

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1445	Date: FEBRUARY 8, 2008
	Change Request 5946

Subject: January 2008 Update of the Hospital Outpatient Prospective Payment System (OPPS)-Manualization

I. SUMMARY OF CHANGES: This Change Request (CR) updates the Medicare Claims Processing Manual, Pub. 100-04, Chapter 4, Sections: 10, 20, 30, 50, 61, 70, 130, 160, 190, 200, 230, and 290; Chapter 16, Section 40.3; and Chapter 17, Section 90.2. CMS is re-organizing or deleting information in these sections. Business requirements related to this instruction are included in CR 5912. The attached Recurring Update Notification applies to chapter 4, sections 50.7, and 61.4.1 and chapter 17, section 90.2.

New / Revised Material

Effective Date: January 1, 2008

Implementation Date: March 10, 2008

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
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R	4/10.2/APC Payment Groups
N	4/10.2.1/Composite APCs
R	4/10.3/Calculation of APC Payment Rates
R	4/10.4/Packaging
N	4/10.4.1/Combinations of Packaged Services of Different Types That are Furnished on the Same Date of Service
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R	4/10.11/Calculation of Overall Cost to Charge Ratios (CCRs) for Hospitals

	Paid Under the Outpatient Prospective Payment System (OPPS) and Community Mental Health Centers (CMHCs) Paid Under the Hospital OPPS
R	4/10.11.1/Requirement to Calculate CCRs for Hospitals Paid Under OPPS and for CMHCs
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N	4/10.11.5/New Providers and Providers with Cost Report Periods Less Than a Full Year
N	4/10.11.6/Substitution of Statewide CCRs for Extreme OPPS Hospital Specific CCRs
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N	4/10.11.8/Methodology for Calculation of Hospital Overall CCR for Hospitals That Have Nursing and Paramedical Education Programs
N	4/10.11.9/Methodology for Calculation of CCR for CMHCs
N	4/10.11.10/Location of Statewide CCRs, Tolerances for Use of Statewide CCRs in Lieu of Calculated CCRs and Cost Centers to be Used in the Calculation of CCRs
N	4/10.11.11/Reporting of CCRs for Hospitals Paid Under OPPS and for CMHCs
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III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):

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

IV. ATTACHMENTS:

Manual Instruction

Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub. 100-04 | **Transmittal: 1445** | **Date: February 8, 2008** | **Change Request: 5946**

SUBJECT: January 2008 Update of the Hospital Outpatient Prospective Payment System (OPPS)-Manualization

Effective Date: January 1, 2008

Implementation Date: March 10, 2008

I. GENERAL INFORMATION

A. Background: This Change Request (CR) updates chapter 4, Sections: 10, 20, 30, 50, 61, 70, 130, 160, 190, 200, 230, and 290; chapter 16, Section 40.3; and chapter 17, Section 90.2. CMS is re-organizing or deleting information in these sections.

B. Policy: Refer to CR 5912 for policy updates and business requirements related to this instruction.

II. BUSINESS REQUIREMENTS TABLE

Use “Shall” to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A /	D M	F I	C A	R H	Shared-System Maintainers				OTHER
	B E	R R	R I	H I	F I	M C	V M	C S	W F		
	M A C	M A C	I E R	S S							
5946.1	Medicare contractors shall refer to the Medicare Claims Processing Manual, Pub. 100-04, Chapters 4, 16 and 17 for the latest updates.	X		X		X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B	D M E	F I	C A R R	R H H I	Shared-System Maintainers				OTHER
M A C	M A C	I E R	S S	F I S S	M C S	V M S	C W F				
5946.2	<p>A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.</p> <p>Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of</p>	X		X		X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B	D M E	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
CR 5912	January 2008 Update of the Hospital Outpatient Prospective Payment System (OPPS)
CR 5865	January 2008 Integrated Outpatient Code Editor (I/OCE) Specifications Version 9.0

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Marina Kusnirova at marina.kusnirova@cms.hhs.gov

Post-Implementation Contact(s): Regional Office

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs):

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: For Medicare Administrative Contractors (MACs):

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

Medicare Claims Processing Manual

Chapter 4 - Part B Hospital

(Including Inpatient Hospital Part B and OPPS)

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10.1.1 - Payment Status Indicators

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

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

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

10.2 - APC Payment Groups

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

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

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

10.2.1 - Composite APCs

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

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

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

The table below identifies the 5 composite APCs that are effective for services furnished on or after January 1, 2008. See Addendum A at www.cms.hhs.gov/HospitalOutpatientPPS/ for the national unadjusted payment rates for these composite APCs.

Composite APC	Composite APC Title	Criteria for Composite Payment
8000	<i>Cardiac Electrophysiologic Evaluation and Ablation Composite</i>	<i>At least one unit of CPT code 93619 or 93620 and at least one unit of CPT code 93650, 93651 or 93652 on the same date of service</i>
8001	<i>Low Dose Rate Prostate Brachytherapy Composite</i>	<i>One or more units of CPT codes 55875 and 77778 on the same date of service</i>
8002	<i>Level I Extended Assessment and Management Composite</i>	<i>1) eight or more units of HCPCS code G0378 are billed--</i> <ul style="list-style-type: none"><i>• On the same day as HCPCS code G0379*; or</i><i>• On the same day or the day after CPT codes 99205 or 99215; and</i> <i>2) There is no service with SI=T on the claim on the same date of service or 1 day earlier than G0378</i>
8003	<i>Level II Extended Assessment and Management Composite</i>	<i>1) eight or more units of HCPCS code G0378** are billed on the same date of service or the date of service after 99284, 99285 or 99291; and</i> <i>2) There is no service with SI=T on the claim on the same date of service or 1 day earlier</i>
0034	<i>Mental Health Services Composite</i>	<i>Payment for any combination of mental health services with the same date of service exceeds the payment for APC 0033. For the list of mental health services to which this composite applies, see the IOCE supporting files for the</i>

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

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

10.3 - Calculation of APC Payment Rates

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

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

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

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

- Hospital-specific, department-specific cost-to-charge ratios *are used* to convert billed charges to costs for each *HCPCS code*;
- *For most APCs, single procedure bills (claims that contain only one separately paid procedure code) for all of the procedures within a particular APC are used to calculate the median costs on which APC payment weights are based to ensure that the median captures the full cost of the procedure when it is the only service furnished. The costs on the bill are summed to add the costs of any packaged services into the procedure with which the packaged services are packaged.* Composite APCs are an exception to this statement since the payment for them is calculated only from multiple procedure claims that meet the criteria for composite APC payment;
- *60 percent of the total cost is wage neutralized and the set of claims for each APC is trimmed at +/- 3 standard deviations from the geometric mean;*

- A median cost is calculated for each APC, using the claims for the procedures that meet the criteria for being assigned to that APC and the array of costs determined from those claims. In some cases, a subset of single procedure bills that meet specified criteria are used to calculate the median cost for the APC. For example, CMS uses only claims with correct device codes, no token charges for devices, no interrupted procedures, and without “no cost” or “full credit” devices to set the median cost for device-dependent APCs. Similarly, the median costs for composite APCs are calculated using only claims that meet the criteria for the composite APC.
- Median costs are converted to relative weights by dividing each APC’s median cost by the median cost for the Level 3 Hospital Clinic Visit APC.
- Relative weights are scaled for budget neutrality.
- Scaled weights are converted to payment rates using a conversion factor which takes into account pass-through payments to be made in the coming year, changes to the wage index (see section 10.8.1), the cost of outlier payments (see section 10.7) and the annual market basket update factor.
- CMS issues a proposed rule with a 60 day comment period in the summer of the year before the year in which the proposed payment rates would be applicable. There is a 60 day comment period, after which CMS issues a final rule with comment period to announce the forthcoming year’s payment policies and rates. The CMS OPPS Webpage at <http://www.cms.hhs.gov/HospitalOutpatientPPS/> is the best source for both rules and the supporting files.

10.4 - Packaging

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

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

A. *Packaging for* Claims Resulting in APC Payments

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

Therefore, it is extremely important that hospitals report all HCPCS codes and all charges for all services they furnish, whether payment for the services is made separately paid or is packaged.

B. Packaging for Claims Resulting in No APC Payments

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

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

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

C. Packaging Types Under the OPPS

1. *Unconditionally packaged services are services for which separate payment is never made because the payment for the service is always packaged into the payment for other services. Unconditionally packaged services are identified in the OPPS Addendum B with status indicator of N. See the OPPS Web site at <http://www.cms.hhs.gov/HospitalOutpatientPPS/> for the most recent Addendum B (HCPCS codes with status indicators). In general, the charges for unconditionally packaged services are used to calculate outlier and TOPS payments when they appear on a claim with a service that is separately paid under the OPPS because the packaged service is considered to be part of the package of services for which payment is being made through the APC payment for the separately paid service.*
2. *STVX-packaged services are services for which separate payment is made only if there is no service with status indicator S, T, V or X reported with the same date of service on the same claim. If a claim includes a service that is assigned status indicator S, T, V, or X reported on the same date of service as the STVX-packaged service, the payment for the STVX-packaged service is packaged into the payment for the service(s) with status indicator S, T, V or X and no separate payment is made for the STVX-packaged service. STVX-packaged services are assigned status indicator Q. See the OPPS Webpage at <http://www.cms.hhs.gov/HospitalOutpatientPPS/> for identification of STVX-packaged codes.*

3. *T-packaged services are services for which separate payment is made only if there is no service with status indicator T reported with the same date of service on the same claim. When there is a claim that includes a service that is assigned status indicator T reported on the same date of service as the T-packaged service, the payment for the T-packaged service is packaged into the payment for the service(s) with status indicator T and no separate payment is made for the T-packaged service. T-packaged services are assigned status indicator Q. See the OPPS Web site at <http://www.cms.hhs.gov/HospitalOutpatientPPS/> for identification of T-packaged codes.*
4. *A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Services mapped to composite APCs are assigned status indicator Q. See the discussion of composite APCs in section 10.2.1.*

