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Do you have your NPI? National Provider Identifiers (NPIs) will be required on claims sent on or after May 23, 2007. Every health care provider needs to get an NPI. Learn more about the NPI and how to apply for an NPI by visiting http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/index.html on the CMS website.

MLN Matters Number: MM5027

Related Change Request (CR) #: 5027

Related CR Release Date: June 9, 2006

Effective Date: October 1, 2006

Related CR Transmittal #: R976CP

Implementation Date: October 2, 2006

Billing of Temporary "C" HCPCS Codes by Non-Outpatient Prospective Payment System (Non-OPPS) Providers

Note: This article was updated on June 20, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

OPPS and Non-OPPS providers billing Medicare fiscal intermediaries (FIs) for hospital outpatient department services and procedures

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 5027, which revises the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 4, Section 20.7 (Billing of 'C' HCPCS Codes by Non-OPPS Providers).

CAUTION – What You Need to Know

CR5027 gives non-OPPS providers the option of billing under a C-code or an appropriate CPT code. CR5027 does not change existing requirements when non-OPPS provider claims require the use of a CPT or HCPCS code.

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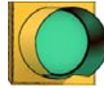

GO – What You Need to Do

See the *Background* and *Additional Information* sections of this article for further details regarding these changes.

Background

The Evolution of C-Codes

The Centers for Medicare & Medicaid Services (CMS) established temporary Healthcare Common Procedure Coding System (HCPCS) C-codes to permit implementation of the Balanced Budget Refinement Act of 1999 (BBRA, Section 201B).

C-codes are unique temporary pricing codes established by CMS for the Prospective Payment System and are only valid for Medicare on claims for hospital outpatient department services and procedures.

Prior to October 1, 2006, C-codes could not be used to bill services payable under other payment systems, and they were used exclusively by hospitals subject to OPPS to identify:

- Items that may have qualified for transitional pass-through payment under OPPS; or
- Items or services for which an appropriate HCPCS code did not exist for the purposes of implementing the OPPS.

Since they were originally established by CMS, C-codes have evolved and they now also target uniquely hospital services that may be provided by:

- OPPS providers;
- Other providers; or
- Providers paid under other payment systems.

Non-OPPS providers subsequently requested the option to bill using C-codes or appropriate Current Procedure Terminology (CPT) codes.

Using C-Codes

In response to this request, CMS is issuing CR5027, which instructs that (effective October 1, 2006) the following Non-OPPS providers may elect to bill using C-codes (or appropriate CPT codes) on Type of Bills (TOBs) 12X, 13X, or 85X:

- Critical access hospitals (CAHs);
- Indian Health Service Hospitals (IHS);

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- Hospitals located in American Samoa, Guam, Saipan, or the Virgin Islands; and
- Maryland waiver hospitals.

Note: Claims will be returned to the provider that contain a temporary C-code when billed on TOB 85X with Revenue codes 96X, 97X, or 98X.

Note that Method I and Method II CAHs:

- Are limited to using C-codes to bill for facility (technical) services; and
- Method II CAHs should not use C-codes to bill for professional services with revenue codes 96X, 97X, or 98X.

Payment Methodology is Unchanged

CR5027 is not changing the payment methodology for OPPS and Non-OPPS providers:

- OPPS providers will continue to receive pass-through payment on items or services that qualify for pass through payment; and
- Non-OPPS providers:
  - Are not eligible for pass through payments;
  - Will be paid under their normal payment methodologies; and
  - Should comply with all existing requirements when claims require the use of a HCPCS or CPT code.

Effective October 1, 2006, processing note 0093 will be updated as follows:

"C-codes are unique temporary pricing codes that were initially established by CMS for the Hospital Outpatient Prospective Payment System (OPPS). The C-codes are used on Medicare OPPS claims but may also be recognized on claims from other providers or by other payment systems."

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

Additional Information

Providers are encouraged to access the CMS Web site to view the quarterly HCPCS Code updates at http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/index.html on the CMS website.

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For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R976CP.pdf on the CMS website.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

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