS incorporates new processing requirements in the Outpatient Code Editor*s* (OCEs) by releasing a new or updated version of the software.

40.1 - *Outpatient Prospective Payment System (OPPS) OCE*

(Rev. 53, 12-22-03)

The *OPPS* OCE performs the following two major functions:

- Edit claims data to identify errors and return a series of edit flags; and
- Assign an ambulatory payment classification (APC) number for each service covered under OPPS and return information to be used as input to the Pricer program.

For instructions for recent OCEs click on the following references:

(The two column headings below indicate the providers to whom the related OCE applies. The column on the left provides links to revised OCE instructions and specifications that will be utilized for OPPS outpatient service providers. The column on the right is self-explanatory for Non-OPPS outpatient service providers.)

All Providers Of Outpatient Services Other Than Those In The Column To The Right	Indian Health Service Hospitals, CAHs, Maryland Hospitals, And Hospitals Located In American Samoa, Guam, And Saipan
October 2003 OCE instructions	
July 2003 OCE instructions	July 2003 Non-OPPS OCE instructions
April 2003 OCE instructions	
January 2003 OCE instructions	January 2003 Non-OPPS OCE instructions
October 2002 OCE instructions	
July_2002_OCE_instructions	

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

40.2 – Non - OPPS OCE (Rejected Items and Processing Requirements)

HO-440.1.B

(Rev. 53, 12-22-03)

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

1 - Invalid Diagnosis or Procedure Code

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

  For a list of all valid ICD-9-CM codes see "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Volume I (Diseases)," The CMS approved ICD-9-CM addenda, and new codes are furnished by the FI for each hospital. For a list of valid HCPCS codes see "Physicians' Healthcare Current Procedural Terminology, 4th Edition, CPT" and "CMS Healthcare Common Procedure Coding System (HCPCS)." Providers should review the

medical record and/or fact sheet and enter the correct diagnosis and procedure codes before returning the bill.

2 - Invalid Fourth or Fifth Digit for Diagnosis Codes

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

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

3 - E-Code as Principal Diagnosis

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

4 - Age Conflict

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

EXAMPLES

1. A 4-year-old patient with benign prostatic hypertrophy.

2. A 78-year-old delivery.

In the above cases, the diagnosis is clinically impossible in a patient of the stated age. Therefore, either the diagnosis or age is presumed to be incorrect. Four age code categories are described below:

- *A subset of diagnoses is intended only for newborns and neonates. These are "Newborn" diagnoses. For "Newborn" diagnoses the patient's age must be 0 years.*

- *Certain diagnoses are only reasonable for children between the ages of 0 and 17. These are "Pediatric" diagnoses.*

- *Diagnoses identified as "Maternity" are only coded for patients between the ages of 12 and 55.*

- *A subset of diagnoses is considered valid only for patients over the age of 14. These are "Adult" diagnoses. For "Adult" diagnoses the age range is 15 through 124.*

5 - Sex Conflict

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

EXAMPLES

1. Male patient with cervical cancer (diagnosis).

2. Male patient with hysterectomy (procedure).

In both instances, the indicated diagnosis or the procedure conflicts with the sex of the patient. Therefore, either the patient's diagnosis, the procedure or the sex is incorrect. The FI returns the bill to the hospital and requests a corrected bill with the proper sex, diagnosis, and procedure.

6 - Questionable Covered Procedures

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

7 - Noncovered Procedures

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

8 - Medicare as Secondary Payer - MSP Alert

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

9 - Invalid Age

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

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

10 - Invalid Sex

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

11 - Date Range

- *This edit is used in internal FI operations.*

12 - Valid Date

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

13 - Unlisted Procedures

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

14 - QIO Review

- *The OCE identifies hospital outpatient bills that contain ASC procedure codes. These are subject to medical review by the State's QIO.*

50 - Outpatient PRICER

(Rev. 1, 10-03-03)

A-02-026

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

This CMS developed software determines the APC line item price based on data from the FI's OPROV specific file, the beneficiary deductible record and the OCE output file. Pricer will prepare an output data record with the following information:

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

- A Pricer assigned review code to indicate why or how Pricer rejected or paid the claim.

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

50.1 - Outpatient Provider Specific File

(Rev. 1, 10-03-03)

A-02-026

The outpatient provider (OPROV) specific file contains the required information about each provider to enable the pricing software to calculate the payment amount. Data elements and format are shown below. FIs must maintain the accuracy of the data, and update the file as changes occur in data element values, e.g., changes in wage index, bed size, cost to charge ratio. Update is accomplished by preparing and adding an additional complete record showing new current values and the effective date of the change. The old record is retained without change until it no longer needs it for claims processing for the period covered by the record.

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

File Position	Format	Title
1-8	X(8)	National Provider Identifier (NPI) (for future use)
9-10	X(2)	NPI Filler
11-16	X(6)	Provider OSCAR Number
17-24	9(8)	Effective Date
25-32	9(8)	Fiscal year Beginning Date
33-40	9(8)	Report Date
41-48	9(8)	Termination Date
49	X	Waiver Indicator
50-54	9(5)	FI Number
55-56	X(2)	Provider Type
57	X	Filler
58	X	Change Code for Wage Index Reclassification

File Position	Format	Title
59-62	X(4)	Actual Geographic Location - MSA
63-66	X(4)	Wage Index Location
67-70	9V9(3)	Payment to Cost Ratios
71-75	9(5)	Bed Size
76-79	9V9(3)	Outpatient Cost to Charge Ratio
80-96	X(17)	Filler
97-100	9(4)	Reduced Coinsurance Trailer Count - Enter the number of APCs the provider has elected to reduce coinsurance for. The number cannot be greater than 999.

The FI enters the number of APCs for which the provider has elected to reduce coinsurance. Cannot be greater than 99.

Reduced Coinsurance Trailer Record - Occurs 0-999 times depending on the reduced Coinsurance Trailer Count in positions 97-100. Due to systems capacity limitations the maximum number of reduced coinsurance trailers allowable is 999 at this time.

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

The Shared system will verify that the last position of the record is equal to the number in positions 97 through 100 times (10) plus 100.

50.2 - Deductible Application

(Rev. 1, 10-03-03)

A-03-066

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

services, if applicable, is applied to the claim for other types of payments on the same claim before submitting to CWF.

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

50.3 - Transitional Pass-Throughs for Designated Drugs or Biologicals

(Rev. 1, 10-03-03)

A-03-066

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

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

50.4 - Transitional Pass-Throughs for Designated Devices

A-03-066

(Rev. 1, 10-03-03)

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

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

50.5 - Changes to Pricer Logic Effective April 1, 2002

(Rev. 1, 10-03-03)

A-02-026

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

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

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

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

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

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

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

EXAMPLE

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

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

G - All charges on lines with a SI of N (bundled services) on the claim will be summed and the charges will then be divided up proportionately to the payment rate for each S, T, V or X line. This proportional amount will be added to the new charges amount from item F above or, if that doesn't apply, they will be added to the actual submitted charges for each S, T, V or X before making a line item outlier calculation.

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

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

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

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

L - Pricer Drug Copayment Changes

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

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

(Rev. 1, 10-03-03)

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

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

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

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

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

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

EXAMPLE

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

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

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

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

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

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

A-00-42, A-00-61, A-00-72, A-00-82, A-00-96, A-01-10, A-01-17, A-01-41, A-01-17, A-01-44, A-02-026

(Rev. 1, 10-03-03)

The list of items eligible for pass-through payments changes as new items are approved for pass-through status and as costs for pass-through items are included in APC rates. The CMS will issue instructions to add and delete services from the pass-through list when appropriate.

The most recent information concerning applications and requirements for APC payments for new technologies, additional device categories and pass-through payments for drugs and biologicals is located on the CMS Web site at www.cms.hhs.gov/medlearn/refopps.htm.

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

(Rev. 1, 10-03-03)

A-01-41, A-02-026

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 requires establishing categories for purposes of determining transitional pass-through payment for devices, effective April 1, 2001. Each category is defined as a separate code in the C series of HCPCS. Codes have been assigned by CMS exclusively for this purpose. Only devices specifically identified in the long descriptions associated

with the codes have been qualified for transitional pass-through payments. In some instances, the same code has been used for several similar devices, each specifically identified. This coding practice has been referred to as "item specific."

The C codes can be viewed and/or downloaded from the CMS Web site at http://www.cms.hhs.gov/manuals/pm_trans/A0096.pdf

Each item determined to qualify for transitional pass-through payments fits in one of the C categories. Other items may be billed using the category codes, even though CMS has not qualified them on an item-specific basis, as long as they:

- Meet the definition of a device that qualifies for transitional pass-through payments and other requirements and definitions put forth below in §60.3.
- Are described by the long descriptor associated with an active category code assigned by CMS in HCPCS "C" codes; and
- Accord with definitions of terms and other general explanations issued by CMS to accompany coding assignments in this or subsequent instructions.

If a device does not meet the description of any established category and the other coding instructions, even though it appears to meet the other requirements in this section, it may not be billed for transitional pass-through payments until an applicable category is established by CMS.

Transitional pass-through payment for a device is based on the charge on the individual bill, reduced to cost, and subject (in some instances) to a deduction that represents the cost of similar devices already included in the APC payment rate and, after March 31, 2002, a pro-rata reduction (see chapter 17). The Pricer software determines the reduction to cost and the deduction for similar devices.

The qualification of a device for transitional pass-through payments is temporary. Initial categories will expire on January 1, 2003. (The underlying provision is permanent, and categories established later will expire in successive years.) At the time of expiration, APC payment rates will be adjusted to reflect the costs of devices (and drugs and biologicals) that received transitional pass-through payments. These adjustments will be based on claims data that reflect the use of transitional pass-through devices, drugs and biologicals in conjunction with the associated procedures.

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

(Rev. 1, 10-03-03)

See §10.12 for procedures for obtaining approval for new devices.

In general, hospitals are ultimately responsible for the content of the bills they present to Medicare. If hospitals have questions about appropriate coding that they cannot resolve

on their own, the appropriate first step would be to review the HCPCS "C" Codes and/or the Regulation governing payment for the year of service. The CMS will post on its Web site the results of any requests received for such decisions. The CMS does not have to have qualified a particular device for transitional pass-through payment before a hospital can bill for the device. Hospitals are expected to make appropriate coding decisions based on these instructions and other information available to them.

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

In general, for CMS to make such a judgment about whether a device is new, it needs information that is readily available only from the manufacturer. Accordingly, a hospital wishing to secure such clarification is encouraged to first work with and through the manufacturer, rather than contacting CMS directly.

60.3 - Devices Eligible for Transitional Pass-Through Payments

(Rev. 1, 10-03-03)

The definition of devices was elaborated in an Interim Final Rule with Comment Period published in the "Federal Register" on August 3, 2000, (65 FR 47670). The regulatory changes in that rule are compiled at 42 CFR 419.43. Devices must meet all the following requirements to be eligible for transitional pass-through payments:

A - They are described by the long descriptor of a C code issued by CMS for this purpose and meet other definitions and general coding instructions in this or subsequent instructions.

B - They have been approved or cleared for use by the Food and Drug Administration (FDA), if such approval or clearance is required and subject to the exception for certain investigational devices noted in C.

C - They are considered to be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part, as required by §1862(a)(1)(A) of the Act. Some investigational devices are refinements or replications of existing technologies and may be considered reasonable and necessary. Such devices that have received an FDA investigational device exemption (IDE) and are classified by the FDA as Category B devices are eligible for transitional pass-through payments if all other requirements are met.

D - They are an integral and subordinate part of the procedure performed, are used for one patient only, are single use, come in contact with human tissue, and are surgically implanted or inserted whether or not they remain with the patient when the patient is released from the hospital outpatient department.

E - They are not equipment, instruments, apparatuses, implements, or such items for which depreciation and financing expenses are recovered as depreciable assets as defined in Chapter 1 of the Medicare Provider Reimbursement Manual (CMS Pub. 15-1).

F - They are not materials and supplies (such as sutures, customized surgical kits, or clips, other than radiological site makers) furnished incident to a service or procedure. Supplies include pharmacological imaging and stressing agents other than radiopharmaceutical or contrast agents (for which transitional pass-through payments are authorized under §1833(t)(6)(A) of the Act).

G - They are not materials such as biologicals or synthetics that may be used to replace human skin.

H - The cost of a device must be "not insignificant," to be applied on the basis of the average cost of devices in a category, not an individual item. (The CMS will make determinations about whether a category passes the "not insignificant" test when it establishes new categories. Hospitals do not make these determinations and should assume any category established by CMS meets this test.)

To qualify for a transitional pass-through payment, a device must meet all of these requirements, and in addition it must be medically necessary in a particular case. Medicare makes transitional pass-through payments for a device only in conjunction with a procedure for its implantation or insertion. Consequently, a device will be considered medically necessary and eligible for a transitional pass-through payment only if the associated procedure is also medically necessary and payable under the outpatient prospective payment system.