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

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

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

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

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

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

10.5 - Discounting

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

- *Fifty percent of the full OPPS amount is paid if a procedure for which anesthesia is planned is discontinued after the patient is prepared and taken to the room where the procedure is to be performed but before anesthesia is provided.*
- *Fifty percent of the full OPPS amount is paid if a procedure for which anesthesia is not planned is discontinued after the patient is prepared and taken to the room where the procedure is to be performed.*
- Multiple surgical procedures furnished during the same operative session are discounted.
 - The full amount is paid for the surgical procedure with the highest weight;
 - Fifty percent is paid for any other surgical procedure(s) performed at the same time;
 - Similar discounting occurs now under the physician fee schedule and the payment system for ASCs;
 - When multiple surgical procedures are performed during the same operative session, beneficiary coinsurance is discounted in proportion to the APC payment

10.6 - Payment Adjustments

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

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

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

10.7 - Outlier Adjustments

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

The OPPS incorporates an outlier adjustment to ensure that outpatient services with variable and potentially significant costs do not pose excessive financial risk to providers. Section 1833(t)(5)(E) of the Act excludes drugs and biologicals from outlier payments. The OPPS determines eligibility for outliers using either a “multiple” threshold, which is the product of a multiplier and the APC payment rate, or a combination of a multiple and fixed dollar threshold. A service or group of services becomes eligible for outlier payments when the cost of the service or group of services

estimated using the hospital's most recent overall cost-to-charge ratio (CCR) separately exceeds each relevant threshold. For community mental health centers (CMHCs), CMS determines whether billed partial hospitalization services are eligible for outlier payments using a multiple threshold specific to CMHCs. The outlier payment is a percentage of the difference between the cost estimate and the multiple threshold. The CMS OPPS Web site includes a table depicting the specific hospital and CMHC outlier thresholds and the payment percentages in place for each year of the OPPS.

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

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

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

The current outlier payment is determined by:

- *Calculating the cost related to an OPPS line-item service, including a pro rata portion of the total cost of packaged services on the claim, by multiplying the total charges for OPPS services by each hospital's overall CCR (see section 10.11.8 of this chapter); and*
- *Determining whether the total cost for a service exceeds 1.75 times the OPPS payment and separately exceeds the fixed dollar threshold determined each year; and*
- *If total cost for the service exceeds both thresholds, the outlier payment is 50 percent of the amount by which the cost exceeds 1.75 times the OPPS payment.*

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

payment rate for that service out of the total APC payment for all separately paid OPPS services on the claim.

To illustrate, assume the *total* cost of all packaged services *and revenue codes* on the claim is \$100, and the three APC payment amounts paid for OPPS services on the claim are \$200, \$300, and \$500 (total APC payments of \$1000). The first OPPS service or line item will be allocated \$20 or 20 percent of the *total* cost of packaged services, because the APC payment for that service/line item represents 20 percent (\$200/\$1000) of total APC payments on the claim. The second OPPS service will be allocated \$30 or 30 percent of the *total* cost of packaged services, and the third OPPS service will be allocated \$50 or 50 percent of the *total* 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 *an* SI of S or T have less than \$1.01 as charges, charges for all S and/or T lines are summed and the charges are then divided *across the two lines in proportion to their APC payment rate*. The new charge amount is used in place of the submitted charge amount in the line item outlier calculation.

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

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

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

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

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

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

10.11.2 - Circumstances in Which CCRs are Used

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

The *contractors* must apply CCRs prospectively to calculate outlier payments (for hospitals paid under OPPS and CMHCs), Transitional Outpatient Payment System (TOPS) payments (for hospitals paid under OPPS), and device pass through payments (for hospitals paid under OPPS).

10.11.3 - Selection of the CCR to be Used

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

Contractors will use the CCR calculated for the most recent period of time, whether based on a tentatively settled cost report or a final settled cost report. For example, if the CCR being used is the tentatively settled CCR for FY 2007, and a tentatively settled CCR for FY 2008 is determined before the final settled CCR for FY 2007, then the *contractor* will use the CCR based on the tentatively settled 2008 cost report.

10.11.4 - Mergers, Acquisitions, and Other Ownership Changes

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

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

Effective for hospitals experiencing a change of ownership after January 1, 2007, that have not accepted assignment of an existing hospital's provider agreement in accordance with 42 CFR 489.18, and do not yet have a Medicare cost report, the *contractor* should use the default statewide CCR to determine cost-based payments until the hospital has submitted its first Medicare cost report. For hospitals experiencing a change of ownership prior to January 1, 2007, the *contractor* should use the prior hospital's cost to charge ratio.

10.11.5 - New Providers and Providers with Cost Report Periods Less Than a Full Year

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

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

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

See §10.11.10 for the location of the Statewide CCRs.

10.11.6 - Substitution of Statewide CCRs for Extreme OPPS Hospital

Specific CCRs

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

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

If the CCR for a hospital paid under OPPS is below the lower limit CCR in the file of overall OPPS hospital CCR limits, *contractors* must recheck the calculation to ensure that the CCR is, in fact, a valid CCR for the provider before entering the CCR into the OPSF. The *contractors* must use the CCR they calculate; they may not use the Statewide average urban or rural hospital as the default ratio in such a circumstance.

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

10.11.7 - Methodology for Calculation of Hospital Overall CCR for Hospitals That Do Not Have Nursing and Paramedical Education Programs

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

In calculating the hospital's costs or charges, do not include departmental CCRs and charges for services that are not paid under the OPPS such as physical, occupational and speech language therapies, clinical diagnostic laboratory services, ambulance, rural health clinic services, non-implantable DME, etc.

See §10.11.10 for the location of the list of exact cost centers that shall be included in the calculation of the overall CCR.

Step 1 – Determining Overall Costs: Calculate costs for each cost center by multiplying the departmental CCR for each cost center (and subscripts thereof) that reflect services subject to the OPPS from *Form CMS 2552-96, Worksheet C, Part I, Column 9* by the Medicare outpatient charges for that cost center (and subscripts thereof) from *Worksheet D, Part V, Columns 2, 3, 4, and 5* (and subscripts thereof). Sum the costs calculated for each cost center to arrive at Medicare outpatient cost of services subject to OPPS.

Step 2 – Determining Overall Charges: Calculate charges by summing the Medicare outpatient charges from *Form CMS 2552-96, Worksheet D, Part V, Columns 2, 3, 4, and 5* (and subscripts thereof) for each cost center (and subscripts thereof) that reflect services subject to the OPPS.

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

10.11.8 - Methodology for Calculation of Hospital Overall CCR for Hospitals That Have Nursing and Paramedical Education Programs
(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

Do not include departmental CCRs and charges for services not subject to the OPPS (such as physical, occupational and speech language therapies, clinical diagnostic laboratory services, ambulance, rural health clinic services, non-implantable DME, etc.) in calculating the hospital's costs or charges.

See §10.11.10 for the location of the list of the exact cost centers that should be included in the overall CCR.

Step 1 -- Determining costs for each department: From Worksheet B, Part 1 – Column 27, deduct the nursing and paramedical education costs found on the applicable line in Columns 21, and 24 of Worksheet B, Part I to calculate a cost for each cost center.

Exception: The costs for 6200 are not calculated on this worksheet. For cost center 6200, non-distinct unit observation beds, use the cost reported on Worksheet D-1, Part IV, line 85. See Step 3 below.

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

Step 3 – Determining the CCRs for each department without nursing and paramedical education costs: For each line, divide the costs from Step1 by the charges from Step 2 to acquire CCRs for each line, without inclusion of nursing and paramedical education costs. *Exception: For cost center 6200, non-distinct unit observation beds, use the cost reported on Worksheet D-1, Part IV, line 85. The total costs for this cost center will include nursing and paramedical education costs.*

Step 4 – Determining Overall Costs: Multiply the CCR in step 3 by the Medicare outpatient charges for that cost center (and subscripts thereof) from Worksheet D Part V, Columns 2, 3, 4, and 5 (and subscripts thereof). Sum the costs calculated for each cost center to arrive at Medicare outpatient cost of services subject to OPPS.

Step 5 – Determining Overall Charges: Calculate charges by summing the Medicare outpatient charges from Form CMS 2552-96, Worksheet D, Part V, Columns 2, 3, 4, and 5 (and subscripts thereof) for each cost center (and subscripts thereof) that reflect service subject to the OPPS.

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

10.11.9 - Methodology for Calculation of CCR for CMHCs
(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

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

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

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

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

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

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

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

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

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

The *contractors* shall report the OPPS hospital overall or CMHC CCR they calculate, or the Statewide CCR they select, for each provider to the Outpatient Provider Specific File (OPSF; see §50.1 of this Chapter) within 30 days after the date of the calculation or selection of the Statewide CCR for the provider. If a cost report reopening results in adjustments that would change the CCR that is currently in effect, the *contractor* shall calculate and enter the CCR in the OPSF within 30 days of the date that the reopening is finalized. In such an instance, *contractors* must create an additional record in the OPSF for the provider. The *contractor* entries in the OPSF shall include the effective date of the CCR being entered. Entries in the OPSF shall not replace a pre-existing entry for the provider.

20.5.1.1 - Packaged Revenue Codes

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

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, **0273**, 0275, 0276, 0278, 0279, 0280, 0289, **0343**, **0344**, 0370, 0371, 0372, 0379, 0390, 0399, 0560, 0569, 0621, 0622, 0624, 0630, 0631, 0632, 0633, 0681, 0682, 0683, 0684, 0689, 0700, **0709**, 0710, **0719**, 0720, 0721, **0732**, 0762, **0801**, **0802**, **0803**, **0804**, **0809**, 0810, 0819, **0821**, **0824**, **0825**, **0829**, 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. **Contractors** should return to provider (RTP) claims which contain revenue codes that require HCPCS when no HCPCS is shown on the line.