In coding devices for transitional pass-through payments, an important concern is to ensure that the items in fact meet the requirements for transitional pass-through payments. These payments are not available for supplies or for capital equipment. Thus, for example, scalpels and coagulators are considered supplies because they are neither implanted (like a pacemaker) nor surgically inserted (like an ablation catheter) in a patient. The cost of these and other supplies are "packaged" into the APC payment rates for surgeries, and they do not qualify for separate transitional pass-through payments. Similarly, monitors or EKG machines that are used on multiple patients are treated as capital equipment. Costs of these items are amortized and packaged in the payments for applicable APCs. In making determinations of which individual devices qualify for transitional pass-through payments, CMS excluded both supplies and capital equipment, and the need to do so is not changed by the introduction of categories. Hospitals should be vigilant in not billing for transitional pass-through payments for either supplies or capital equipment.

60.4 - General Coding and Billing Instructions and Explanations

(Rev. 1, 10-03-03)

A-01-73

Explanations of Terms

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

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

Old codes and grace period - The previous, item-specific C codes will remain active for a 90-day grace period. Hospitals may use these codes for services delivered up until June 30, 2001, when they will be retired. During this period, hospitals may bill an item under either an item-specific code, if one has been specified by CMS as applicable for that item, or an appropriate category code, but not both.

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

Also, for items packaged as kits that contain a catheter and an introducer, report both appropriate categories. For example, the "Clinicath 16G Peripherally Inserted Central Catheter (PICC) Dual-Lumen PolyFlow Polyurethane" contains a catheter and an introducer. To appropriately bill for this item, hospitals report category C1751 for the catheter and C1894 for the introducer.

Reprocessed devices - Hospitals may bill for transitional pass-through payments only for those devices that are "single use." Reprocessed devices may be considered "single use" if they are reprocessed in compliance with enforcement guidance of the Food and Drug Administration (FDA) relating to the reprocessing of devices applicable at the time the service is delivered. The FDA is phasing in new enforcement guidance relating to reprocessing during 2001 and 2002. For further information, see FDA's guidance document entitled "Enforcement Priorities for Single-Use Devices Reprocessed by Third Parties and Hospitals," published August 14, 2000.

3D mapping catheter - Refers to a catheter used for mapping the electrophysiological properties of the heart. Signals are identified by a specialized catheter and changed into a 3-dimensional map of a specific region of the heart.

Ablation catheter - Used to obliterate or necrose tissues in an effort to restore normal anatomic and physiologic function.

Adaptor for a pacing lead - Interposed between an existing pacemaker lead and a new generator. The end of the adaptor lead has the appropriate connector pin that will enable utilization of the existing pacemaker lead with a new generator that has a different receptacle. These are required when a generator is replaced or when two leads are connected to the same port in the connector block.

Anchor for opposing bone-to-bone or soft tissue-to-bone - Implantable pins and/or screws that are used to oppose soft tissue-to-bone, tendon-to-bone, or bone-to-bone. Screws oppose tissues via drilling as follows: soft tissue-to-bone, tendon-to-bone, or bone-to-bone fixation. Pins are inserted or drilled into bone, principally with the intent to facilitate stabilization or oppose bone-to-bone. Anchors do not include screws, washers, and nuts used for anchoring plates to bone.

Adhesion barrier - A bioresorbable substance placed on and around the neural structures, which inhibits cell migration (fibroblasts) and minimizes scar tissue formation. It is principally used in spine surgeries, such as laminectomies and diskectomies.

Balloon dilatation catheter, non-vascular - Catheter used to dilate strictures or stenoses through the insertion of an uninflated balloon affixed to the end of a flexible catheter, followed by the inflation of the balloon at the specified site (e.g., common bile duct, ureter, small or large intestine). (For the reporting of vascular balloon dilatation catheters, see category "Transluminal angioplasty catheter.")

Balloon tissue dissector catheter (insertable) - Balloon tipped catheter used to separate tissue planes, used in procedures such as hernia repairs.

Coated stent - Refers to a stent bonded with drugs (e.g., heparin) or layered with biocompatible substances (e.g., phosphorylcholine).

Connective tissue, human - These tissues include a natural, cellular collagen or extracellular matrix obtained from autologous rectus fascia, decellularized cadaveric fascia lata, or decellularized dermal tissue. They are intended to repair or support damaged or inadequate soft tissue. They are used to treat urinary incontinence resulting from hypermobility or Intrinsic Sphincter Deficiency (ISD), pelvic floor repair, or for implantation to reinforce soft tissues where weakness exists in the urological anatomy. (This excludes those items that are used to replace skin.) (For reporting mesh when used to treat urinary incontinence, see the category "Mesh.") (For reporting urinary incontinence repair device when used to treat urinary incontinence, see the category "Urinary incontinence repair device.")

Connective tissue, non-human (includes synthetic) - These tissues include a natural, acellular collagen matrix typically obtained from porcine or bovine small intestinal sub-mucosa, or pericardium. This biomaterial is intended to repair or support damaged or inadequate soft tissue.

They are used to treat urinary incontinence resulting from hypermobility or Intrinsic Sphincter Deficiency (ISD), pelvic floor repair, or for implantation to reinforce soft tissues where weakness exists in the urological or musculoskeletal anatomy. (This excludes those items that are used to replace skin.) (For reporting mesh when used to treat urinary incontinence, see the category "Mesh.") (For reporting urinary incontinence repair device when used to treat urinary incontinence, see the category "Urinary incontinence repair device.")

Covered stent - Refers to a stent layered with silicone or a silicone derivative (e.g., PTFE, polyurethane).

Drainage catheter - Intended to be used for percutaneous drainage of fluids. (**Note** : This category does NOT include Foley catheters or suprapubic catheters. Refer to category C2627 to report suprapubic catheters.)

Electrophysiology (EP) catheter - Assists in providing anatomic and physiologic information about the cardiac electrical conduction system. Electrophysiology catheters are categorized into two main groups: (1) diagnostic catheters that are used for mapping, pacing, and/or recording only, and (2) ablation (therapeutic) catheters that also have diagnostic capability. The electrophysiology ablation catheters are distinct from non-cardiac ablation catheters.

Extension for a pacing lead - Provides additional length to an existing pacing lead but does not have the capability of an adaptor.

Extension for a neurostimulator lead - Conducts electrical pulses from the power source (generator or neurostimulator) to the lead. The terms neurostimulator and generator are used interchangeably.

Guiding catheter - Intended for the introduction of interventional/diagnostic devices into the coronary or peripheral vascular systems. It can be used to inject contrast material, function as a conduit through which other devices pass, and/or provide a mechanism for measuring arterial pressure, and maintain a pathway created by the guide wire during the performance of a procedure.

Infusion pump, non-programmable, temporary (implantable) - Short-term pain management system that is a component of a permanent implantable system used for chronic pain management.

Insertable retrieval device - A device designed to retrieve other devices or portions thereof (e.g., fractured catheters, leads) lodged within the vascular system.

Intraocular lens (new technology) - Refers to the intraocular lenses approved by CMS as "new technology." A list of these lenses is published annually in the "Federal Register."

Intraoperative ocular device for detached retina - A perfluorocarbon substance instilled during a vitreoretinal procedure to treat retinal detachment.

Joint device - An artificial joint such as a finger or toe that is implanted in a patient. Typically, a joint device functions as a substitute to its natural counterpart and is not used (as are anchors) to oppose soft tissue-to-bone, tendon-to-bone, or bone-to-bone.

Liquid pulmonary sealant - An absorbable, synthetic solution that forms a seal utilizing a photochemical polymerization process. It is used to seal visceral pleural air leaks incurred during pulmonary resection.

Material for vocal cord medialization, synthetic - Synthetic material that is composed of a non-absorbable substance such as silicone and can be injected or implanted to result in vocal cord medialization.

Mesh - A mesh implant or synthetic patch composed of absorbable or non-absorbable material that is used to repair hernias, support weakened or attenuated tissue, cover tissue defects, etc. (For reporting connective tissue (human or non-human) when used to treat urinary incontinence, see the category "Connective tissue, human" or "Connective tissue, non-human.") (For reporting urinary incontinence repair device when used to treat urinary incontinence, see the category "Urinary incontinence repair device.")

Morcellator - Used for cutting, coring, and extracting tissue in laparoscopic procedures. These are distinct from biopsy devices because morcellators are used for the laparoscopic removal of tissue.

Patient programmer - Programmer that allows the patient to operate their neurostimulator, for example, programming the amplitude and rate of stimulation of a neurostimulator system. Only a nonconsole patient programmer is eligible for transitional pass-through payments.

Peel-away introducer/sheath - A non-absorbable sheath or introducer that separates into two pieces. This device is used primarily when removal of the sheath is required after a catheter or lead is in the desired position.

Septal defect implant system - An intracardiac metallic implant used for closure of various septal defects within the heart. The septal defect implant system includes a delivery catheter. The category code for the septal defect implant system (C1817) includes the delivery catheter; therefore, the delivery catheter should not be reported separately.

Stents with delivery system - Stents packaged with delivery systems generally include the following components: stent mounted or unmounted on a balloon angioplasty catheter, introducer, and sheath. These components should not be reported separately.

Temperature-controlled electrophysiology catheter - Ablation catheter that contains a cooling mechanism and has temperature sensing capability.

Temporary non-coronary stent - Usually composed of a substance, such as plastic or other non-absorbable material, designed to permit removal. Typically, this type of stent is placed for a period of less than one year.

Tissue marker - A material that is placed in subcutaneous or parenchymal tissue for radiopaque identification of an anatomic site. These markers are distinct from topical skin markers, which are positioned on the surface of the skin to serve as anatomical landmarks.

Transluminal angioplasty catheter - Designed to dilate stenotic blood vessels (arteries and veins). For vascular use, the terms "balloon dilatation catheter" and "transluminal angioplasty catheter" are frequently used interchangeably. (For the reporting of non-vascular balloon dilatation catheters, see the category "Balloon dilatation catheter.")

Transvenous VDD single pass pacemaker lead - A transvenous pacemaker lead that paces and senses in the ventricle and senses in the atrium.

Urinary incontinence repair device - Used to attach or insert a sling graft for the purpose of strengthening the pelvic floor. It consists of the device components used to deliver (suprapubically or transvaginally) and/or fixate (via permanent sutures or bone anchors) the sling graft. The device may or may not be packaged with a sling graft. Report the appropriate category for a device with or without a sling graft. (For reporting connective tissue (human or non-human) when used to treat urinary incontinence, see the category "Connective tissue, human" or "Connective tissue, non-human.") (For reporting mesh when used to treat urinary incontinence, see the category "Mesh.")

Vascular closure device (implantable/insertable) - Used to achieve hemostasis at arterial puncture sites following invasive or interventional procedures using biologic substances (e.g., collagen) or suture through the tissue tract.

Vector mapping catheter - Refers to an electrophysiology catheter with an "in-plane" orthogonal array of electrodes. This catheter is used to locate the source of a focal arrhythmia.

60.5 - Devices Eligible for New Technology Payments Effective January 1, 2001

(Rev. 1, 10-03-03)

A-00-82

Under OPPS, the "new technology procedures/services" are those codes that are assigned APC 0706-0721 and APC 0970-0985. OPPS considers any HCPCS assigned to these APCs to be "new technology procedures/services".

The list of HCPCS codes indicating the APCs to which each is assigned can be found in Addendum C of the Regulation each year at http://cms.hhs.gov/regulations/hopps/default.asp

60.6 - Appropriate Revenue Codes to Report Medical Devices That Have Been Granted Pass-Through Status

(Rev. 1, 10-03-03)

A-01-50, A-03-035

Hospitals must report all pass-through devices using HCPCS codes that begin with a "C" under any of the following revenue codes 0272, 4, 0275, 0276, 0278, 0279, 0280, 0289, or 0624 to bill implantable devices that have been granted pass-through status under OPPS. Devices eligible for pass-through payment, as designated by payment status indicator "H," should not be reported utilizing any other revenue code series or sub-categories. FIs should instruct hospitals to report implantable orthotic and prosthetic devices and implantable durable medical equipment (DME) under another revenue code such as 0278 – *other implants*. Hospitals are not to use revenue codes 0274 or 0290 to report implantable orthotic and prosthetic devices or implantable DME. Similar requirements apply to reporting revenue codes for non-pass-through devices

For services furnished on or after April 1, 2001, devices that qualify for transitional pass-through payments are those that fit in one of the established active device categories. To qualify for pass-through payments, a device must meet the definition of a device and all of the requirements compiled in 42 CFR 419.43 and other requirements set forth in PM A-01-41. In particular, one aspect of that definition states that devices are "single use," come in contact with human tissue, and are surgically implanted or inserted.

70 - Transitional Corridor Payments

(Rev. 1, 10-03-03)

A-01-15, A-02-26

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) established transitional payments to limit provider's losses under OPPS; the additional payments are for 3 1/2 years for CMHCs and most hospitals, and permanent for the 10 cancer hospitals and permanent for children's hospitals effective August 1, 2000.

Section 405 of BIPA provides that children's hospitals described in §1886(d)(1)(B)(iii) will be held harmless permanently for purposes of calculating TOP amounts. This means that children's hospitals that are excluded from the inpatient hospital prospective payment system will receive the same transitional corridor hold-harmless protection as cancer hospitals under the OPPS. This provision is effective retroactively to August 1, 2000. FIs follow the TOP calculation steps described below and determine the TOP amount the children's hospital should have received retroactively to August 1, 2000. FIs

compare the newly calculated amount to the interim TOP amounts that were already made to the hospital and make a lump sum payment for any additional estimated amounts due to the hospital. Future monthly TOPs calculations to these hospitals are described in the steps listed below. Note steps for TOP calculations prior to 2002 and revised calculations beginning calendar year 2002.

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 amount for each hospital and CMHC. The software must calculate and pay the TOP amount for OPPS services on claims processed during the preceding month, maintain an audit trail (including the ability to generate a hardcopy report) of these TOP amounts, and transfer to the PS&R system any necessary data. TOP amounts should be paid before the next month begins and they are not subject to normal payment floor requirements.

Eight items contained in the provider file and defined under the OPROV Specific File section above are needed to calculate the TOP amount for each hospital or CMHC. They are:

- The provider number;
- Fiscal year begin date;
- The provider type;
- Change code for wage index reclassification;
- Actual geographic location - MSA;
- Wage index location - MSA;
- Bed size; and
- Outpatient cost to charge ratio.

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

Calculate interim TOP amounts for hospitals and CMHCs that did not have a cost report ending in calendar year 1996, but do have a cost report for a later period that ends prior to calendar year 2001 retroactively to August 1, 2000. FIs make a lump sum payment for any estimated amounts due the provider for prior months retroactive to August 1, 2000, and continue monthly payments as necessary for future months.

One additional item will be output from the Pricer software in 9(7)V99 format. It is the outlier payment amount. The shared system will sum the following items for use in steps 1 and 2 below:

- Total charges for all covered OPPS services on the claim;
- Total OPPS Medicare program payments on the claim; and,
- Total unreduced OPPS coinsurance on the claim and total OPPS deductible on the claim.

70.1 - Revised Transitional Outpatient Payment (TOP) Calculation for Calendar Year 2002

(Rev. 1, 10-03-03)

A-02-026

Beginning January 1, 2002, TOPs are 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, as soon as possible, but no later than July 1, 2002, FIs revise the monthly interim TOP calculations to reflect the new calculation.

The calculation of monthly interim TOPs payments described in §70 above, is revised as follows for calendar year 2002:

Step 1 - Find 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 multiply this amount by the provider-specific payment-to-cost ratio (PSPCR).

Step 2 - Find 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 under OPPS. If the result is greater than the result of step 1, go to step 8. No transitional payment is due this month.

Step 3 - If the hospital is a children's hospital, a small rural hospital with not more than 100 beds or a cancer hospital go to step 4. If any other type of hospital, divide the result of step 2 by the result of step 1, skip step 4 and perform step 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 greater than or equal to .9 and 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 greater than or equal to .8 and 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.

A - TOP Overpayments

Because the revised TOP calculation will be implemented in the system sometime after the January 1, 2002, effective date of the TOP reduction, overpayments to providers are expected. Once the system change is completed, FIs must determine whether overpayments have been made by comparing TOP amounts already paid for OPPS charges attributable to services furnished in calendar year 2002 to what TOP amounts would be using the revised calculation. Because interim TOPs are based on charges billed during the previous month rather than on actual dates of service, in determining whether an overpayment exists, apply the new calculation to monthly TOP amounts paid for OPPS charges billed beginning in February 2002.

If an overpayment exists, recoup the overpayments by withholding future monthly interim TOPs until the overpayment is recouped.

FIs should advise providers of the revised TOP calculations for calendar year 2002 and other changes in OPPS using their normal communication protocols (Web site, regularly scheduled bulletins, electronic bulletin boards, or listserv).

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

(Rev. 1, 10-03-03)

A-01-44

80.1 - Background - Payment-to-Cost Ratios

(Rev. 1, 10-03-03)

A-01-44

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, rural hospitals with 100 or fewer beds, qualifying cancer centers, and children's hospitals will receive the entire amount of the difference between their OPPS payments and their pre-BBA amount. All other hospitals and CMHCs will receive a portion of the difference as a TOP.

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

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

(Rev. 1, 10-03-03)

A-01-44

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

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

80.3 - Using the Newly Calculated PCR for Determining Interim TOPs

(Rev. 1, 10-03-03)

A-01-44

Providers that are eligible for TOPs receive monthly interim payments. The calculation of the monthly payment uses a national uniform PCR of 80 percent for all providers in step 1. Once fiscal FIs calculate a provider-specific PCR, that PCR will 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), continue to use the national PCR of 80 percent. The change to the provider-specific file and the change in the calculation of TOPs payments were effective on July 1, 2001.

90 - Discontinuation of Value Code 05 Reporting

(Rev. 1, 10-03-03)

A-03-066

Value code 05, "Professional Component Included in Charges and Also Billed Separately to Carrier," was discontinued with the implementation of OPPS, but still applies to cost reimbursement claims for CAHs and other hospitals not subject to OPPS.

100 - Medicare Summary Notice (MSN)

(Rev. 1, 10-03-03)

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

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

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

The Spanish version should read as follows:

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

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

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

Spanish Version:

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

110 - Procedures for Submitting Late Charges Under OPPS

(Rev. 1, 10-03-03)

A-01-93

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

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

120 - General Rules for Reporting Outpatient Hospital Services

(Rev. 1, 10-03-03)

A3-3626.2, A-02-026

Hospitals use Form UB-92 or related electronic data sets to bill for covered outpatient services (type of bill 13X or 14X, 83X, and 85X). See:

- Medicare Benefit Policy Manual, Chapter 6, for definition of an outpatient;
- Medicare Claims Processing Manual, Chapter 3, "Inpatient Part A Hospital Billing," for outpatient services treated as inpatient services; and
- Medicare Claims Processing Manual, Chapter 25, for general instructions for completing the UB-92 and related electronic data sets.

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

120.1 - Bill Types Subject to OPPS

(Rev. 1, 10-03-03)

A-01-93, A-02-026, A-03-066

The following bill types are subject to OPPS:

- All outpatient hospital Part B bills (bill types 12X, 13X with condition code 41, 13X without condition code 41 or 14X) with the exception of bills from hospitals in Maryland, Indian Health Service, CAHs, hospitals located in Saipan, American Samoa, the Virgin Islands and Guam; and hospitals that provide Part B only services to their inpatients.
- CMHC bills (bill type 76X);
- CORF claims for hepatitis B vaccines (bill type 75X);
- HHA claims for antigens, hepatitis B vaccines, splints and casts (bill type 34X); and
- For splints, casts and antigens when provided to hospice patients for treatment of a non-terminal illness by other than a hospital outpatient department. This requires reporting of condition code 07.

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

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

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

120.2 - Routing of Claims

(Rev. 1, 10-03-03)

A-02-00-026

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

22X	Skilled Nursing Facility (SNF) Inpatient Part B
23X	SNF/Outpatient
24X	SNF Part B
32X	Home Health Agency (HHA) visits under a Part B Plan of Treatment (POT)
33X	HHA visits under a Part A (POT)
34X	HHA visits under a POT
71X	Rural Health Clinic
72X	Hospital Based or Independent Renal Dialysis Center
73X	Federally Qualified Health Center
74X	Other Rehabilitation Facilities
75X	Comprehensive Outpatient Rehabilitation Facility (CORF)
81X	Hospice (non-hospital based)
82X	Hospice (hospital based)

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

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

NOTE: TOBs (12X, 13X, 14X, and 85X) from Critical Access Hospitals, Maryland Hospitals, Indian Health Service Hospitals, U.S. Virgin Island Hospitals, and those

hospitals located in the Pacific (American Samoa, Guam, and Saipan) do not have to be rerouted since they are sent through the non-OPPS OCE.

130 - Coding and Billing for Services Furnished On or After January 1, 2002, Through March 31, 2002, That Are Payable Under the OPPS

(Rev. 1, 10-03-03)

A-02-26

The effective date for the 2002 update of the OPPS was delayed until April 1, 2002. For services during the period on or after January 1, 2002, through March 31, 2002, outpatient hospitals and Community Mental Health Centers (CMHC) must continue using 2001 HCPCS codes and modifiers to bill for OPPS services. The following rules apply to the period on or after January 1, 2002, through March 31, 2002.

- For services furnished on or after January 1, 2002, through March 31, 2002, that are paid under the OPPS, hospitals are to use the same HCPCS codes and modifiers that they used during 2001. For services that were not covered under the OPPS in 2001, but that are covered in 2002, hospitals must use 2001 HCPCS codes and modifiers that most closely describe the services furnished in order to receive payment for this period.

- Hospitals and CMHCs are not to use 2002 HCPCS codes or modifiers to bill for services furnished on or after January 1, 2002, through March 31, 2002, that are paid under the OPPS.

- Claims that contain any new 2002 HCPCS codes or modifiers for dates of service preceding April 1, 2002, are to be returned unprocessed to the provider. When this occurs, instruct the provider to resubmit the claim within the timeframes specified in Chapter 1, "General Billing Requirements," utilizing a 2001 HCPCS code(s) and/or modifiers(s) that most closely describe the service(s) furnished.

- Instructions issued prior to December 21, 2001, that reflect a January 1, 2002, effective date for new 2002 codes payable under the OPPS, were effective April 1, 2002, for hospitals and CMHCs.

- FIs must not make retroactive payment for new 2002 codes for services furnished prior to April 1, 2002. Return to the provider, without processing, claims for services furnished between December 31, 2001, and April 1, 2002, that are submitted after April 1, 2002, with new 2002 codes.

FIs are not to reprocess claims for outpatient services with dates of services prior to April 1, 2002, that use new 2002 codes.

140 - All-Inclusive Rate Hospitals

(Rev. 1, 10-03-03)

A-01-93, A-03-066

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

150 - Hospitals That Do Not Provide Outpatient Services

(Rev. 1, 10-03-03)

HO-440.1, A-00-21, A-02-064

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

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

160 - Coding for Clinic and Emergency Visits

(Rev. 1, 10-03-03)

A-01-93

OPPS hospitals previously reported CPT code 99201 to indicate a visit of any type. Under OPPS, 31 codes are used to indicate visits, with payment differentials for more or less intense services.

Hospitals code the site of the visit and the level of intensity, using the following codes:

92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99271, 99272, 99273, 99274, 99275, 99281, 99282, 99283, 99284, 99285, 99291, and G0175.

Because CPT is more descriptive of practitioner than of facility services, hospitals must use CPT guidelines when applicable, or crosswalk hospital coding structures to CPT. For example, a hospital that has eight levels of emergency and trauma care, depending on nursing ratios, should crosswalk those eight levels to the CPT codes for emergency care.

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

(Rev. 1, 10-03-03)

A-01-91

Hospitals and Community Mental Health Centers (CMHCs) are required to report all OPPS services that are provided on the same day on the same claim with the exception of claims containing condition codes 20, 21, or G0 (zero). If an individual OPPS service is provided on the same day as an OPPS repetitive service, the individual OPPS service must be billed on the OPPS monthly repetitive claim. (See below for a listing of outpatient repetitive services that are required to be billed monthly). The policy for repetitive services continues under OPPS for all providers. If a non-OPPS repetitive service is provided on the same day as an OPPS service, separate claims may be submitted. In addition, if a 13X and 14X type of bill (TOB) contains OPPS services that were performed on the same day for the same beneficiary, the services must be reported on the same claim. Providers must submit one claim in the situation utilizing the 13X TOB.

The following revenue codes are considered to be repetitive services and must be billed monthly or at the conclusion of treatment. Please note that all repetitive services with the exception of physical, occupational and speech therapy are subject to OPPS.

Type of Service	Revenue Code
Therapeutic Radiology	0330-0339
Therapeutic Nuclear Medicine	0342
Respiratory Therapy	0410-0419
Physical Therapy	0420-0429
Occupational Therapy	0430-0439
Speech Pathology	0440-0449

Type of Service	Revenue Code
Cardiac Rehabilitation Services	0943
Psychological Services	0910-0919

EXAMPLE 1

If a patient receives a laboratory service on May 1st and has an emergency room (ER) visit on the same day, two separate bills may be submitted since the laboratory service is paid under the clinical diagnostic laboratory fee schedule and not subject to OPPS. In this situation, the laboratory service was not related to the ER visit or done in conjunction with the ER visit.

EXAMPLE 2

If a patient was seen in the emergency room (ER) and the same patient received nonpartial hospitalization psychological services on the same day as well as several other days in the month, the provider should report the ER visit on the monthly repetitive claim along with the psychological services, since both services are paid under OPPS.

EXAMPLE 3

If a patient has an ER visit on the same day as a chemotherapy visit, the provider should report both of these services on the monthly chemotherapy repetitive claim since both services are paid under OPPS.

EXAMPLE 4

If the patient receives chemotherapy on July 7th, 29th, and 30th, and receives services in the ER on July 28th, the provider may submit separate claims since the isolated individual service (ER visit) did not occur on the same day as the repetitive services (chemotherapy services). In this situation, it does not matter whether the services are reimbursed under OPPS or not.