20.5.1.4 - Revenue Codes for "Sometimes Therapy" Services *(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)*

Certain wound care services described by CPT codes are classified as "sometimes therapy" services that may be appropriately provided under either a certified therapy plan of care or without a certified therapy plan of care.

Hospitals receive separate payment under the OPPS when they bill for certain wound care services that are furnished to hospital outpatients independent of a certified therapy plan of care.

When billing for wound care services under the OPPS that are furnished independent of a certified plan of care, providers should neither attach a therapy modifier (that is, GP for physical therapy, GO for occupational therapy, and GN for speech language pathology) to the wound care CPT codes nor report their charges under a therapy revenue code (that is, 042x, 043x, or 044x), to receive payment under the OPPS.

20.6.4 - Use of Modifiers for Discontinued Services *(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)*

A. General

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

Modifier -73 is used by the facility to indicate that a procedure requiring anesthesia was terminated due to extenuating circumstances or to circumstances that threatened the well being of the patient after the patient had been prepared for the procedure (including

procedural pre-medication when provided), and been taken to the room where the procedure was to be performed, but prior to administration of anesthesia. For purposes of billing for services furnished in the hospital outpatient department, anesthesia is defined to include local, regional block(s), moderate sedation/analgesia (“conscious sedation”), deep sedation/analgesia, or general anesthesia. This modifier code was created so that the costs incurred by the hospital to prepare the patient for the procedure and the resources expended in the procedure room and recovery room (if needed) could be recognized for payment even though the procedure was discontinued. Prior to January 1, 1999, modifier -52 was used for reporting these discontinued services.

Modifier -74 is used by the facility to indicate that a procedure requiring anesthesia was terminated after the induction of anesthesia or after the procedure was started (e.g., incision made, intubation started, scope inserted) due to extenuating circumstances or circumstances that threatened the well being of the patient. For purposes of billing for services furnished in the hospital outpatient department, anesthesia is defined to include local, regional block(s), moderate sedation/analgesia (“conscious sedation”), deep sedation/analgesia, and general anesthesia. This modifier code was created so that the costs incurred by the hospital to initiate the procedure (preparation of the patient, procedure room, recovery room) could be recognized for payment even though the procedure was discontinued prior to completion. Prior to January 1, 1999, modifier -53 was used for reporting these discontinued services.

Modifiers -52 and -53 are no longer accepted as modifiers for certain diagnostic and surgical procedures under the hospital outpatient prospective payment system. Coinciding with the addition of the modifiers -73 and -74, modifiers -52 and -53 were revised. Modifier -52 is used to indicate partial reduction or discontinuation of services *for which anesthesia is not planned*. The modifier provides a means for reporting reduced services without disturbing the identification of the basic service. Modifier -53 is used to indicate discontinuation of physician services and is not approved for use for outpatient hospital services.

The elective cancellation of a procedure should not be reported.

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

B. Effect on Payment

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

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

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

C. Termination Where Multiple Procedures Planned

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

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

30 - OPPS Coinsurance

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

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

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

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

For screening colonoscopies and *screening flexible* sigmoidoscopies, the coinsurance amount is 25 percent of the payment rate.

Coinurance 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.

50 - Outpatient Pricer

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

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

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

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

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

50.1 - Outpatient Provider Specific File

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

The Outpatient Provider Specific File (OPSF) contains the required information about each provider to enable the pricing software to calculate the payment amount. Data elements and formats are shown below. *Contractors* must maintain the accuracy of the

data, and update the file as changes occur in data element values, e.g., changes in metropolitan statistical area (MSA), bed size, cost to charge ratio. An update is accomplished by preparing and adding an additional complete record showing new current values and the effective date of the change. The old record is retained without change.

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

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

File Position	Format	Title	Description
1-10	X(10)	National Provider Identifier (NPI)	Alpha-numeric 10 character provider number.
11-16	X(6)	Provider Oscar Number	Alpha-numeric 6 character provider number.
17-24	9(8)	Effective Date	Must be numeric, CCYYMMDD. This is the effective date of the provider's first OPPS period. For subsequent OPPS periods, the effective date is the date of a change to the PROV file. If a termination date is present for this record, the effective date must be equal to or less than the termination date.
25-32	9(8)	Fiscal Year Beginning Date	Must be numeric, CCYYMMDD. Month: 01-12 Day:01-31 The date must be greater than 19990630.
33-40	9(8)	Report Date	Must be numeric, CCYYMMDD. Month: 01-12 Day:01-31 The created/run date of the PROV report for submittal to CO.
41-48	9(8)	Termination Date	Must be numeric, CCYYMMDD. Must be zeros or contain a termination date. Must be equal to or greater than the effective date. (Termination date is the date on which the reporting intermediary ceased servicing the provider in question).

49	X(1)	Waiver Indicator	Enter a "Y" or "N." Y = waived (provider is not under OPPS) N = not waived (provider is under OPPS)
50-54	9(5)	Intermediary Number	Enter the Intermediary #.
55-56	X(2)	Provider Type	<p>This identifies providers that require special handling. Enter one of the following codes as appropriate.</p> <p>00 or blanks = Short Term Facility</p> <p>02 Long Term</p> <p>03 Psychiatric</p> <p>04 Rehabilitation Facility</p> <p>05 Pediatric</p> <p>06 Hospital Distinct Parts (Provider type "06" is effective until July 1, 2006. At that point, provider type "06" will no longer be used. Instead, <i>contractors</i> will assign a hospital distinct part as one of the following provider types: 49, 50, 51, 52, 53, or 54)</p> <p>07 Rural Referral Center</p> <p>08 Indian Health Service</p> <p>13 Cancer Facility</p> <p>14 Medicare Dependent Hospital (during cost reporting periods that began on or after April 1, 1990.</p> <p>15 Medicare Dependent Hospital/Referral Center (during cost reporting periods that began on or after April 1, 1990. Invalid October 1, 1994 through September 30, 1997).</p> <p>16 Re-based Sole Community Hospital</p> <p>17 Re-based Sole Community Hospital /Referral Center</p>

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

			49 Psychiatric Distinct Part 50 Rehabilitation Distinct Part 51 Short-Term Hospital – Swing Bed 52 Long-Term Care Hospital – Swing Bed 53 Rehabilitation Facility – Swing Bed 54 Critical Access Hospital – Swing Bed
57	X(1)	Special Locality Indicator	Indicates the type of special locality provision that applies. Does not apply to ESRD Facilities.
58	X(1)	Change Code For Wage Index Reclassification	Enter “Y” if the hospital’s wage index location has been reclassified for the year. Enter “N” if it has not been reclassified for the year. Adjust annually. Does not apply to ESRD Facilities.
59-62	X(4)	Actual Geographic Location—MSA	Enter the appropriate code for MSA, 0040–9965, or the rural area, <u>(blank)(blank)</u> 2-digit numeric State code, such as <u> 3 6</u> for Ohio, where the facility is physically located.
63-66	X(4)	Wage Index Location—MSA	The appropriate code for the MSA, 0040-9965, or the rural area, <u>(blank)(blank)</u> (2 digit numeric State code) such as <u> 3 6</u> for Ohio, to which a hospital has been reclassified for wage index. Leave blank or enter the actual location MSA if not reclassified. Does not apply to ESRD Facilities.
67-70	9V9(3)	Payment-to-Cost Ratio	Enter the provider’s payment-to-cost ratio. Does not apply to ESRD Facilities.
71-72	9(2)	State Code	<p>Enter the 2-digit state where the provider is located. Enter only the first (lowest) code for a given state. For example, effective October 1, 2005, Florida has the following State Codes: 10, 68 and 69. Contractors shall enter a “10” for Florida’s State Code.</p> <p>List of valid State Codes is located in Pub. 100-07, Chapter 2, Section 2779A1.</p>
73	X(1)	TOPs Indicator	<p>Enter the code to indicate whether TOPs applies or not.</p> <p>Y = qualifies for TOPs</p> <p>N = does not qualify for TOPs</p>

74-75	X(2)	Filler	Blank.
76-79	9V9(3)	Outpatient Cost-to-Charge Ratio	Derived from the latest available cost report data. See §10.11 of this chapter for instructions on how to calculate and report the Cost-to-Charge Ratio. Does not apply to ESRD Facilities.
80-84	X(5)	Actual Geographic Location CBSA	00001-89999, or the rural area, (blank)(blank)(blank) 2 digit numeric State code such as ___ 3 6 for Ohio, where the facility is physically located.
85-89	X(5)	Wage Index Location CBSA	Enter the appropriate code for the CBSA, 00001-89999, or the rural area, (blank)(blank)(blank) (2 digit numeric State code) such as ___ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the Actual Geographic Location CBSA, if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank. Does not apply to ESRD Facilities.
90-95	9(2) V9(4)	Special Wage Index	Enter the special wage index that certain providers may be assigned. Enter zeroes unless the Special Payment Indicator equals a "1" or "2."
96	X(1)	Special Payment Indicator	The following codes indicate the type of special payment provision that applies. Blank = not applicable Y = reclassified 1 = special wage index indicator 2 = both special wage index indicator and reclassified
97-100	9(4)	Reduced Coinsurance Trailer Count	Enter the number of APCs the provider has elected to reduce coinsurance for. The number cannot be greater than 999.

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

1-4	9(4)	APC Classification - Enter the 4-digit APC classification for which the provider has elected to reduce coinsurance.
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5-10	9(4)V9(2)	Reduced Coinsurance Amount - Enter the reduced coinsurance amount elected by the provider
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The Shared system will verify that the last position of the record is equal to the number in file positions 97 through 100 multiplied by 10 plus 100 (last position of record = (# in file position 97-100)(10) + 100).

50.7 - Changes to the OPPS Pricer Logic Effective January 1, 2003
(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

For January Pricers occurring between CY 2003 and 2007, you may find the updates outlined in the following CRs:

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

Starting with the January 2007 update, all changes within the OPPS Pricer are explained within recurring update notifications located at the Hospital OPPS Transmittals Web site.

61 - Billing for Devices Under the OPPS
(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

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

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

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

Each unit of a billable source is identified by the unit measurement in the respective source's long descriptor. Seed-like sources are generally billed and paid "per source" based on the number of units of the source HCPCS code reported, including the billing of

the number of sources within a stranded configuration of sources. Providers therefore must bill the number of units of a source used with the brachytherapy service rendered.

61.4.2 - Definition of Brachytherapy Source for Separate Payment

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

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

61.4.3 - Billing of Brachytherapy Sources Ordered for a Specific Patient

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

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

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

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

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

- 1. Report the charge separately using CPT code 77790 (Supervision, handling, loading of radiation source), in addition to reporting the associated HCPCS procedure code(s) for application of the radiation source;*
- 2. Include the supervision, handling, and/or loading charges as part of the charge reported with the HCPCS procedure code(s) for application of the radiation source.*

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

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

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

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

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

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

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

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

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

Step 2 – Add together the total Medicare program payments, unreduced coinsurance and deductible applied for all APCs, as well as all outlier payments and transitional pass-through payments for drugs, biologicals and/or devices for those same claims

paid during the month as those used in Step 1. If the result is greater than the result of step 1, go to step 9. No transitional payment is due this month.

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

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

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

160 - Clinic and Emergency Visits

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

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

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

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

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

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

- (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
- (3) During the calendar year immediately preceding the calendar year in which a determination under *42 CFR 489.24* is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

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

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

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

160.1 - Critical Care Services

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

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

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

When critical care services are provided without trauma activation, the hospital may bill CPT code 99291, Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes (and 99292, if appropriate). If trauma

activation occurs under the circumstances described by the NUBC guidelines that would permit reporting a charge under 68x, the hospital may also bill one unit of code G0390, which describes trauma activation associated with hospital critical care services. Revenue code 68x must be reported on the same date of service. The OCE will edit to ensure that G0390 appears with revenue code 68x on the same date of service and that only one unit of G0390 is billed. *CMS* believes that trauma activation is a one-time occurrence in association with critical care services, and therefore, *CMS* will only pay for one unit of G0390 per day.

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

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

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

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

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

200 - Special Services for OPPS Billing

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

200.1 - Billing for Corneal Tissue

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

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

200.2 - Hospital Services For Patients with End Stage Renal Disease (ESRD)

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

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.

Generally, Medicare does not allow payment under the OPPS for routine dialysis treatments furnished to End Stage Renal Disease (ESRD) patients in the outpatient department of a hospital that does not have a certified dialysis facility. However, in certain medical situations in which the ESRD patient cannot obtain her or his regularly scheduled dialysis treatment at a certified ESRD facility, the OPPS rule for 2003 allows payment for non-routine dialysis treatments furnished to ESRD patients in the outpatient department of a hospital that does not have a certified dialysis facility. Payment is limited to unscheduled dialysis for ESRD patients in the following circumstances:

- Dialysis performed following or in connection with a vascular access procedure;
- Dialysis performed following treatment for an unrelated medical emergency; e.g., if a patient goes to the emergency room for chest pains and misses a regularly scheduled dialysis treatment that cannot be rescheduled, CMS allows the hospital to provide and bill Medicare for the dialysis treatment; or
- Emergency dialysis for ESRD patients who would otherwise have to be admitted as inpatients in order for the hospital to receive payment.

In these situations, non-ESRD certified hospital outpatient facilities are to bill Medicare using a new Healthcare Common Procedure Coding System (HCPCS) code, G0257 - Unscheduled or emergency treatment for dialysis for ESRD patient in the outpatient department of a hospital that does not have a certified ESRD facility.

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

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

200.3.1 - Billing for IMRT Planning and Delivery

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

Effective for services furnished on or after April 1, 2002, HCPCS codes G0174 (IMRT delivery) and G0178 (IMRT planning) are no longer valid codes. HCPCS code G0174 has been replaced with CPT codes 77418 and 0073T for IMRT delivery and HCPCS code

G0178 with CPT code 77301. Therefore, hospitals must use CPT codes 77418 or 0073T for IMRT delivery and CPT code 77301 for IMRT planning. Any of the CPT codes 77401 through 77416 or 77418 may be reported on the same day as long as the services are furnished at separate treatment sessions. In these cases, modifier -59 must be appended to the appropriate codes. Additionally, in the context of billing 77301, regardless of the same or different dates of service, CPT codes **77014**, 77280-77295, 77305-77321, 77331, 77336, and 77370 may only be billed in addition to 77301 if they are not provided as part of developing the IMRT treatment plan.

77301	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications
77418	Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC , per treatment session
0073T	Compensator-based beam modulation treatment delivery of inverse planned treatment using three or more high resolution (milled or cast) compensator convergent beam modulated fields, per treatment session

200.3.2 - Additional Billing Instructions for IMRT Planning

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

Payment for the services identified by CPT codes **77014**, 77280-77295, 77305-77321, 77331, 77336, and 77370 is included in the APC payment for IMRT planning when these services are performed as part of developing an IMRT plan that is reported using CPT code 77301. Under those circumstances, these codes should not be billed in addition to CPT code 77301 for IMRT planning.

200.3.3 - Billing for Multi-Source Photon (Cobalt 60-Based) Stereotactic Radiosurgery (SRS) Planning and Delivery

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

Effective for services furnished on or after January 1, 2006, hospitals must bill for multi-source photon (cobalt 60-based) SRS planning using existing CPT codes that most accurately describe the service furnished, and HCPCS code G0243 for the delivery. For CY 2007, HCPCS code G0243 *is* no longer be reportable under the hospital OPPS because the code *has been* deleted and replaced with CPT code 77371, effective January 1, 2007.

77371	Radiation treatment delivery, stereotactic radiosurgery (SRS) (complete course of treatment of cerebral lesion[s] consisting of 1 session); multi-source Cobalt 60 based.
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Payment for CPT code 20660 is included in CPT code 77371; therefore, hospitals should not report 20660 separately.

200.3.4 - Billing for Linear Accelerator (Robotic Image-Guided and Non-Robotic Image-Guided) SRS Planning and Delivery
(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

Effective for services furnished on or after January 1, 2006, hospitals must bill using existing CPT codes that most accurately describe the service furnished for both robotic and non-robotic image-guided SRS planning. For robotic image-guided SRS delivery, hospitals must bill using HCPCS code G0039 for the first session and HCPCS code G0340 for the second through the fifth sessions. For non-robotic image-guided SRS delivery, hospitals must bill G0173 for delivery if the delivery occurs in one session, and G0251 for delivery per session (not to exceed five sessions) if delivery occurs during multiple sessions.

Linear Accelerator-Based Robotic Image-Guided SRS	
Planning	Use existing CPT codes
Delivery	G0339 (complete, 1 st session) G0340 (2 nd – 5 th session)

Linear Accelerator-Based Non-Robotic Image-Guided SRS	
Planning	Use existing CPT codes
Delivery	G0173 (single session) G0251 (multiple)

- G0173 Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, complete course of treatment in one session, all lesions.
- G0251 Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum 5 sessions per course of treatment.
- G0339 Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment.
- G0340 Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment

200.4 - Billing for Amniotic Membrane
(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

Hospitals should report HCPCS code V2790 (Amniotic membrane for surgical reconstruction, per procedure) to report amniotic membrane tissue when the tissue is used. A specific procedure code associated with use of amniotic membrane tissue is CPT code 65780 (Ocular surface reconstruction; amniotic membrane transplantation).

Payment for the amniotic membrane tissue is packaged into payment for CPT code 65780 or other procedures with which the amniotic membrane is used.

200.5 - Billing and Payment for Cardiac Rehabilitation Services
(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

The National Coverage Determination for cardiac rehabilitation programs requires that programs must be comprehensive and to be comprehensive they must include a medical evaluation, a program to modify cardiac risk factors (e.g., nutritional counseling), prescribed exercise, education, and counseling. See the National Coverage Determination (NCD) Manual, Pub. 100-03, section 20.10, for more information. A cardiac rehabilitation session may include more than one aspect of the comprehensive program. For CY 2008, hospitals will continue to use CPT code 93797 (Physician services for outpatient cardiac rehabilitation, without continuous ECG monitoring (per session)) and CPT code 93798 (Physician services for outpatient cardiac rehabilitation, with continuous ECG monitoring (per session)) to report cardiac rehabilitation services. However, effective for dates of service on or after January 1, 2008, hospitals may report more than one unit of HCPCS code 93797 or 97398 for a date of service if more than one cardiac rehabilitation session lasting at least 1 hour each is provided on the same day. In order to report more than one session for a given date of service, each session must last a minimum of 60 minutes. For example, if the cardiac rehabilitation services provided on a given day total 1 hour and 50 minutes, then only one session should be billed to report the cardiac rehabilitation services provided on that day.