EXAMPLE 5

If a patient has an ER visit (OPPS service) on May 15th and also received a physical therapy visit (non-OPPS service) on the same day (as well as other physical therapy visits provided May 1st through May 31st) the services may be billed on separate claims. The provider would bill the ER service on one claim and the therapy services on the monthly repetitive claim. Please note, as stated above, the procedures for billing of repetitive services remain in effect under OPPS. Therefore, in this example, it would not be appropriate to submit one therapy claim for services provided May 1st through May 15th, a second claim for the ER visit provided on May 15th, and a third claim for therapy visits provided on May 16th through May 31st. Providers should not split repetitive services in mid-month when another outpatient service occurs.

The FI shall return claims submitted for the same date of service to the provider (except exact duplicates or those containing condition codes 20, 21, or G0) with a notification that an adjustment bill should be submitted. Claims containing condition code G0 shall not automatically be rejected as a duplicate claim. When returning claims that do not meet the above requirement, the basis of the returned claim must be determined at the line level and not solely on the "From" and "Thru" dates on the claim.

The FI shall not reject or return claims to providers that have been billed appropriately in accordance with these instructions. Claims that are unable to process for payment due to duplicate payment edits in the Shared System or the contractor's internal claims processing system must be manually reviewed to determine if they were submitted appropriately. These claims are not considered part of the medical review workload.

180 - Accurate Reporting of Surgical Procedures

(Rev. 1, 10-03-03)

A-01-93, A-02-074, A3-3626.4.B.3

180.1 - General Rules

(Rev. 1, 10-03-03)

Hospitals subject to OPPS are required, beginning with claims with dates of service on or after August 1, 2000, to report in Form Locator 6 "Statement Covers Period From Date" the earliest date that services were rendered. As a result, preoperative laboratory services will always have a line item date of service within the "from and through" dates on the claim.

Indian Health Service hospitals continue to bill for surgeries utilizing bill type 83X. For other hospitals outpatient surgery subject to the ASC payment limit with dates of service prior to August 1, 2000, is reported on bill type 83X, and surgeries performed August 1, 2000 and later are reported with bill type 13X.

180.2 - Selecting and Reporting Procedure Codes

(Rev. 1, 10-03-03)

A-01-50, A3-3626.4.B.3

Using medical records as basic sources, hospitals report HCPCS surgical procedure codes for outpatient surgery in FL 44 adjacent to the revenue code for the operating room or other room used for the surgery. The bill includes the hospital's charges for the surgery as well as all other services provided on the day the procedure was performed.

When multiple surgical procedures are performed at the same session, it is not necessary to bill separate charges for each procedure. It is acceptable to bill a single charge under the revenue code that describes where the procedure was performed (e.g., operating

room, treatment room, etc.) on the same line as one of the surgical procedure CPT/HCPCS codes and bill the other procedures using the appropriate CPT/HCPCS code and the same revenue code, but with "0" charges in the charge field.

In the past, some hospitals billed a single emergency room (ER) visit charge, which included charges for any surgical procedures that were performed in the ER at the time of the ER visit. Under the OPPS, CMS requires hospitals to bill a separate charge for ER visits and surgical procedures effective with claims with dates of service on or after July 1, 2001. If a surgical procedure is performed in the ER, the charge for the procedure must be billed with the emergency room revenue code. If an ER visit occurs on the same day, a charge should be billed for the ER visit and a separate charge should be billed for the surgical procedure(s) performed. As described above, a single charge may be billed for all surgical procedures if more than one is performed in the ER during the same session.

EXAMPLE

The following is an example of how a claim should be completed under these reporting requirements:

Date of Service	Revenue Code	HCPCS	Modifier	Charges
7/5/2001	0450	99283	25	$150
7/5/2001	0450	12011		$300
7/5/2001	0450	12035		
7/5/2001	0250			$70
7/5/2001	0270			$85

The charge for both surgical procedures in this example is reflected in the $300 charge shown on the line with procedure code 12011.

180.3 - Unlisted Service or Procedure

(Rev. 1, 10-03-03)

This section does not apply to OPPS hospitals.

There may be services or procedures performed that are not found in HCPCS. These are typically services that are rarely provided, unusual, variable, or new. A number of specific code numbers have been designated for reporting unlisted procedures. When an unlisted procedure code is used, a report describing the service is submitted with the claim. Pertinent information includes a definition or description of the nature, extent, and

need for the procedure and the time, effort, and equipment necessary to provide the service.

When an FI receives a claim with an unlisted procedure code, it reviews it to verify that there is no existing code that adequately describes the procedure. If it determines that an adequately descriptive code is contained in HCPCS, it advises the hospital of the proper code and processes the claim. If it determines that no existing code is sufficiently descriptive, it pays the claim using the unlisted procedure code. If the frequency of the procedure warrants assignment of a local code, the FI forwards a copy and the operative report to the RO HCPCS coordinator for a code determination. When it receives a determination, the FI informs the hospital of the correct code for future reporting. Local codes are not accepted under OPPS and line items for local codes are no longer paid on cost.

NOTE: If the claim is submitted via EMC or identified after the bill has been processed, an operative report, the provider number, revenue codes, and charges are sufficient.

The "Unlisted Procedures" and codes for surgery are:

HCPCS code	Unlisted Procedure
15999	Unlisted procedure, excision pressure ulcer
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
19499	Unlisted procedure, breast
20999	Unlisted procedure, musculoskeletal system, general
21299	Unlisted craniofacial and maxillofacial procedures
21499	Unlisted orthopedic procedure, head
21899	Unlisted procedure, neck or thorax
22899	Unlisted procedure, spine
22999	Unlisted procedure, abdomen, musculoskeletal system
23929	Unlisted procedure, shoulder
24999	Unlisted procedure, humerus or elbow
25999	Unlisted procedure, forearm or wrist
26989	Unlisted procedure, hands or fingers

HCPCS code	Unlisted Procedure
27299	Unlisted procedure, pelvis or hip joint
27599	Unlisted procedure, femur or knee
27899	Unlisted procedure, leg or ankle
28899	Unlisted procedure, foot or toes
29799	Unlisted procedure, casting or strapping
29909	Unlisted procedure, arthroscopy
30999	Unlisted procedure, nose
31299	Unlisted procedure, accessory sinuses
31599	Unlisted procedure, larynx
31899	Unlisted procedure, trachea, bronchi
32999	Unlisted procedure, lungs, and pleura
33999	Unlisted procedure, cardiac surgery
36299	Unlisted procedure, vascular injection
37799	Unlisted procedure, vascular surgery
38999	Unlisted procedure, hemic or lymphatic system
39499	Unlisted procedure, mediastinum
39599	Unlisted procedure, diaphragm
40799	Unlisted procedure, lips
40899	Unlisted procedure, vestibule of mouth
41599	Unlisted procedure, tongue, floor of mouth
41899	Unlisted procedure, dentoalveolar structures
42299	Unlisted procedure, palate, uvula
42699	Unlisted procedure, salivary glands or ducts

HCPCS code	Unlisted Procedure
42999	Unlisted procedure, pharynx, adenoids, or tonsils
43499	Unlisted procedure, esophag
43999	Unlisted procedure, stomach
44799	Unlisted procedure, intestine
44899	Unlisted procedure, Meckel's diverticulum and the mesentery
45999	Unlisted procedure, rectum
46999	Unlisted procedure, anus
47399	Unlisted procedure, liver
47999	Unlisted procedure, biliary tract
48999	Unlisted procedure, pancreas
49999	Unlisted procedure, abdomen, peritoneum, and omentum
53899	Unlisted procedure, urinary system
55899	Unlisted procedure, male genital system
56399	Unlisted procedure, laparoscopy, hysteroscopy
58999	Unlisted procedure, female genital system non-obstetrical
59899	Unlisted procedure, maternity care and delivery
60699	Unlisted procedure, endocrine system
64999	Unlisted procedure, nervous system
66999	Unlisted procedure, anterior segment of eye
67299	Unlisted procedure, posterior segment
67399	Unlisted procedure, ocular muscle
67599	Unlisted procedure, orbit
67999	Unlisted procedure, eyelids

HCPCS code	Unlisted Procedure
68399	Unlisted procedure, conjunctiva
68899	Unlisted procedure, lacrimal system
69399	Unlisted procedure, external ear
69799	Unlisted procedure, middle ear
69949	Unlisted procedure, inner ear
69979	Unlisted procedure, temporal bone, middle fossa approach

180.4 - Proper Reporting of Condition Code G0 (Zero)

(Rev. 1, 10-03-03)

Hospitals subject to OPPS report Condition Code G0 on FLs 24-30 (or the corresponding electronic location) when multiple medical visits occurred on the same day in the same revenue center but the visits were distinct and constituted independent visits. An example of such a situation would be a beneficiary going to the emergency room twice on the same day, in the morning for a broken arm and later for chest pain.

Multiple medical visits on the same day in the same revenue center may be submitted on separate claims. Hospitals should report condition code G0 on the second claim. Appropriate reporting of Condition Code G0 allows for accurate payment under OPPS in this situation. The OCE contains an edit that will reject multiple medical visits on the same day with the same revenue code without the presence of Condition Code G0.

To further illustrate, the following table describes actions the OCE takes when multiple medical visits occur on the same day in the same revenue code center:

Evaluation and Management (E&M)	Revenue Center	Condition Code	OCE Action
2 or more	Two or more E&M codes have the same revenue center	No G0	Assign medical APC to each line item with E&M code and deny all line items with E&M code except the line item with the highest APC payment
2 or more	Two or more E&M codes have the same revenue	G0	Assign medical APC to each line item with

Evaluation and Management (E&M)	Revenue Center	Condition Code	OCE Action
	center		E&M code.

180.5 - Proper Reporting of Condition Codes 20 and 21

(Rev. 1, 10-03-03)

Hospitals and CMHCs report condition codes 20 and 21 when they realize the services are excluded from coverage but:

- The beneficiary has requested a formal determination (condition code 20) (claim may contain both covered and noncovered charges); or
- The provider is requesting a denial notice from Medicare to bill Medicaid or other insurers (condition code 21).

FIs advise hospitals and CMHCs when billing condition code 21 that a separate claim must be submitted. Claims with condition code 21 must be submitted with all noncovered charges.

190 - Implanted DME, Prosthetic Devices and Diagnostic Devices

(Rev. 1, 10-03-03)

Implanted DME, implanted prosthetic devices, and implanted diagnostic devices are paid under OPPS and therefore are no longer payable under the DME Orthotic/Prosthetic fee schedules. The following are the appropriate HCPCS codes for payment under OPPS:

- Implanted DME: E0749, E0782, E0783, E0785
- Implanted Prosthetic Devices: E0751, E0753, L8600, L8603, L8610, L8612, L8613, L8614, L8630, L8641, L8642, L8658, L8670, L8699
- Implanted Diagnostic Device: C1361

Effective with claims with dates of service on or after August 1, 2000, hospitals under OPPS do not bill the local carrier for these services.

200 - Billing for Corneal Tissue

(Rev. 1, 10-03-03)

Corneal tissue will be paid on a cost basis, not under OPPS. To receive cost based reimbursement hospitals must bill charges for corneal tissue using HCPCS code V2785.

210 - Hospital-Based End Stage Renal Dialysis (ESRD) Facility Billing

(Rev. 1, 10-03-03)

A-01-93, A-03-066

Effective with claims with dates of service on or after August 1, 2000, hospital-based ESRD facilities must submit ESRD dialysis and those items and services directly related to dialysis (e.g., drugs, supplies) on a separate claim from services not related to ESRD. Items and services not related to the dialysis must be billed by the hospital using the hospital bill type. ESRD related services use the ESRD bill type. This requirement is necessary to properly pay the unrelated ESRD services under OPPS.

220 - Billing Codes for Intensity Modulated Radiation Therapy (IMRT) and Stereotactic Radiosurgery

(Rev. 1, 10-03-03)

A-00-42

Effective for services furnished on or after April 1, 2002, codes G0174 and G0178 are no longer valid codes. Hospitals must use CPT code 77301 for IMRT planning and CPT code 77418 for IMRT delivery. Any of the CPT codes 77401 through 77416 or 77418 may be reported on the same day as long as the services are furnished at a separate treatment sessions. In these cases, modifier -59 must be appended to the appropriate codes.

220.1 - Billing for IMRT Planning and Delivery

(Rev. 1, 10-03-03)

A-02-026

Effective for services furnished on or after April 1, 2002, codes G0174, and G0178 are no longer valid codes. Hospitals must use CPT code 77301 for IMRT planning and CPT code 77418 for IMRT delivery. Any of the CPT codes 77401 through 77416 or 77418 may be reported on the same day as long as the services are furnished at a separate treatment sessions. In these cases, modifier -59 must be appended to the appropriate codes.