200.6 - Billing and Payment for Alcohol and/or Substance Abuse Assessment and Intervention Services
(Rev. 1445, Issued: 02-08-08; Effective: 01-01-08; Implementation: 03-10-08)

For CY 2008, the CPT Editorial Panel has created two new Category I CPT codes for reporting alcohol and/or substance abuse screening and intervention services. They are CPT code 99408 (Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes); and CPT code 99409 (Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes). However, screening services are not covered by Medicare without specific statutory authority, such as has been provided for mammography, diabetes, and colorectal cancer screening. Therefore, beginning January 1, 2008, the OPPS recognizes two parallel G-codes (HCPCS codes G0396 and G0397) to allow for appropriate reporting and payment of alcohol and substance abuse structured assessment and intervention services that are not provided as screening services, but that are performed in the context of the diagnosis or treatment of illness or injury.

Contractors shall make payment under the OPPS for HCPCS code G0396 (Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST) and brief intervention, 15 to 30 minutes) and HCPCS code G0397, (Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST) and

intervention greater than 30 minutes), only when reasonable and necessary (i.e., when the service is provided to evaluate patients with signs/symptoms of illness or injury) as per section 1862(a)(1)(A) of the Act.

HCPCS codes G0396 and G0397 are to be used for structured alcohol and/or substance (other than tobacco) abuse assessment and intervention services that are distinct from other clinic and emergency department visit services performed during the same encounter. Hospital resources expended performing services described by HCPCS codes G0396 and G0397 may not be counted as resources for determining the level of a visit service and vice versa (i.e., hospitals may not double count the same facility resources in order to reach a higher level clinic or emergency department visit). However, alcohol and/or substance structured assessment or intervention services lasting less than 15 minutes should not be reported using these HCPCS codes, but the hospital resources expended should be included in determining the level of the visit service reported.

200.7 - Billing for Cardiac Echocardiography Services

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

200.7.1 - Cardiac Echocardiography Without Contrast

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

Hospitals are instructed to bill for echocardiograms without contrast in accordance with the CPT code descriptors and guidelines associated with the applicable Level I CPT code(s) (93303-93350).

200.7.2 - Cardiac Echocardiography With Contrast

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

Hospitals are instructed to bill for echocardiograms with contrast using the applicable HCPCS code(s) included in Table 200.7.2 below. Hospitals should also report the appropriate units of the HCPCS codes for the contrast agents used in the performance of the echocardiograms.

Table 200.7.2 – HCPCS Codes For Echocardiograms With Contrast

HCPCS	Long Descriptor
C8921	<i>Transthoracic echocardiography with contrast for congenital cardiac anomalies; complete</i>
C8922	<i>Transthoracic echocardiography with contrast for congenital cardiac anomalies; follow-up or limited study</i>
C8923	<i>Transthoracic echocardiography with contrast, real-time with image documentation (2D) with or without</i>

HCPSC	Long Descriptor
	<i>M-mode recording; complete</i>
C8924	<i>Transthoracic echocardiography with contrast, real-time with image documentation (2D) with or without M-mode recording; follow-up or limited study</i>
C8925	<i>Transesophageal echocardiography (TEE) with contrast, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report</i>
C8926	<i>Transesophageal echocardiography (TEE) with contrast for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report</i>
C8927	<i>Transesophageal echocardiography (TEE) with contrast for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis</i>
C8928	<i>Transthoracic echocardiography with contrast, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report</i>

200.8 - Billing for Nuclear Medicine Procedures

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

Effective January 1, 2008, the I/OCE will begin editing for the presence of a diagnostic radiopharmaceutical HCPCS code when a separately payable nuclear medicine procedure is present on a claim. Hospitals should begin including diagnostic radiopharmaceutical HCPCS codes on the same claim as a nuclear medicine procedure beginning on January 1, 2008. Hospitals are also instructed to submit the claim so that the services on the claim each reflect the date the particular service was provided. Therefore, if the nuclear medicine procedure is provided on a different date of service from the diagnostic radiopharmaceutical, the claim will contain more than one date of

service. More information regarding these edits is available on the OPPS Web site at <http://www.cms.hhs.gov/HospitalOutpatientPPS/>.

230.1 - Coding and Payment for Drugs, Biologicals, and Radiopharmaceuticals

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

This section provides hospitals with coding instructions and payment information for drugs paid under OPPS. *For additional information on coding and payment for drugs and biologicals under the OPPS, see the Medicare Claims Processing Manual, Chapter 17 "Drugs and Biologicals."*

230.2 - Coding and Payment for Drug Administration

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

A. Overview

Drug administration services furnished under the Hospital Outpatient Prospective Payment System (OPPS) during CY 2005 were reported using CPT codes 90780, 90781, and 96400-96459.

Effective January 1, 2006, some of these CPT codes were replaced with more detailed CPT codes incorporating specific procedural concepts, as defined and described by the CPT manual, such as initial, concurrent, and sequential.

Hospitals are instructed to use the full set of CPT codes, including those codes referencing concepts of initial, concurrent, and sequential, to bill for drug administration services furnished in the hospital outpatient department beginning January 1, 2007. In addition, hospitals are instructed to continue billing the HCPCS codes that most accurately describe the service(s) provided.

Hospitals are reminded to bill a separate Evaluation and Management code (with modifier 25) only if a significant, separately identifiable E/M service is performed in the same encounter with OPPS drug administration services.

B. Billing for Infusions and Injections

Beginning in CY 2007, hospitals were instructed to use the full set of drug administration CPT codes (90760-90779; 96401-96549), (96413-96523 beginning in CY 2008) when billing for drug administration services provided in the hospital outpatient department. In addition, hospitals are to continue to bill HCPCS code C8957 (Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump) when appropriate. Hospitals are expected to report all drug administration CPT codes in a manner consistent with their descriptors, CPT instructions, and correct coding principles. Hospitals should note the conceptual changes between CY 2006 drug administration codes effective under the OPPS and the CPT codes in effect beginning January 1, 2007, in order to ensure accurate billing under the

OPPS. *Hospitals should report all HCPCS codes that describe the drug administration services provided, regardless of whether or not those services are separately paid or their payment is packaged.*

Medicare's general policy regarding physician supervision within hospital outpatient departments meets the physician supervision requirements for use of CPT codes 90760-90779, 96401-96549, (*96413-96523 beginning in CY 2008*). (Reference: Medicare Benefit Policy Manual, Pub.100-02, chapter 6, §20.4.1.)

C. Payments For Drug Administration Services

For CY 2007, OPPS drug administration APCs *were* restructured, resulting in a six-level hierarchy where active HCPCS codes have been assigned according to their clinical coherence and resource use. Contrary to the CY 2006 payment structure that bundled payment for several instances of a type of service (non-chemotherapy, chemotherapy by infusion, non-infusion chemotherapy) into a per-encounter APC payment, structure *introduced in CY 2007* provides a separate APC payment for each reported unit of a separately payable HCPCS code.

Hospitals should note that the transition to the full set of CPT drug administration codes provides for conceptual differences when reporting, such as those noted below.

- In CY 2006, hospitals were instructed to bill for the first hour (and any additional hours) by each type of infusion service (non-chemotherapy, chemotherapy by infusion, non-infusion chemotherapy). *Beginning* in CY 2007, the first hour concept no longer exists. CPT codes *in CY 2007 and beyond* allow for only one initial service per encounter, for each vascular access site, no matter how many types of infusion services are provided; however, hospitals will receive an APC payment for the initial service and separate APC payment(s) for additional hours of infusion or other drug administration services provided that are separately payable .
- In CY 2006, hospitals providing infusion services of different types (non-chemotherapy, chemotherapy by infusion, non-infusion chemotherapy) received payment for the associated per-encounter infusion APC even if these infusions occurred during the same time period. *Beginning* in CY 2007, CPT instructions allow reporting of only one initial drug administration service, including infusion services, per encounter for each distinct vascular access site, with other services through the same vascular access site being reported via the sequential, concurrent or additional hour codes.

(**NOTE:** This list *above* provides a brief overview of a limited number of the conceptual changes between CY 2006 OPPS drug administration codes and CY 2007 OPPS drug administration codes - this list is not comprehensive and does not include all items hospitals will need to consider during this transition)

For APC payment rates, refer to *the most current quarterly version of* Addendum B on the CMS Web site at <http://www.cms.hhs.gov/HospitalOutpatientPPS/>.

D. Infusions Started Outside the Hospital

Hospitals may receive Medicare beneficiaries for outpatient services who are in the process of receiving an infusion at their time of arrival at the hospital (e.g., a patient who arrives via ambulance with an ongoing intravenous infusion initiated by paramedics during transport). Hospitals are reminded to bill for all services provided using the HCPCS code(s) that most accurately describe the service(s) they provided. This includes hospitals reporting an initial hour of infusion, even if the hospital did not initiate the infusion, and additional HCPCS codes for additional or sequential infusion services if needed.

290.1 - Observation Services Overview

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

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients who present to the emergency department and who then require a significant period of treatment or monitoring *in order to make* a decision concerning their admission or discharge. Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services.

Observation services must also be reasonable and necessary to be covered by Medicare. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

290.2.2 - Reporting Hours of Observation

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

Observation time begins at the clock time documented in the patient's medical record, which coincides with the time the patient is placed in a bed for the purpose of initiating observation care in accordance with a physician's order. Hospitals should 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 of the reported observation HCPCS code.

General standing orders for observation services following all outpatient surgery are not recognized. Hospitals should not report as observation care, services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours), which should be billed as recovery room services. Similarly, in the case of patients who undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished prior to the testing and recovery afterwards are included in the payments for those diagnostic services. Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy). In situations where such a procedure interrupts observation services, hospitals would record for each period of observation services the beginning and ending times during the hospital outpatient encounter and add the length of time for the periods of observation services together to reach the total number of units reported on the claim for the hourly observation services HCPSC code G0378 (Hospital observation service, per hour).

Observation time ends when all medically necessary services related to observation care are completed. For example, this could be before discharge when the need for observation has ended, but other medically necessary services not meeting the definition of observation care are provided (in which case, the additional medically necessary services would be billed separately or included as part of the emergency department or clinic visit). Alternatively, the end time of observation services may coincide with the time the patient is actually discharged from the hospital or admitted as an inpatient.

Observation time may include medically necessary services and follow-up care provided after the time that the physician writes the discharge order, but before the patient is discharged. However, reported observation time would not include the time patients remain in the observation area after treatment is finished for reasons such as waiting for transportation home.

If a period of observation spans more than 1 calendar day, all of the hours for the entire period of observation must be included on a single line and the date of service for that line is the date *that observation care begins*.

290.4 - Billing and Payment for Observation Services Furnished

Between January 1, 2006 and December 31, 2007

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

290.4.1 - Billing and Payment for All Hospital Observation Services

Furnished Between January 1, 2006 and December 31, 2007

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

Since January 1, 2006, two G-codes have been used to report observation services and direct admission for observation care. For claims for dates of service January 1, 2006 through December 31, 2007, the Integrated Outpatient Code Editor (I/OCE) determines whether the observation care or direct admission services are packaged or separately payable. Thus, hospitals provide consistent coding and billing under all circumstances in which they deliver observation care.

Beginning January 1, 2006, hospitals should not report CPT codes 99217-99220 or 99234-99236 for observation services. In addition, the following HCPCS codes *were* discontinued as of January 1, 2006: G0244 (Observation care by facility to patient), G0263 (Direct Admission with congestive heart failure, chest pain or asthma), and G0264 (Assessment other than congestive heart failure, chest pain, or asthma).

The three discontinued G-codes and the CPT codes that *were* no longer recognized *were* replaced by two new G-codes to be used by hospitals to report all observation services, whether separately payable or packaged, and direct admission for observation care, whether separately payable or packaged:

- G0378- Hospital observation service, per hour; and
- G0379- Direct admission of patient for hospital observation care.

The *I/OCE* determines whether observation services billed as units of G0378 are separately payable under APC 0339 (Observation) or whether payment for observation services will be packaged into the payment for other services provided by the hospital in the same encounter. Therefore, hospitals should bill HCPCS code G0378 when observation services are provided to any patient in “observation status,” regardless of the patient’s condition. The units of service should equal the number of hours the patient is in observation status.

Hospitals should report G0379 when observation services are the result of a direct admission to “observation” *care* without an associated emergency room visit, hospital outpatient clinic visit, critical care service, *or hospital outpatient surgical procedure (status indicator T procedure)* on the day of initiation of observation services. Hospitals should only report HCPCS code G0379 when a patient is admitted directly to observation care after being seen by a physician in the community (see §290.4.2 below)

Change Request 4047, issued on November 25, 2005, (Transmittal 763), explains that some non-repetitive OPPS services provided on the same day by a hospital may be billed on different claims, provided that all charges associated with each procedure or service *being reported* are billed on the same claim with the HCPCS code which describes that service. It is vitally important that all of the charges that pertain to a non-repetitive, separately paid procedure or service be reported on the same claim with that procedure or service. It should also be emphasized that this relaxation of same day billing requirements for some non-repetitive services does not apply to non-repetitive services provided on the same day as either direct admission to observation care or observation services because the OCE claim-by-claim logic cannot function properly unless all services related to the episode of observation care, including diagnostic tests, lab services, hospital clinic visits, emergency department visits, critical care services, and *status indicator T* procedures, are reported on the same claim. Additional guidance can be found in the Change Request cited above.

290.4.2 - Separate and Packaged Payment for Direct Admission to Observation *Between January 1, 2006 and December 31, 2007*

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

In order to receive separate payment for a direct admission to observation (APC **0604**), the claim must show:

1. Both HCPCS codes G0378 (Hourly Observation) and G0379 (Direct Admit to Observation) with the same date of service;
2. That no services with a status indicator T or V or Critical care (APC **0617**) were provided on the same day of service as HCPCS code G0379; and
3. The observation care does not qualify for separate payment under APC 0339.

Only direct admission to observation services billed on a 13X bill type may be considered for a separate APC payment.

Separate payment is not allowed for HCPCS code G0379, direct admission to observation care, when billed with the same date of service as a hospital clinic visit, emergency room visit, critical care service, or “T” status procedure.

If a bill for direct admission to observation does not meet the **three** requirements listed above, then payment for the direct admission service will be packaged into payments for other separately payable services provided to the beneficiary in the same encounter.

290.4.3- Separate and Packaged Payment for Observation *Services*

Furnished Between January 1, 2006 and December 31, 2007

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

Separate payment may be made for observation services provided to a patient with congestive heart failure, chest pain, or asthma. The list of ICD-9-CM diagnosis codes eligible for separate payment is reviewed annually. Any changes in applicable ICD-9-CM diagnosis codes are included in the October quarterly update of the OPPS and also published in the annual OPPS Final Rule. The list of qualifying ICD-9-CM diagnosis codes is also published on the OPPS Web page.

All of the following requirements must be met in order for a hospital to receive a separate APC payment for observation services through APC 0339:

1. Diagnosis Requirements
 - a. The beneficiary must have one of three medical conditions: congestive heart failure, chest pain, or asthma.
 - b. Qualifying ICD-9-CM diagnosis codes must be reported in Form Locator (FL) 76, Patient Reason for Visit, or FL 67, principal diagnosis, or both in order for the

hospital to receive separate payment for APC 0339. If a qualifying ICD-9-CM diagnosis code(s) is reported in the secondary diagnosis field, but is not reported in either the Patient Reason for Visit field (FL 76) or in the principal diagnosis field (FL 67), separate payment for APC 0339 is not allowed.

2. Observation Time

- a. Observation time must be documented in the medical record.
- b. A beneficiary's time in observation (and hospital billing) begins with the beneficiary's admission to an observation bed.
- c. A beneficiary's time in observation (and hospital billing) ends when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.
- d. The number of units reported with HCPCS code G0378 must equal or exceed 8 hours.

3. Additional Hospital Services

- a. The claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line item date of service on the same day or the day before the date reported for observation:
 - An emergency department visit (APC **0609, 0613, 0614, 0615, 0616**) or
 - A clinic visit (APC **0604, 0605, 0606, 0607, 0608**); or
 - Critical care (APC **0617**); or
 - Direct admission to observation reported with HCPCS code G0379 (APC **0604**) *must be reported on the same date of service as the date reported for observation services.*
- b. No procedure with a T status indicator can be reported on the same day or day before observation care is provided.

4. Physician Evaluation

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

- b. The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

Only observation services that are billed on a 13X bill type may be considered for a separate APC payment.

Hospitals should bill all of the other services associated with the observation care, including direct admission to observation, hospital clinic visits, emergency room visits, critical care services, and T status procedures, on the same claim so that the claims processing logic may appropriately determine the payment status (either packaged or separately payable) of HCPCS codes G0378 and G0379.

If a bill for observation care does not meet all of the requirements listed above, then payment for the observation care will be packaged into payments for other separately payable services provided to the beneficiary in the same encounter.

290.5 - Billing and Payment for Observation Services Furnished on or After January 1, 2008

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

290.5.1 - Billing and Payment for Observation Services Beginning January 1, 2008

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

Observation services are reported using HCPCS code G0378 (Hospital observation service, per hour). Beginning January 1, 2008, HCPCS code G0378 for hourly observation services is assigned status indicator N, signifying that its payment is always packaged. No separate payment is made for observation services reported with HCPCS code G0378, and APC 0339 is deleted as of January 1, 2008. In most circumstances, observation services are supportive and ancillary to the other services provided to a patient. In certain circumstances when observation care is billed in conjunction with a high level clinic visit (Level 5), high level emergency department visit (Level 4 or 5), critical care services, or direct admission as an integral part of a patient's extended encounter of care, payment may be made for the entire extended care encounter through one of two composite APCs when certain criteria are met. For information about payment for extended assessment and management composite APCs, see §10.2.1 (Composite APCs) of this chapter.

APC 8002 (Level I Extended Assessment and Management Composite) describes an encounter for care provided to a patient that includes a high level (Level 5) clinic visit or direct admission to observation in conjunction with observation services of substantial duration (8 or more hours). APC 8003 (Level II Extended Assessment and Management Composite) describes an encounter for care provided to a patient that includes a high level (Level 4 or 5) emergency department visit or critical care services in conjunction with observation services of substantial duration. There is no limitation on diagnosis for

payment of these composite APCs; however, composite APC payment will not be made when observation services are reported in association with a surgical procedure (T status procedure) or the hours of observation care reported are less than 8. The I/OCE evaluates every claim received to determine if payment through a composite APC is appropriate. If payment through a composite APC is inappropriate, the I/OCE, in conjunction with the Pricer, determines the appropriate status indicator, APC, and payment for every code on a claim.

All of the following requirements must be met in order for a hospital to receive an APC payment for an extended assessment and management composite APC:

1. Observation Time

- a. Observation time must be documented in the medical record.*
- b. A beneficiary's time in observation (and hospital billing) begins with the beneficiary's admission to an observation bed.*
- c. A beneficiary's time in observation (and hospital billing) ends when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.*
- d. The number of units reported with HCPCS code G0378 must equal or exceed 8 hours.*

2. Additional Hospital Services

- a. The claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line item date of service on the same day or the day before the date reported for observation:*
 - An emergency department visit (CPT code 99284 or 99285) or*
 - A clinic visit (CPT code 99205 or 99215); or*
 - Critical care (CPT code 99291); or*
 - Direct admission to observation reported with HCPCS code G0379 (APC 0604) must be reported on the same date of service as the date reported for observation services.*
- b. No procedure with a T status indicator can be reported on the same day or day before observation care is provided.*

3. Physician Evaluation

- a. *The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.*
- b. *The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.*

Criteria 1 and 3 related to observation care beginning and ending time and physician evaluation apply regardless of whether the hospital believes that observation services will be packaged or will meet the criteria for extended assessment and management composite payment.