220.2 - Billing for Multi-Source Photon Stereotactic Radiosurgery (SR) Planning and Delivery

(Rev. 1, 10-03-03)

A-02-026

Effective for services furnished on or after April 1, 2002, hospitals must bill for multi-source photon SR planning and delivery using HCPCS codes G0242 for planning and G0243 for delivery. Services represented by CPT codes 77401 through 77416 should never be reported on the same day as code G0243, unless the services were furnished at a separate treatment session.

G0242	Multi-source Photon Stereotactic Radiosurgery (Cobalt 60 multi-source converging beams) plan, including dose volume histograms for target and critical structure tolerances, plan optimization performed for highly conformal distributions, plan positional accuracy and dose verification, all lesions treated, per course of treatment.
G0243	Multi-source Photon Stereotactic Radiosurgery, delivery including collimator changes and custom plugging, complete course of treatment, all lesions.

220.3 - Billing for Linear Accelerator (Gantry or Image Directed) SR Planning and Delivery

(Rev. 1, 10-03-03)

Effective for services furnished on or after April 1, 2002, hospitals must bill for gantry or image directed linear accelerator SR using G0242 for planning. Hospitals must bill G0173 for delivery if the delivery occurs in one session, and G0251 for delivery per session (not to exceed five sessions) if delivery occurs during multiple sessions.

G0173	Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, complete course of treatment in one session, all lesions.
G0251	Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum 5 sessions per course of treatment.

NOTE: Although Code G0251 is effective on April 1, 2002, the Outpatient Code Editor or the OPPS Pricer will not recognize the code until July 1, 2002. Therefore, FIs instruct hospitals to either hold all bills that contain this code and submit the bills after July 1, 2002, or submit bills but omit this code and submit an adjustment bill reflecting this service after July 1, 2002.

220.4 - Additional Billing Instructions for IMRT and SR Planning

(Rev. 1, 10-03-03)

A-02-026

Payment for the services identified by CPT codes 77280 through 77295, 77300, and 77305 through 77321, 77336, and 77370 are included in the APC payment for IMRT and SR planning. These codes should not be billed in addition to 77301 and G0242.

Payment for IMRT and SR planning does not include payment for services described by CPT codes 77332 through 77334. When provided, these services should be billed in addition to the IMRT and SR planning codes 77301 and G0242.

Payment for CPT code 20660 is included in G0243; therefore, hospitals should not report 20660 separately.

230 - Billing for Drugs and Biologicals

(Rev. 1, 10-03-03)

A-03-066, A3-3626, A-01-50

Most drugs are packaged under OPPS. Their costs are recognized and captured but paid as part of the service with which they were billed in the base year, 1996. Certain drugs, however, are paid separately. These include chemotherapeutic agents and the supportive and adjunctive drugs used with them, immunosuppressive drugs, orphan drugs, radiopharmaceuticals, and certain other drugs such as those given in the emergency room for heart attacks. These drugs and the codes used to bill for them are listed in Addendum B of the Final Rule and on CMS' Web site, http://www.cms.hhs.gov/. The classes of drugs required to have "pass through" payments made under BBRA (chemotherapeutic agents and the supportive and adjunctive drugs used with them, immunosuppressive drugs, orphan drugs, radiopharmaceuticals, and some new drugs) have coinsurance amounts that can be less than 20 percent of the Average Wholesale Price (AWP). This is because pass-through amounts, by law, are not subject to coinsurance. We consider the amount of the payment rate that exceeds the estimated acquisition cost of the drug to be the pass-through amount. Thus, the coinsurance is based on a portion of the payment rate, not the full payment rate. Drugs should be billed in multiples of the dosage, rounded up, associated with the covered code.240 - Inpatient Part B Services

240 - Inpatient Part B Hospital Services

Inpatient Part B services which are paid under OPPS include:

- Diagnostic x-ray tests, and other diagnostic tests (excluding clinical diagnostic laboratory tests);

- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;
- Surgical dressings applied during an encounter at the hospital and splints, casts, and other devices used for reduction of fractures and dislocations (splints and casts, etc., include dental splints);
- Implantable prosthetic devices;
- Hepatitis B vaccine and its administration, and certain preventive screening services (pelvic exams, screening sigmoidoscopies, screening colonoscopies, bone mass measurements, and prostate screening.)

NOTE: Payment for some of these services is packaged into the payment rate of other separately payable services.

Inpatient Part B services paid under other payment methods include:

- Clinical diagnostic laboratory tests, prosthetic devices other than implantable ones and other than dental which replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices;
- Leg, arm, back and neck braces; trusses and artificial legs; arms and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition; take home surgical dressings; outpatient physical therapy; outpatient occupational therapy; and outpatient speech pathology services;
- Ambulance services;
- Screening pap smears, screening colorectal tests, and screening mammography.
- Influenza virus vaccine and its administration, pneumococcal vaccine and its administration.

See Chapter 6 of the Medicare Benefit Policy Manual for a discussion of the circumstances under which the above services may be covered as Part B Inpatient services.

250 - Special Rules for Critical Access Hospital Outpatient Billing

(Rev. 41, 12-08-03)

A3-3610.19, ***A3-3610.22.B***
See Business Requirements at http://www.medicaid.com/manuals/pm_trans/R41CP.pdf

For cost reporting periods beginning before October 1, 2000, a CAH will be paid for outpatient services under the method in *§250.1*. The BIPA legislation on payment for professional services at 115 percent of what would otherwise be paid under the fee schedule is effective for services furnished on or after July 1, 2001. This provision was implemented with respect to cost reporting periods starting on or after October 1, 2001.

For cost reporting periods beginning on or after October 1, 2001, the CAH will be paid under the method in item 1 below unless it elects to be paid under the method in §250.1.

If a CAH elects payment under the elective method (cost-based facility payment plus fee schedule for professional services) for a cost reporting period, that election is effective for the entire cost reporting period to which it applies. If the CAH wishes to change an election, that election should be made in writing by the CAH, to the appropriate FI, 60 days in advance of the beginning of the affected cost reporting period.

All outpatient CAH services, other than pneumococcal pneumonia vaccines, influenza vaccines, administration of the vaccines, screening mammograms, and clinical diagnostic laboratory tests are subject to Part B deductible and coinsurance. Regardless of the payment method applicable for a period, payment for outpatient CAH services is not subject to the following payment principles:

- Lesser of cost or charges,
- Reasonable compensation equivalent (RCE) limits,
- Any type of reduction to operating or capital costs under 42 CFR 413.124 or 413.30(j)(7), or
- Blended payment rates for ASC-type, radiology, and other diagnostic services.

The mammography services are not exempt from the "lower than" rules. However, see §250.4 below regarding payment for screening mammography services.

250.1 - *Standard Method - Cost-Based Facility Services, With Billing of Carrier for Professional Services*

(Rev. 41, 12-08-03)

Payment for outpatient CAH services under this method will be made for 80 percent of the reasonable cost of the CAH in furnishing those services, after application of the Part B deductible. Payment for professional medical services furnished in a CAH to CAH

outpatients is made by the carrier on a fee schedule, charge, or other fee basis, as would apply if the services had been furnished in a hospital outpatient department. For purposes of CAH payment, professional medical services are defined as services provided by a physician or other practitioner, e.g., a physician assistant that could be billed directly to a carrier under Part B of Medicare or a nurse practitioner that could be billed directly to a carrier under Part B of Medicare.

In general, payment for professional medical services, under the cost-based CAH payment plus professional services billed to the carrier method should be made on the same basis as would apply if the services had been furnished in the outpatient department of a hospital.

Bill type 85X is used for all outpatient services including services approved as ASC services. Referenced diagnostic services will continue to be billed on a 14X type of bill.

250.2 - Optional Method for Outpatient Services: Cost-Based Facility Services Plus 115 percent Fee Schedule Payment for Professional Services

(Rev. 41, 12-08-03)

R1870.A.3, A3-3610.22

The BIPA legislation on payment for professional services at 115 percent of what would otherwise be paid under the fee schedule is effective for services furnished on or after 1, 2001. A CAH may elect to be paid for outpatient services in any cost reporting period under this method. An election of this payment method, once made for a cost reporting period, remains in effect for all of that period and applies to all CAH services furnished in the CAH outpatient department during that period. Under this election a CAH will receive payment for all professional services received in that CAH's outpatient department (all licensed professionals who otherwise would be entitled to bill the carrier under Part B).

Payment to the CAH for each outpatient visit will be the sum of the following:

- For facility services, not including physician or other practitioner, payment will be the reasonable costs of the services. On the Form CMS-1450, (or electronic equivalent) list the facility service(s) rendered to outpatients along with the appropriate revenue code. Pay the amount equal to the sum of 80 percent of its reasonable costs of its outpatient services after application of the Part B deductible and coinsurance, plus

- On a separate line, list the professional services, along with the appropriate HCPCS code (physician or other practitioner) and in one of the following revenue codes - 096X, 097X, or 098X.

    - Use the Medicare Physician Fee Schedule (MPFS) supplementary file, established for use by the CORF, and the CORF Abstract File, to pay for

all the physician/professional services rendered in a CAH that elected the all-inclusive method. The FI will pay 115 percent of whatever Medicare would pay of the physician fee schedule. (The fee schedule amount, after applicable deductions, will be multiplied by 1.15 percent.) Payment for nonphysician practitioners will be 115 percent of 85 percent of the allowable amount under the physician fee schedule; and

- Outpatient services, including ASC, rendered in an all-inclusive rate provider method should be billed using the 85X type of bill. Referenced diagnostic services (non-patients) are billed on bill type 14X.

The Medicare Physician Fee Schedule (MPFS) supplementary file and the CORF Abstract File are used for payment of all physician/professional services rendered in a CAH that has elected the optional method. The data in the supplemental file will be in the same format as the abstract file.

If a nonphysician (e.g., Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist) renders a service, the "GF" modifier must be on the applicable line. **The "GF" modifier is not to be used for CRNA services. If a claim is received and it has the "GF" modifier for CRNA services, the claim is returned the claim to the provider.**

Health Professional Shortage Area (HPSA) Incentive Payments for Physicians.- In accordance with §1833(m) of the Social Security Act, physicians who provide covered professional services in any rural or urban HPSA are entitled to an incentive payment. Physicians providing services in either rural or urban HPSAs are eligible for a 10-percent incentive payment. It is not enough for the physician merely to have his/her office or primary service location in a HPSA, nor must the beneficiary reside in a HPSA, although frequently this will be the case. The key to eligibility is where the service is actually provided (place of service). For example, a physician providing a service in his/her office, the patient's home, or in a hospital, qualifies for the incentive payment as long as the specific location of the service provision is within an area designed as a HPSA. On the other hand, a physician may have an office in a HPSA but go outside the office (and the designated HPSA area) to provide the service. In this case, the physician would not be eligible for the incentive payment.

*If the CAH electing the Optional Method (Method II) is located within a HPSA, the physicians providing (outpatient) professional services in the CAH are eligible for HPSA physician incentive payments. Therefore, payments to such a CAH for professional services of physicians in the outpatient department will be 115 percent **times** the amount payable under fee schedule times 110 percent. An approved Optional Method CAH that is located in a HPSA County should notify you of its HPSA designation **in writing**. Once you receive the information, place an indicator on the provider file showing the effective date of the CAH's HPSA status. One of the following modifiers must be on the claim along with the physician service:*

- *QB - physician providing a service in a rural HPSA; or*
- *QU - physician providing a service in an urban HPSA.*

The HPSA incentive payment is 10 percent of the amount actually paid, not the approved amount. Do not include the incentive payment in each claim. Create a utility file so that you can run your paid claims file for a quarterly log. From this log you will send a quarterly report with the following information to the CAHs for each physician payment, one month following the end of each quarter. The sum of the "10% of line Reimbursement" column should equal the payment sent along with the report to the CAH. If any of the claims included on report are adjusted, be sure the adjustment also goes to the report. If an adjustment request is received after the end of the quarter, any related adjustment by the FI will be included on next quarter's report. CAHs must be sure to keep adequate records to permit distribution of the HPSA bonus payment when received. The required format for the quarterly report:

Quarterly HPSA Report for CAHs

Provider Number	*Beneficiary HICN*	*DCN*	*Rev. Code*	*HCPCS*	*LIDOS*	*Line Item Payment Amount*	*10% of Line Payment Amount*
123456	*Abcdefghijk*	*xxxxxxxxx*	*xxx*	*12345*	*3/2/03*	*$1000.00*	*$100.00*
789012	*Lmnopqrstu*		*xxx*	*67890*	*10/30/02*	*$5378.22*	*$537.82*

Use the information in the Professional Component/Technical Component (PC/TC) indicator field of the CORF extract of the Medicare Physician Fee Schedule Supplementary File to identify professional services eligible for HPSA bonus payments. The following are the rules to apply in determining whether to pay the bonus on services furnished within a geographic HPSA and billed with a QB or QU modifier, as appropriate.

(Field 20 on the full MPFS file layout)

PC/TC Indicator	*HPSA Payment Policy*
0	Physician services. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. ACTION: *Pay the HPSA bonus.*
1	*Globally billed. Only the professional component of this service qualifies for the HPSA bonus payment. The HPSA bonus cannot be paid on the technical component of globally billed services.* *ACTION: Return the service as unprocessable. Instruct the provider to re-bill the service as separate professional and technical component revenue codes. The HPSA modifier should only be used with the professional*

component code. Do not pay the incentive payment unless the professional component can be separately identified.

2 *Professional Component only.*
ACTION: Pay the bonus.

3 *Technical Component only.*
ACTION: Do not pay the bonus

4 *Global test only. (See 1 above)*

5 *Incident to codes.*
ACTION: Do not pay the bonus.

6 *Laboratory physician interpretation codes.*
ACTION: Pay the bonus.

7 *Physical therapy service.*
ACTION: Do not pay the bonus.

8 *Physician interpretation codes.*
ACTION: Pay the bonus.

9 (Status of "X" *Concept of PC/TC does not apply.*
ACTION: Do not pay the bonus.

NOTE: *Codes that have a status of "X" on the CORF extract Medicare Physician Fee Schedule Database (MFSDB) have been assigned PC/TC indicator 9 and are not considered physician services for MFSDB payment purposes. Therefore, the HPSA bonus payment will not be paid for these codes.*

250.3 - Payment for Anesthesia in a Critical Access Hospital (CAH)

(Rev 41, 12-08-03)

Payment for anesthesia services is based on the HCPCS FILE, the Anesthesia Conversion Factor File, and the CORF extract of the MPFS Summary File.

250.3.1 – Anesthesia File

(Rev. 41, 12-08-03)

Conversion Factor File = MU00.@BF12390.MPFS.CY04.ANES.V1023

Record Layout for the Anesthesia Conversion Factor File

Data Element Name	Picture	Location	Length

Data Element Name	Picture	Location	Length
Carrier Number	X (5)	1-5	5
Locality Number	X (2)	13-14	2
Locality Name	X (30)	19-48	30
Anesthesia CF 2002	99V99	74-77	4

250.3.2 – Physician Rendering Anesthesia in a Hospital Outpatient Setting

(Rev. 41, 12-08-03)

When a medically necessary anesthesia service is furnished within a HPSA area by a physician, a HPSA bonus is payable. In addition to using the PC/TC indicator on the CORF extract of the MPFS Summary File to identify HPSA services, pay physicians the HPSA bonus when CPT codes 00100 through 01999 are billed with the following modifiers: QY, QK, AA, or GC and "QB" or "QU" in revenue code 963. The modifiers signify that a physician performed an anesthesia service. Using the Anesthesia File (See Section above) the physician service will be 115 percent times the payment amount to be paid to a CAH on Method payment plus 10 percent HPSA bonus payment.

Anesthesiology modifiers:

AA = anesthesia services performed personally by anesthesiologist.
GC = service performed, in part, by a resident under the direction of a teaching physician.
QK = medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.
QY = medical direction of one CRNA by an anesthesiologist.

Modifiers AA and GC result in physician payment at 80% of the allowed amount.
Modifiers QK and QY result in physician payment at 50% of the allowed amount.

Data elements needed to calculate payment:

- *HCPCS plus Modifier,*
- *Base Units,*
- *Time units, based on standard 15 minute intervals,*
- *Locality specific anesthesia Conversion factor, and*
- *Allowed amount minus applicable deductions and coinsurance amount.*

***Formula 1**: Calculate payment for a physician performing anesthesia alone*

HCPCS = xxxxx

Modifier = AA
Base Units = 4
Anesthesia Time is 60 minutes. Anesthesia time units = 4 (60/15)
Sum of Base Units plus Time Units = 4 + 4 = 8
Locality specific Anesthesia conversion factor = $17.00 (varies by localities)
Coinsurance = 20%

Example 1: *Physician personally performs the anesthesia case*

Base Units plus time units - 4+4=8
Total units multiplied by the anesthesia conversion factor times .80
8 x $17= ($136.00 – (deductible) x .80 = $108.80*
Payment amount times 115 percent for the CAH method II payment.
$108.80 x 1.15 = $125.12 (Payment amount)
$125.12 x .10 = $12.51 (HPSA bonus payment)

**Assume the Part B deductible has already been met for the calendar year*

Formula 2*: Calculate the payment for the physician's medical direction service when the physician directs two concurrent cases involving CRNAs. The medical direction allowance is 50% of the allowance for the anesthesia service personally performed by the physician.*

HCPCS = xxxxx
Modifier = QK
Base Units = 4
Time Units 60/15=4
Sum of base units plus time units = 8
Locality specific anesthesia conversion factor = $17(varies by localities)
Coinsurance = 20 %

(Allowed amount adjusted for applicable deductions and coinsurance and to reflect payment percentage for medical direction).

Example 2: *Physician medically directs two concurrent cases involving CRNAs*

Base units plus time - 4+4=8
Total units multiplied by the anesthesia conversion factor times .50 equal allowed amount minus any remaining deductible

8 x $17 = $136 x .50 = $68.00 –(deductible) = $68.00*

Allowed amount Times 80 percent times 1.15
$68.00 x .80 = $54.40 x 1.15 = 62.56 (Payment amount)
$62.56 x .10 = $6.26 (HPSA bonus payment)

**Assume the deductible has already been met for the calendar year.*

250.3.3 - CRNA Services (CRNA Pass-Through Exemption of 115 percent Fee Schedule Payments for CRNA Services)

(Rev. 41, 12-08-03)

If a CAH that meets the criteria for a pass-through exemption is interested in selecting the Method II option, it can choose this option for all outpatient professionals except the CRNA's and still retain the approved CRNAs exemption for both inpatient and outpatient professional services of CRNAs. The CAH, with an approved exemption, can choose to give up its exemption for both inpatient and outpatient professional services of CRNAs in order to include its CRNA outpatient professional services along with those of all other professional services under the Method II option. By choosing to include the CRNAs under the Method II for outpatient services, it loses its CRNA pass-through exemption for not only the outpatient CRNA services, but also the inpatient CRNA services. In this case the CAH would have to bill the Part B carrier for the CRNA inpatient professional services.

Provider Billing Requirements for Method I - CRNA Services

Billing requirement

TOB = 85X

Revenue Code = 37X for CRNA technical services

Value code = Blank

Reimbursement

Revenue Code 37X = CRNA technical service - Cost Reimbursement

Deductible and coinsurance apply.

Provider Billing Requirements for Method II CRNA Services

TOB = 85X

Revenue Code = 37X for CRNA Technical service

Revenue Code = 964 for CRNA Professional service

HCPCS Code = Anesthesia HCPCS code (00100 through 01999 HCPCS range)

Units = Anesthesia

Reimbursement

Revenue Code 37X for CRNA Technical = cost reimbursement

Revenue Code 964 for CRNA Professional = 50% of Allowed Amount times 115%; or

Revenue Code 964 and the "QZ" modifier for non-medically directed CRNA Professional = 80% of Allowed Amount times 115%

How to calculate payment for anesthesia claims based on the formula

Identify anesthesia claims by HCPCS code range from 00100 through 01999

Add the anesthesia code base unit and time units. The time units are calculated by dividing actual anesthesia time (Units field on the UB92) by 15. Multiply the sum of base and time units by the locality specific anesthesia conversion factor (file name below).

The Medicare program pays the CRNA 80% of this allowable charge (non-medically directed). Deductible and coinsurance apply.

If the CRNA is medically directed, pay 50% of the allowable charge. Deductible and coinsurance apply.

Base Formula

Number of minutes divided by 15, plus the base units = Sum
Sum times the conversion factor = allowed amount

Source

Number of minutes = Number of units on the claim (Units field of the UB92)
Base Units = Anesthesia HCPCS

Conversion Factor = File – MU00.@BF12390.MPFS.CY04.ANES.V1023

250.*4* - CAH Outpatient Services Part B Deductible and Coinsurance

(Rev. 41, 12-08-03)

3610.22.C

Payment for outpatient services of a CAH is subject to applicable Part B deductible and coinsurance amounts, except as follows:

A - Part B of Medicare pays 100 percent for pneumococcal pneumonia vaccines (PPV) and influenza virus vaccines and their administration. Payment is on a reasonable cost basis. Deductible and coinsurance does not apply. Part B of Medicare also covers the reasonable cost of hepatitis B vaccine and its administration. Deductible and coinsurance apply.

B - For claims with dates of service on or after January 1, 2002, §104 of the Benefit Improvement and Protection Act (BIPA) 2000, provides for payment of screening mammography under the Medicare Physician Fee Schedule (MPFS) for such services furnished in hospitals, skilled nursing facilities (SNFs), and in CAHs not electing the optional method of payment for outpatient services.

Method I (Standard)

CAHs paid under the standard method bill the **technical** component (CPT codes 76092 or G0202 and 76085) using revenue code 403 and Type of Bill (TOB) 85X. The contractor pays for these services at 80 percent of the lesser of the fee schedule amount or the actual charges.

Professional component services (CPT codes G0202 or 76092 and 76085 (Use 76085 in conjunction with code 76092)) in standard-method CAHs are billed by the physician to the carrier and are paid at 80 percent of the lesser of the fee schedule amount or the actual charges. The payment for code 76092 is equal to the lower of the actual charge or the locality specific technical component payment amount under the MPFS. Program payment for the service is 80 percent of the lower amount and coinsurance is 20 percent. This is a final payment.

Method II (Optional Method)

For CAHs that elected the optional method of payment for outpatient services, the payment for **technical** services would be the same as the CAHs that did not elect the optional method. TOB 85X and revenue code 403 are used for the technical service.

However, the **professional** component is paid at 115 percent of the lesser of fee schedule amount or actual charge. There is no deductible but coinsurance is applicable.

CAHs electing the optional method of outpatient payment will bill the professional amount for CPT codes G0202, or 76092 and 76085 (Use 76085 in conjunction with 76092) using revenue code 97X. These services are paid at 115 percent of 80 percent (that is, 92 percent) of the lesser of the fee schedule amount or the actual charge.

Regardless of the payment method that applies under paragraph B, payments for clinical diagnostic laboratory tests furnished to CAH outpatients on or after November 29, 1999, are made on a reasonable cost basis with no beneficiary cost-sharing – no coinsurance, deductible, copayment, or any other cost-sharing.

250.5 - Medicare Payment for Ambulance Services Furnished by Certain CAHs

(Rev. 41, 12-08-03)

A-01-52

Ambulance services furnished on or after December 21, 2000, by eligible CAHs will be paid on a reasonable cost basis. Eligible CAHs will continue to be paid based on reasonable cost after implementation of the ambulance fee schedule.

Section 205 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 exempts certain CAHs from the current Medicare ambulance cost per trip payment limit as well as from the ambulance fee schedule. Section 205(a) of BIPA states:

> The Secretary shall pay the reasonable costs incurred in furnishing ambulance services if such services are furnished (A) by a CAH (as defined in §1861(mm)(1)), or (B) by an entity that is owned and operated by a CAH, but only if the CAH or entity is the only provider or supplier of ambulance services that is located within a 35-mile drive of such CAH.

This provision is effective for ambulance services furnished on or after December 21, 2000.

250.6 - Clinical Diagnostic Laboratory Tests Furnished by CAHs

(Rev. 41, 12-08-03)

A-01-31, A-01-68

Medicare beneficiaries are not liable for any coinsurance, deductible, copayment, or other cost sharing amount for clinical diagnostic laboratory services furnished as a CAH outpatient service.

Effective for services furnished on or after November 29, 1999, CAHs are excluded from the lab fee schedule for outpatient clinical diagnostic lab services. Payment is made under reasonable cost. Lab services provided by CAHs before November 29, 1999, were paid under the clinical diagnostic fee schedule.

CAH clinical diagnostic lab services provided for nonpatients of the CAH **are** paid under the lab fee schedule.

260 - Outpatient Partial Hospitalization Services

(Rev. 1, 10-03-03)

A3-3661, A-01-93

Medicare Part B coverage is available for outpatient partial hospitalization services provided by hospitals, CAHs, and CMHCs.

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

(Rev. 1, 10-03-03)

A3-3651, A3-3661

Section 1861 of the Act defines the services under the partial hospitalization benefit in a hospital or CAH outpatient setting.

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 and 4600-4799. See §260.7 for CMHC partial hospitalization bill review directions.

Hospitals and CAHs report condition code 41 in FLs 24-30 (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 HCPCS code for this benefit.

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
0904	Activity Therapy
0910	Psychiatric/Psychological Services
0914	Individual Therapy
0915	Group Therapy

Revenue Code	Description
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
0904	Activity Therapy (Partial Hospitalization)	**G0176
0910	Psychiatric General Services	90801, 90802, 90899
0914	Individual Psychotherapy	90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, or 90829
0915	Group Therapy	90849, 90853, or 90857
0916	Family Psychotherapy	90846, 90847, or 90849
0918	Psychiatric Testing	96100, 96115 or 96117
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 day,

**The definition of code G0176 is as follows:

> Activity therapy, such as music, dance, art or play therapies not for recreation, related to care and treatment of patient's disabling mental problems, per session (45 minutes or more).

***The definition of code G0177 is as follows:

> Training and educational services related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more).