Only observation services that are billed on a 13X bill type may be considered for a composite APC payment.

Non-repetitive services provided on the same day as either direct admission to observation care or observation services must be reported on the same claim because the OCE claim-by-claim logic cannot function properly unless all services related to the episode of observation care, including hospital clinic visits, emergency department visits, critical care services, and T status procedures, are reported on the same claim.

Additional guidance can be found in Change Request 4047, Transmittal 763, issued on November 25, 2005.

If a claim for services providing during an extended assessment and management encounter including observation care does not meet all of the requirements listed above, then the usual APC logic will apply to separately payable items and services on the claim; the special logic for direct admission will apply, and payment for the observation care will be packaged into payments for other separately payable services provided to the beneficiary in the same encounter.

290.5.2 - Billing and Payment for Direct Admission to Observation Care Beginning January 1, 2008

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

Direct admission to observation care continues to be reported using HCPCS code G0379 (Direct admission of patient for hospital observation care). Hospitals should report G0379 when observation services are the result of a direct admission to observation care without an associated emergency room visit, hospital outpatient clinic visit, or critical care service on the day of initiation of observation services. Hospitals should only report HCPCS code G0379 when a patient is admitted directly to observation care after being seen by a physician in the community.

Payment for direct admission to observation will be made either separately as a low level hospital clinic visit under APC 0604 or packaged into payment for composite APC 8002

(Level I Prolonged Assessment and Management Composite) or packaged into the payment for other separately payable services provided in the same encounter. For information about payment for extended assessment and management composite APCs, see, §10.2.1 (Composite APCs) of this chapter.

The criteria for payment of HCPCS code G0379 under either APC 0604 or APC 8002 include:

- 1. Both HCPCS codes G0378 (Hospital observation services, per hr) and G0379 (Direct admission of patient for hospital observation care) are reported with the same date of service.*
- 2. No service with a status indicator of T or V or Critical Care (APC 0617) is provided on the same day of service as HCPCS code G0379.*

If either of the above criteria is not met, HCPCS code G0379 will be assigned status indicator N and will be packaged into payment for other separately payable services provided in the same encounter.

Only direct admission to observation services billed on a 13X bill type may be considered for a composite APC payment.

290.6 - Services Not Covered as Observation Services

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

Hospitals must not bill beneficiaries directly for reasonable and necessary observation services for which the OPPS packages payment for observation as part of the payment for the separately payable items and services on the claim. Hospitals should not confuse packaged payment with non-coverage or nonpayment. See the Medicare Benefit Policy Manual, Pub 100-02, chapter 6, section 20.6 for further explanation of non-covered services and notification of the beneficiary in relation to observation care.

Medicare Claims Processing Manual

Chapter 16 - Laboratory Services

40.3 - Hospital Billing Under Part B

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

Hospital laboratories, billing for either outpatient or non-patient claims, bill the FI.

Neither deductible nor coinsurance applies to laboratory tests paid under the fee schedule.

Hospitals must follow requirements for submission of the ANSI X12N 837 I or the hardcopy Form CMS-1450 (see Chapter 25 for billing requirements).

When the hospital obtains laboratory tests for outpatients under arrangements with clinical laboratories or other hospital laboratories, only the hospital can bill for the arranged services.

If the hospital is a sole community hospital identified in the PPS Provider Specific File with a qualified hospital laboratory identified on the hospital's certification; tests for outpatients are reimbursable at 62 percent.

If the hospital bills claims for both *hospital outpatient and non-patient* laboratory tests *on different dates of service*, it should prepare two bills: one for the outpatient (13X type of bill) laboratory test *and* the other for the non-patient laboratory specimen (14X type of bill) tests. The hospital includes laboratory tests *provided to hospital outpatients* on the same bill with other *hospital* outpatient services to the same beneficiary, unless it is billing for non-patient laboratory specimen *tests provided on a different day from the other hospital outpatient services*, in which case it submits a separate bill for the non-patient laboratory specimen tests.

For all hospitals except CAHs and Maryland waiver hospitals, if a patient receives hospital outpatient services on the same day as a specimen collection and laboratory test, then the patient is considered to be a registered hospital outpatient and cannot be considered to be a non-patient on that day for purposes of the specimen collection and laboratory test. However if the non-CAH or Maryland waiver hospital only collects or draws a specimen from the beneficiary and the beneficiary does not also receive hospital outpatient services on that day, the hospital may choose to register the beneficiary as an outpatient for the specimen collection or bill for these services as non-patient on the 14x bill type.

For CAHs, payment for clinical diagnostic laboratory tests is made at 101 percent of reasonable cost only if the individuals are outpatients of the CAH (85X type of bill), as

defined in 42 CFR 410.2, and are physically present in the CAH at the time the specimens are collected. Clinical diagnostic laboratory tests performed for persons who are not physically present at the CAH (non-patients 14X type of bill) when the specimens are collected are made in accordance with the provisions of sections 1833(a)(1)(D) and 1833(a)(2)(D) of the Social Security Act. See also 42 CFR 413.70(b)(iii). Similarly, for Maryland waiver hospitals, the waiver is limited to services to inpatients and registered outpatients as defined in 42 CFR 410.2. Therefore payment for non-patients (specimen only, TOB 14X) who are not registered outpatients at the time of specimen collection will be made on the clinical diagnostic laboratory fee schedule.

Hospitals should not submit separate bills for laboratory tests performed in different departments on the same day.

Section 416 of the Medicare Prescription, Drug, Improvement, and Modernization Act (MMA) of 2003 also eliminates the application of the clinical laboratory fee schedule for hospital outpatient laboratory testing by a hospital laboratory with fewer than 50 beds in a qualified rural area for cost reporting periods beginning during the 2-year period beginning on July 1, 2004. Payment for these hospital outpatient laboratory tests will be reasonable costs without coinsurance and deductibles during the applicable time period. A qualified rural area is one with a population density in the lowest quartile of all rural county populations.

The reasonable costs are determined using the ratio of costs to charges for the laboratory cost center multiplied by the PS&R's billed charges for outpatient laboratory services for cost reporting periods beginning on or after July 1, 2004 but before July 1, 2006.

In determining whether clinical laboratory services are furnished as part of outpatient services of a hospital, the same rules that are used to determine whether clinical laboratory services are furnished, as an outpatient critical access hospital service will apply.

Medicare Claims Processing Manual

Chapter 17 - Drugs and Biologicals

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90.2 - Drugs, Biologicals, *and Radiopharmaceuticals*

10 - Payment Rules for Drugs and Biologicals

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

Drugs for inpatient hospital and inpatient skilled nursing facility (SNF) beneficiaries are included in the respective prospective payment system (PPS) rates, except for hemophilia clotting factors for hospital inpatients under Part A.

All hospital outpatient drugs are excluded from SDP because the payment allowance for such drugs is determined by a different *methodology*. *Non pass-through drugs with estimated per day costs less than or equal to the applicable drug packaging threshold that are* furnished to hospital outpatients are packaged under the outpatient prospective payment system (OPPS). Their costs are recognized and included but paid as part of the ambulatory payment classification (APC) *group payment* for the service with which they are billed. *Non pass-through drugs with estimated per day costs greater than the applicable drug packaging threshold* are paid separately.

Drugs that are granted “pass through” payment status are required by law to be paid at either the amount paid under the physician fee schedule, or, if the drug is included in the Part B drug competitive acquisition program (CAP), at the Part B drug CAP rate. Drugs that have pass-through status may have coinsurance amounts that are less than 20 percent of the OPPS payment amount. This is because pass-through *payment* amounts, by law, are not subject to coinsurance. CMS considers the amount of the *pass-through drug* payment rate that exceeds the *otherwise applicable OPPS payment rate* to be the pass-through *payment* amount. Thus, *in situations where the pass-through payment rate exceeds the otherwise applicable OPPS payment rate*, the coinsurance is based on a portion of the *total drug* payment rate, not the full payment rate.

Hospitals must report all appropriate HCPCS codes and charges for separately payable drugs, in addition to reporting the applicable drug administration codes. Hospitals should also report the HCPCS codes and charges for drugs that are packaged into payments for the corresponding drug administration or other separately payable services. Historical hospital cost data may assist with future payment packaging decisions for such drugs. Drugs are billed in multiples of the dosage specified in the HCPCS code *long descriptor*. If the *drug dose used in the care of a patient* is not a multiple of the HCPCS code *dosage descriptor*, the provider rounds to the next highest unit *based on* the HCPCS *long descriptor* for the code *in order to report the dose provided*.

If the full dosage provided is less than the dosage for the *HCPCS code descriptor* specifying the minimum dosage for the drug, the provider reports *one unit of* the *HCPCS code* for the minimum dosage amount.

OPPS *Pricer* includes a table of drugs and prices and provides the *contractor* with the appropriate prices.

Section 90 relates specifically to billing for hospital outpatients. The remainder of this chapter relates to procedures for pricing and paying DME recipients, and to beneficiaries who receive drugs under special benefits such as pneumococcal, flu and hepatitis vaccines; clotting factors, immunosuppressive therapy, self administered cancer and anti emetic drugs, and drugs incident to physicians' services.

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 defines a *Specified Covered Outpatient Drug (SCOD)* as a covered outpatient drug for which a separate APC has been established and that is either a radiopharmaceutical agent, or a drug or biological for which payment was made on a pass-through basis on or before December 31, 2002. Payment for SCODs is set, by law, at the average acquisition cost. Under the OPPS, a single payment is made for SCODs that represents payment for both the acquisition cost of the drug and any associated pharmacy overhead or nuclear medicine handling costs.

Drugs or biologicals must meet the coverage requirements in Chapter 15 of the Medicare Benefit Policy Manual. Additionally, for end stage renal disease (ESRD) patients, see the Medicare Benefit Policy Manual, Chapter 11. For ESRD patient billing for drugs and claims processing, see Chapter 8 of this manual.

The following chart describes the payment provisions for drugs.

Table - Drug Payment Methodology

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

In the table below, if the item does not have an asterisk ("*") the bill is submitted to the *contractor*. An asterisk ("*") indicates the bill is submitted to the local carrier or DMERC, as applicable.

Key to the following Table:

* Bills carrier; no asterisk means bill *the hospital's contractor* or RHII **NOTE:** DMERCs do not process claims for blood clotting factors.

† - Drugs & biologicals outside the composite rate are paid as described in 2 below. Those inside the composite rate are paid as described in 1.

1 - Included in PPS rate, or other provider-type all inclusive encounter rate

2 – Price taken from CMS drug/biological pricing file effective on the specific date of service.

3 - Reasonable cost

4 - Lower of cost or 95% AWP paid for drug in addition to PPS rate, or in addition to reasonable cost if excluded from PPS

5 - OPPS-APC, whether pass-thru drug or not

6 - Can not furnish as that “provider” type;

7 - \$10.00 per 1000 units (Payment rate for EPO set in statute)

8 - May get carrier billing number if qualified and bill carrier

++ Except in the State of Washington, where *CMS* permits the RDF to bill immunosuppressives due to the unique State assistance to the beneficiary provided only via the RDF.

Provider/Drug	Hepatitis B Vaccine	Pneumococcal & Flu Vaccines	Hemophilia Clotting Factors	Immuno - Suppressive	Erythro- (EPO)	Self Admin Anti-Cancer Anti-Emetic	Other
Hospital Inpatient (IP) A -	1	1	4	1	1	1	1

Provider/Drug	Hepatitis B Vaccine	Pneumococcal & Flu Vaccines	Hemophilia Clotting Factors	Immuno - Suppressive	Erythro-(EPO)	Self Admin Anti-Cancer Anti-Emetic	Other
Prospective Payment System (IPPS)							
Hospital IP A - not IPPS	3	3	3	3	3	3	3
Hospital IP B Outpatient Prospective Payment System (OPPS)	5	3	5	5	5	5	5
Hospital IP B - not OPPS	3	3	3	3	3	3	3
Hospital Outpatient (OP) - OPPS	5	3	5	5 (30 day supply)	5	5	5
Hospital OP - not OPPS hospital	3	3	3	3	3	3	5
Skilled Nursing Facility (SNF)	1	1	1	1	1	1	1
SNF IP B	3	3	3	3	6	6	6
SNF OP	3	3	3	3	6	6	6
Independent Renal Dialysis Facility (RDF)	3	3	6	6++	7	6	1/2†
Hospital based RDF	5	5	5	6	7	6	3
Comprehensive Outpatient Rehabilitation Facility (CORF)/	5	2	6	2 *	2	6	2

Provider/Drug	Hepatitis B Vaccine	Pneumococcal & Flu Vaccines	Hemophilia Clotting Factors	Immuno - Suppressive	Erythro-(EPO)	Self Admin Anti-Cancer Anti-Emetic	Other
Outpatient Rehabilitation Facility (ORF)							
Community Mental Health Clinic (CMHC)	6	6	6	6	6	6	6
Rural Health Clinical (RHC)/Federally Qualified Health Clinic (FQHC) -hospital based	1	1	5	5	5	5	5
RHC/FQHC-independent	1	1	8,2*	8,2*	8,2*	8,2*	8,2*
Home Health Agencies (HHA)	5	3	5	5	5	5	5
Hospice	6 1	6 1	6 1	6 1	6 1	6 1	6 1
Physicians	2*	2 *	2 *	2 *	2 *	2 *	2 *
Pharmacy	2*	2 *	2 *	2 *	7 *	2 *	2 *
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier	2*	2 *	2 *	2 *	7 *	2	2 *
Critical Access Hospital (CAH) Outpt-Method I	3	3	3	3	3	3	3
CAH Outpt-Method II	3	3	3	3	3	3	3

Provider/Drug	Hepatitis B Vaccine	Pneumococcal & Flu Vaccines	Hemophilia Clotting Factors	Immuno - Suppressive	Erythro-(EPO)	Self Admin Anti-Cancer Anti-Emetic	Other
CAH Inpt	3	3	3	3	3	3	3

NOTE: RHCs do not bill for vaccines. These are paid on the cost report. Vaccine payment to FQHCs is bundled into the encounter rate.

Hepatitis B vaccine is paid on a *reasonable cost basis* in a hospital outpatient department. Deductible and coinsurance apply.

Influenza and pneumococcal vaccines are also paid on *a reasonable cost basis* in a hospital outpatient department. Neither deductible nor coinsurance apply.

HHAs cannot bill for vaccines, except on TOB 34X, since vaccines are not part of the HH benefit and cannot be paid under HH PPS.

Pneumococcal and influenza are paid once for the vaccine and once for the administration of the vaccine. The provider or supplier (including physician) must enter each of the HCPCS on separate lines of the claim.

A Part B blood clotting factor claim from a Part B supplier is processed by the Local Part B Carrier.

A Part A blood clotting factor claim from a Part A provider, including a hospital-based hemophilia center, is processed by the *hospital's Medicare contractor*.

90.2 - Drugs, Biologicals, and Radiopharmaceuticals

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

A. General Billing and Coding for Hospital Outpatient Drugs, Biologicals, and Radiopharmaceuticals

Hospitals should report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. It is also of great importance that hospitals billing for these products make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used in the care of the patient.

Payment for drugs, biologicals and radiopharmaceuticals under the OPPS is inclusive of both the acquisition cost and the associated pharmacy overhead or nuclear medicine handling cost. Hospitals should include these costs in their line-item charges for drugs, biologicals, and radiopharmaceuticals.

Under the OPPS, if commercially available products are being mixed together to facilitate their concurrent administration, the hospital should report the quantity of each product (reported by HCPCS code) used in the care of the patient. Alternatively, if the hospital is compounding drugs that are not a mixture of commercially available products, but are a different product that has no applicable HCPCS code, then the hospital should report an appropriate unlisted drug code (J9999 or J3490). In these situations, it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, Unclassified drug or biological, is for new drugs and biologicals that are approved by FDA on or after January 1, 2004, for which a specific HCPCS code has not been assigned.

The HCPCS code list of retired codes and new HCPCS codes reported under the hospital OPPS is published quarterly via *Recurring Update Notifications*. The latest payment rates associated with each APC and HCPCS code may be found *in the most current Addendum A and Addendum B, respectively, that can be found under the CMS quarterly provider updates on the CMS Web site at:*

<http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp>

B. Pass-Through Drugs, Biologicals, and Radiopharmaceuticals

Payment for drugs, biologicals, and radiopharmaceuticals may be made under the pass-through provision which provides additional payments for drugs, biologicals, and radiopharmaceuticals that meet certain requirements relating to newness and relative costs. According to section 1833(t) of the Social Security Act, transitional pass-through payments can be made for at least 2 years, but no more than 3 years. For the process and information required to apply for transitional pass-through payment status for drugs, biologicals, and radiopharmaceuticals, go to the main OPPS Web page, currently at http://www.cms.hhs.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPa

ge to see the latest instructions. (NOTE: Due to the continuing development of the new cms.hhs.gov Web site, this link may change.) Payment rates for pass-through drugs, biologicals, and radiopharmaceuticals are updated quarterly. The all-inclusive list of billable drugs, biologicals, and radiopharmaceuticals for pass-through payment is included in the current quarterly Addendum B. The most current Addendum B can be found under the CMS quarterly provider updates on the CMS Web site at: <http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp>.

C. Non Pass-Through Drugs and Biologicals

Under the OPPS, drugs and biologicals that are not granted pass-through status receive either packaged payment or separate payment. Payment for drugs and biologicals with estimated per day costs equal to or below the applicable drug packaging threshold is packaged into the payment for the associated procedure, commonly a drug administration procedure. Drugs and biologicals with per day costs above the applicable drug packaging threshold are paid separately through their own APCs.

D. Radiopharmaceuticals

1. General

Beginning in CY 2008, the OPPS divides radiopharmaceuticals into two groups for payment purposes: diagnostic and therapeutic. Diagnostic radiopharmaceuticals function effectively as products that enable the provision of an independent service, specifically, a diagnostic nuclear medicine scan. Therapeutic radiopharmaceuticals are themselves the primary therapeutic modality.

2. Diagnostic Radiopharmaceuticals

Beginning in CY 2008, payment for non pass-through diagnostic radiopharmaceuticals is packaged into the payment for the associated nuclear medicine procedure.

Beginning January 1, 2008, the I/OCE will begin requiring claims with separately payable nuclear medicine procedures to include a diagnostic radiopharmaceutical. Hospitals are required to submit the diagnostic radiopharmaceutical on the same claim as the nuclear medicine procedure. Hospitals are also instructed to submit the claim so that the services on the claim each reflect the date the particular service was provided. Therefore, if the nuclear medicine procedure is provided on a different date of service from the diagnostic radiopharmaceutical, the claim will contain more than one date of service. More information regarding these edits is available on the OPPS Web site at <http://www.cms.hhs.gov/HospitalOutpatientPPS/>.

3. Therapeutic Radiopharmaceuticals

The OPPS will continue to pay for non pass-through therapeutic radiopharmaceuticals at charges adjusted to cost From January 1, 2008 through June 30, 2008. Beginning July 1, 2008, payment for separately payable therapeutic radiopharmaceuticals under the OPPS will be made on a prospective basis with payment rates based upon mean costs from hospital claims data, unless otherwise required by law.