Codes G0129, G0176, and G0177 are used only for partial hospitalization programs.

Revenue code 250 does not require HCPCS coding. However, Medicare does not cover drugs that can be self-administered.

260.2 - Professional Services Related to Partial Hospitalization

(Rev. 1, 10-03-03)

A3-3661

The professional services listed below when provided in a hospital or CAH outpatient department are separately covered and paid as the professional services of physicians and other practitioners. These professional services are unbundled and these practitioners (other than physician assistants (PA)) bill the Medicare Part B carrier directly for the professional services furnished to hospital outpatient partial hospitalization patients. The hospitals or CAHs can also serve as a billing agent for these professionals by billing the Part B carrier on their behalf under their billing number for their professional services. Only a PA's employer can bill the carrier for professional services of a PA.

The following direct professional services are unbundled and not paid as partial hospitalization services:

- Physician services that meet the criteria of 42 CFR 415.102, for payment on a fee schedule basis;
- Physician assistant (PA) services as defined in §1861(s)(2)(K)(i) of the Act;
- Nurse practitioner and clinical nurse specialist services, as defined in §1861(s)(2)(K)(ii) of the Act; and
- Clinical psychologist services as defined in §1861(ii) of the Act.

The services of other practitioners (including clinical social workers and occupational therapists), are bundled when furnished to hospital or CAH patients, including partial hospitalization patients. The hospital or CAH must bill their FI for such nonphysician

practitioner services as partial hospitalization services. Payment is made to the provider for these services.

Only the actual employer of the PA can bill for these services. The employer of a PA may be such entities or individuals such as a physician, medical group, professional corporation, hospital, SNF, or nursing facility. For example, if a physician is the employer of the PA and the PA renders services in the hospital or CAH, the physician and not the hospital or CAH is responsible for billing the carrier on the Form CMS-1500 for the services of the PA.

260.3 - Outpatient Mental Health Treatment Limitation for Partial Hospitalization Services

(Rev. 1, 10-03-03)

A-01-93

The outpatient mental health treatment limitation applies to services to partial hospitalization patients to treat mental, psychoneurotic, and personality disorders when furnished by physicians, clinical psychologists, NPs, CAHs, and PAs. It does not apply to such mental health treatment services billed to the FI by a CMHC, hospital or CAH as partial hospitalization services.

260.4 - Reporting Service Units for Partial Hospitalization

(Rev. 1, 10-03-03)

A3-3661

Hospitals report number of times the service or procedure, as defined by the HCPCS code, was performed. CAHs report the number of times the revenue code visit was performed**.**

EXAMPLE

A beneficiary received psychological testing (HCPCS code 96100 which is defined in one-hour intervals) for a total of three hours during one day. The hospital reports revenue code 0918 in FL 42, HCPCS code 96100 in FL 44, and three units in FL 46. The CAH would report revenue code 0918, leave HCPCS blanks, and report 1 unit in FL 46.

When reporting service units for HCPCS codes where the definition of the procedure does not include any reference to time (either in minutes, hours, or days), hospital outpatient departments do not bill for sessions of less than 45 minutes.

The FI must return to the provider claims other than CAH claims that do not contain service units for each HCPCS code.

Also, FIs return to the provider claims that contain more than one unit for HCPCS codes G0129, Q0082, and G0172.

NOTE: Service units do not need to be reported for drugs and biologicals (Revenue Code 0250).

Hospitals must retain documentation to support the medical necessity of each service provided, including beginning and ending time.

260.5 - Line Item Date of Service Reporting for Partial Hospitalization

(Rev. 1, 10-03-03)

A3-3661

Hospitals other than CAHs are required to report line item dates of service per revenue code line for partial hospitalization claims. Where services are provided on more than one day included in the billing period, the date of service must be identified. Each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. See examples below of reporting line item dates of service. These examples are for group therapy services provided twice during a billing period.

For the UB-92 flat file, report as follows:

Record Type	Revenue Code	HCPCS	Dates of Service	Units	Total Charges
61	0915	90849	19980505	1	$80.00
61	0915	90849	19980529	2	$160.00

For the hardcopy UB-92 (CMS-1450), report as follows:

FL42	**FL44**	**FL45**	**FL46**	**FL47**
0915	90849	050598	1	$80.00
0915	90849	052998	2	$160.00

For the Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, report as follows:

LX*1~

SV2*0915*HC:90849*80*UN*1~

DTP*472*D8*19980505~

LX*2~

SV2*0915*HC:90849*160*UN*2~

DTP*472*D8*19980529~

The FI must return to the hospital (RTP) claims where a line item date of service is not entered for each HCPCS code reported, or if the line item dates of service reported are outside of the statement covers period. Line item date of service reporting is effective for claims with dates of service on or after June 5, 2000.

260.6 - Payment for Partial Hospitalization Services

(Rev. 1, 10-03-03)

A3-3661

For hospital outpatient departments, the FI makes payments on a reasonable cost basis until August 1, 2000 for partial hospitalization services. The Part B deductible and coinsurance apply. During the year, the FI will make payment at an interim rate based on a percentage of the billed charges. At the end of the year, the hospital will be paid at the reasonable cost incurred in furnishing partial hospitalization services, based upon the Medicare cost report filed with the FI.

Beginning with services provided on or after August 1, 2000, payment is made under the hospital outpatient prospective payment system for partial hospitalization services.

For CAHs, payment is made on a reasonable cost basis regardless of the date of service.

The Part B deductible, if any, and coinsurance apply.

260.7 - Bill Review for Partial Hospitalization Services Provided in Community Mental Health Centers (CMHC)

(Rev. 1, 10-03-03)

A3-3651

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 and 4600-4799.

C - Billing Requirements

CMHCs bill for partial hospitalization services on Form CMS-1450 or electronic equivalent under bill type 76X. FIs follow bill review instructions in Chapter 25 except for those listed below.

The acceptable revenue codes are as follows:

Code	Description
0250	Drugs and Biologicals
043X	Occupational Therapy
0904	Activity Therapy
0910	Psychiatric/Psychological Services
0914	Individual Therapy
0915	Group Therapy
0916	Family Therapy
0918	Testing
0942	Education Training

CMHCs are also required to report appropriate HCPCS codes as follows:

Revenue Codes	Description	HCPCS Code
043X	Occupational Therapy (Partial Hospitalization)	*G0129
0904	Activity Therapy (Partial Hospitalization)	**G0176
0910	Psychiatric General Services	90801, 90802, 90899
0914	Individual Psychotherapy	90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, or 90829
0915	Group Psychotherapy	90849, 90853, or 90857

Revenue Codes	Description	HCPCS Code
0916	Family Psychotherapy	90846, 90847, or 90849
0918	Psychiatric Testing	96100, 96115, or 96117
0942	Education Training	***G0177

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 day.

**The definition of code G0176 is as follows:

> Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more).

***The definition of code G0177 is as follows:

> Training and educational services related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more).

Codes G0129, G0176, and G0177 are used only for partial hospitalization programs.

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.

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.

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 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.

PA services can be billed only by the actual employer of the PA. 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.

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 Form Locator (FL) 46, "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 one hour intervals) for a total of three hours during one day. The CMHC reports revenue code 0918 in FL 42, HCPCS code 96100 in FL 44, and "three" units in FL 46.

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 FI returns to the provider claims that contain more than one unit for HCPCS codes G0129, Q0082, and G0172 or that do not contain service units for a given HCPCS code.

NOTE: The CMHC need not report service units for drugs and biologicals (Revenue Code 0250)

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 FL 45 "Service Date" (MMDDYY). See examples below of reporting line item dates of service. These examples are for group therapy services provided twice during a billing period.

For the UB-92 flat file as well as the HIPAA 837, FIs report as follows:

Record Type	Revenue Code	HCPCS	Dates of Service	Units	Total Charges
61	0915	90849	19980505	1	$80
61	0915	90849	19980529	2	$160

For the hardcopy UB-92 (CMS-1450), FIs report as follows:

FL 42	FL 44	FL 45	FL 46	FL 47
0915	90849	050598	1	$80
0915	90849	052998	2	$160

For the Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, FIs report as follows:

LX*1~

SV2*0915*HC:90849*80*UN*1~

DTP*472*D8*19980505~

LX*2~

SV2*0915*HC:90849*160*UN*2~

DTP*472*D8*19980529~

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 05, 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. FIs are to furnish each CMHC with one copy of that manual.

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.

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

FIs follow medical review guidelines in the Medicare Program Integrity Manual.

I - Coordination With CWF

See Chapter 27. 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.

270 - Billing for Hospital Outpatient Services Furnished by Clinical Social Workers (CSW)

(Rev. 1, 10-03-03)

A3-3662

Payment may be made for covered diagnostic and therapeutic services furnished by CSWs in a hospital outpatient setting. CSW services furnished under a partial hospitalization program are included in the partial hospitalization rate. Other CSW services must be billed to the carrier on Form CMS-1500 or the electronic equivalent.

See Chapters 13 and 15 of the Medicare Benefit Policy Manual for a discussion of the coverage requirements for CSW.

270.1 - Fee Schedule to be Used for Payment for CSW Services

(Rev. 1, 10-03-03)

The fee schedule for CSW services is set at 75 percent of the fee schedule for comparable services furnished by **clinical** psychologists, except for services under a CAH partial hospitalization program. These are paid on a reasonable cost basis.

270.2 - Outpatient Mental Health Payment Limitation for CSW Services

(Rev. 1, 10-03-03)

CSW services are subject to the outpatient mental health services limitation in §1833 of the Act. The imitation of 62.5 percent is applied to the lesser of the actual charge or fee schedule amount. Diagnostic services are not subject to the limitation.

270.3 - Coinsurance and Deductible for CSW Services

(Rev. 1, 10-03-03)

The annual Part B deductible and the 20 percent coinsurance apply to CSW services.

280 - Hospital-Based Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Billing for Non RHC/FQHC Services

(Rev. 1, 10-03-03)

A-01-93, A-03-066

Hospitals sometimes operate hospital based RHCs or FQHCs. Prior to implementation of outpatient PPS, hospital based RHCs/FQHCc were permitted to include both RHC/FQHC and non-RHC/FQHC services on the same claim, under the RHC/FQHC bill type, with appropriate revenue codes.

Beginning with the implementation of OPPS, non-RHC/FQHC services provided by the hospital based RHC/FQHC, including RHCs/FQHCs that are parts of CAHs or other exempted or excluded (from OPPS) hospitals, must be billed under the host hospital's provider number, using hospital billing procedures and bill types. These services are not covered or paid as RHC/FQHC services but instead may be covered hospital outpatient services and paid under the applicable methodology for the hospital.

RHC/FQHC services remain subject to the encounter rate payment methodology and are billed using the RHC/FQHC provider number, bill type and revenue codes.

See the Medicare Benefit Policy Manual for a description of covered RHC/FQHC services.

See Chapter 9 in this manual for billing instructions for provider based and independent RHC/FQHC services.

290 - Outpatient Observation Services

(Rev. 1, 10-03-03)

A3-3663, A3-3112.8.D, A-01-91

290.1 - Observation Services

(Rev. 1, 10-03-03)

Observation services are those services furnished by a hospital on the hospital's premises, including use of a bed and **at least** periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. Most observation services do not exceed one day. Some patients, however, may require a second day of outpatient observation services. In only rare and exceptional cases do outpatient observation services span **more** than two calendar days.

A hospital, which believes that exceptional circumstances in a particular case justify approval of additional time in outpatient observation status, may request an exception to the denial of services from the FI. For coverage requirements, see the Medicare Benefit Policy Manual, Chapter 6.

Most outpatient observation services are bundled into the APCs with other services. If outpatient observation services are the **sole** services provided, these are not reimbursed (separately).

Effective April 1, 2002, CMS implemented three APCs designed primarily to recognize and reimburse for outpatient observation services involving three specific conditions: chest pain, asthma, and congestive heart failure (see §§290.4 for additional criteria which must be met).

290.2 - Billing Entries for Observation Services

(Rev. 1, 10-03-03)

A-01-91

Hospitals are required to report observation charges under the following revenue code:

Revenue Code	Description
0762	Observation Room
0760	Treatment/Observation Room (used for routine monitoring and post-operative monitoring.).

HCPCS codes are not required. The appropriate HCPCS codes, if reported, are 99217 through 99220 and 99234 through 99236. The units field should reflect the number of hours the patient is in observation status. Begin counting when the patient is placed in the observation bed. If necessary, they should verify the time in the nurses' notes. Round to the nearest hour. For example, a patient who was placed in an observation bed at 3:03 p.m. according to the nurses' notes and discharged to home at 9:45 p.m. should have a "7" placed in the units field.

When ancillary services are performed while the patient is in observation status, the hospital reports these services under revenue code 0760 "Treatment/Observation Room." Hospitals should not report these services under revenue code 0762. In addition, hospitals should report any laboratory, radiology, etc. services under revenue codes 030X, 031X, 032X etc. as appropriate.

290.3 - Services Not Covered as Observation Services

(Rev. 1, 10-03-03)

A3-3112.8.E

If the hospital has provided noncovered services as defined in the Medicare Benefit Policy Manual, Chapter 6, and given proper notification to the beneficiary, it will show only those charges associated with covered services.

290.4 - Payment for Observation Services Furnished On or After April 1, 2002

(Rev. 1, 10-03-03)

A-02-026, A-03-051

Since the beginning of OPPS, observation services have been packaged services. No separate payment was made for observation services, as the payment for observation was included in the APC payment for the procedure or visit with which it was furnished.

Although observation services continue to be packaged in most situations, the final rule for 2002 provides a separate APC payment for observation that is provided under certain specific conditions. The APC for observation services was effective for services furnished on or after April 1, 2002.

The instructions contained in §290.2 above, remain in effect for all observation services provided prior to April 1, 2002, and continue to be in effect for observation services that do not qualify for separate APC payment on or after April 1, 2002.

A hospital may receive a separate APC payment for observation services for patients having diagnoses of chest pain, asthma, or congestive heart failure, when certain additional criteria are met. So long as each meets the observation criteria, more than one non-overlapping observation is allowed on a single claim and each observation is paid separately.

Hospitals must use the new code G0244 for observation services that meet the criteria for separate payment and must submit the claim using bill type 13X. Observation is not separately paid if a surgical procedure or any service that has a status indicator of "T" under the OPPS occurs on the day before or the day that the patient is admitted to observation.

Effective for services furnished on or after January 1, 2003, when a patient with congestive heart failure, chest pain, or asthma is a "direct admission," hospitals should bill

- * G0263 – Direct admission of patient with diagnosis of congestive heart failure, chest pain, or asthma for observation services that meet all criteria for separate payment, or

- *G0264 – Initial nursing assessment of patient directly admitted to observation with diagnosis of congestive heart failure, chest pain, or asthma or patient directly admitted to observation with diagnosis of congestive heart failure, chest pain, or asthma when the observation stay does not qualify for separate payment

A "direct admission" occurs when a physician in the community reefers a patient to the hospital for observation, bypassing the clinic or emergency department (ED).

* Hospitals should bill G0263 and G0264 with revenue code 0762.

Diagnostic services performed on the day before a patient is admitted to observation are not automatically allowed in meeting the requirement that certain diagnostic tests be performed in order to receive a separate payment for observation services. Hospitals must perform the specified diagnostic services during the period that begins with the date of the E/M visit, or the date the patient is admitted to critical care or directly admitted to observation, and ends when the patient has been in observation for 24 hours.

If the E/M visit that led to the observation is the day before, e.g., overnight ER visit leading to observation, any ancillary tests performed during that E/M visit are allowed toward the observation criteria. However, for patients who are direct admissions to observation from the physician's office, ancillary tests done the day before would be unrelated to the observation period and would not be counted toward meeting the observation criteria.

290.4.1 - Required Diagnoses for Separate Observation APC Payment

(Rev. 1, 10-03-03)

A-02-026

One of the following ICD-9-CM diagnoses must be present on the bill as the principal or secondary diagnosis:

NOTE: Admitting Diagnosis is not a required field for Medicare outpatient claims. Admitting diagnosis will not be taken into account to determine that a patient has a qualifying diagnosis for purposes of paying an APC for observation.

For Chest Pain

Code	Definition	Code	Definition
411.0	Postmyocardial infarction syndrome	411.1	Intermediate coronary syndrome
411.81	Coronary occlusion without myocardial infarction	411.89	Other acute ischemic heart disease
413.0	Angina decubitus	413.1	Prinzmetal angina
413.9	Other and unspecified angina pectoris	786.05	Shortness of breath
786.50	Chest pain, unspecified	786.51	Precordial pain
786.52	Painful respiration	786.59	Other chest pain

For Asthma

Code	Definition	Code	Definition
493.01	Extrinsic asthma with status asthmaticus	493.02	Extrinsic asthma with acute exacerbation
493.11	Intrinsic asthma with status asthmaticus	493.12	Intrinsic asthma with acute exacerbation
493.21	Chronic obstructive asthma with status asthmaticus	493.22	Chronic obstructive asthma with acute exacerbation
493.91	Asthma, unspecified with status asthmaticus	493.92	Asthma, unspecified with acute exacerbation

For Congestive Heart Failure

Code	Definition	Code	Definition
391.8	Other acute rheumatic heart disease	398.91	Rheumatic heart failure (congestive)
402.01	Malignant hypertensive heart disease with congestive heart failure	402.11	Benign hypertensive heart disease with congestive heart failure
402.91	Unspecified hypertensive heart disease with congestive heart failure	404.01	Malignant hypertensive heart and renal disease with congestive heart failure
404.03	Malignant hypertensive heart and renal disease with congestive heart and renal failure	404.11	Benign hypertensive heart and renal disease with congestive heart failure
404.13	Benign hypertensive heart and renal disease with congestive heart and renal failure	404.91	Unspecified hypertensive heart and renal disease with congestive heart failure
404.93	Unspecified hypertensive heart and renal disease with congestive heart and renal failure	428.0	Congestive heart failure
428.1	Left heart failure	428.9	Heart failure, unspecified

290.4.2 - Additional Requirements for Separate Observation APC Payment

(Rev. 1, 10-03-03)

A-02-026

In addition to having one of the above diagnoses on the bill, the following requirements must also be met in order to receive a separate APC payment for observation services:

A - An emergency department visit (APC 0610, 0611, or 0612), a clinic visit (APC 0600, 0601,or 0602), or critical care (APC 620) is billed in conjunction with each bill for observation services. An Emergency Management (E/M) code for the emergency room, clinic visit, or critical care is required to be billed on the day before or the day that the patient is admitted to observation. Both the associated E/M code and the observation are paid separately if the observation criteria are met. Observation services are packaged into the E/M visit if all observation criteria are not met. More than one period of observation is allowed to be billed on a single claim. However each observation period must be paired with a separate E/M visit. The E/M code associated with observation must be billed on the same claim as the observation service.

NOTE: An E/M visit must be billed with a modifier -25 if it has the same date of service as the observation code G0244.

B - The hospital must furnish certain other diagnostic services along with observation services to ensure that separate payment is made only for those beneficiaries truly requiring observation care. These tests are typically performed on beneficiaries requiring observation care for the three specified medical conditions. The tests are medically necessary to determine whether a beneficiary will benefit from being admitted to observation care and the appropriate disposition of a patient in observation care. The specified diagnostic services must be performed within the dates of the E/M visit plus the first 24 hours of observation and must be billed on the same claim as the observation services to which they are related. The diagnostic tests are as follows:

- For chest pain, at least two sets of cardiac enzymes (two CPK [82550, 82552, or 82553] or two troponin [84484 or 84512]) and two sequential electrocardiograms (93005);
- For asthma, a peak expiratory flow rate (94010) or pulse oximetry (94760 or 94761);
- For congestive heart failure, a chest x-ray (71010, 71020 or 71030) **and** an electrocardiogram (93005) **and** pulse oximetry (94760 or 94761).

NOTE: Pulse oximetry codes 94760 and 94761 are treated as packaged services under the OPPS. Although as packaged codes no separate payment is made for these codes, hospitals must separately report the HCPCS code and a charge for

pulse oximetry in order to establish that observation services for congestive heart failure and asthma diagnoses meet the criteria for separate APC payment.

Multiple observation periods on a claim may be paid separately if the required criteria are met for each observation. If there are multiple observation periods for the same diagnoses, each of the required tests must be performed multiple times, that is, the tests must be rerun for each period of observation. Therefore, if a claim contains two separate periods of observation related to chest pain, four EKGs and four cardiac enzyme tests must be performed. If multiple observations are for different diagnoses, the re-use of tests will be permitted. For example, if there are two periods of observation on a claim, one for chest pain and one for congestive heart failure, two EKGs - not three - are needed. The EKGs that are performed to meet the diagnostic test requirements for observation related to chest pain may also be used for the observation related to congestive heart failure.

C - Observation services must be billed hourly for a minimum of eight hours up to a maximum of 48 hours. In billing for observation services, the units of services represent the number of hours the patient spends in observation. The CMS will not pay separately for any hours a beneficiary spends in observation over 24 hours, but all costs beyond 24 hours will be included in the APC payment for observation services. Observation services of less than eight hours do not qualify for an APC payment. If a period of observation spans more than one calendar day, all of the hours for the entire period of observation must be included on a single line and the date of service for that line is the date the patient is admitted to observation.

Observation time begins at the clock time appearing on the nurse's observation admission note. (We note that this coincides with the initiation of observation care or with the time of the patient's arrival in the observation unit.)

Observation time ends at the clock time documented in the physician's discharge orders, or, in the absence of such a documented time, the clock time when the nurse or other appropriate person signs off on the physician's discharge order. (This time coincides with the end of the patient's period of monitoring or treatment in observation.)

The beneficiary must be under the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes, timed, written, and signed by the physician.

The medical record must include documentation that the physician used risk stratification criteria to determine that the beneficiary would benefit from observation care.

(These criteria may be either published generally accepted medical standards or established hospital-specific standards.)

D - Only observation services that are billed on a 13X bill type maybe considered for a separate APC payment.

E - To receive an APC payment for observation services that qualify for separate payment, a hospital must bill using HCPCS code G0244. HCPCS code G0244 is to be used only when billing for observation services that meet the requirements for separate APC payment as outlined above. If the observation services furnished by a hospital do not meet the requirements for separate APC payment, the hospital must bill observation services using revenue code 0762 only, or using revenue code 0762 with one of the HCPCS codes for packaged observation services i.e., 99218 - 99220 or 99234 - 99236.

F - **Note** that because the status indicator on HCPCS G0244 is an "S," any claim with an E/M visit on the same day as the observation will be subject to OPPS OCE edit 21 (medical visit on same day as type T or S procedure without modifier -25). Therefore, the **E/M code for the visit must be billed with modifier -25** in order for the observation to be paid.

300 - Medical Nutrition Therapy Services

(Rev. 1, 10-03-03)

A-02-026 §XIX, B-02-10

Section 105 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) permits Medicare coverage of Medical Nutrition Therapy (MNT) services when furnished by a registered dietitian or nutrition professional meeting certain requirements. The benefit is available for beneficiaries with diabetes or renal disease, when referral is made by a physician as defined in §1861(r)(l) of the Act. It also allows registered dietitians and nutrition professionals to receive direct Medicare reimbursement for the first time. The effective date of this provision is January 1, 2002.

Hospitals bill for the following HCPCS codes to their local FI: 97802, 97803 and 97804.

The benefit consists of an initial visit for an assessment; follow-up visits for interventions; and reassessments as necessary during the 12-month period beginning with the initial assessment ("episode of care") to assure compliance with the dietary plan. For purposes of coverage, the benefit is defined as a maximum number of hours that may be reimbursed in an episode of care. The maximum number of hours covered will be provided in a future instruction when that requirement has been finalized. The CMS will further define "intervention" in the national coverage determination process. Note that the number of hours covered for diabetes may be different than the number of hours covered for renal disease.

For the purposes of this benefit, renal disease means chronic renal insufficiency and the medical condition of a beneficiary who has been discharged from the hospital after a

successful renal transplant within the last six months. Chronic renal insufficiency means a reduction in renal function not severe enough to require dialysis or transplantation (glomerular filtration rate (GFR) 13-50 ml/min/1.73m²). Diabetes is defined as diabetes mellitus Type 1 (an autoimmune disease that destroys the beta cells of the pancreas, leading to insulin deficiency) and Type 2 (familial hyperglycemia). The diagnostic criterion for a diagnosis of diabetes is a fasting glucose greater than or equal to 126 mg/dl. These definitions come from the Institute of Medicare 2000 Report, "The Role of Nutrition in Maintaining Health in the Nation's Elderly."

310 - Lung Volume Reduction Surgery

(Rev. 26, 11-04-03)

Lung Volume Reduction Surgery (LVRS) (also known as reduction pneumoplasty, lung shaving, or lung contouring) is an invasive surgical procedure to reduce the volume of a hyperinflated lung in order to allow the underlying compressed lung to expand, and thus, establish improved respiratory function.

Effective for 'from' dates of service on or after January 1, 2004, Medicare will cover LVRS under certain conditions as described in §240 of the Pub. 100-03, "National Coverage Determinations".

LVRS can only be performed in the facilities listed on the following website:
www.cms.hhs.gov/coverage/lvrsfacility.pdf

LVRS is an inpatient procedure. However pre- and post- operative services are performed on an outpatient basis and must be performed at one of the facilities certified to do so. These procedures are paid under the Outpatient Prospective Payment System (OPPS), except for hospitals located in Maryland.

Medicare previously only covered LVRS as part of the National Emphysema Treatment Trial (NETT). The study is limited to 18 hospitals, and patients are randomized into two arms, either medical management and LVRS or medical management. The study is conducted by The National Heart, Lung, and Blood Institute of the National Institutes of Health and coordinated by Johns Hopkins University (JHU). Claims for patients in the NETT are identified by the presence of Condition Code EY. JHU instructs hospitals of the correct billing procedures for billing claims under the NETT. Claims processing procedures in place for the NETT remain the same.