CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2141	**Date: January 24, 2011**
	Change Request 7271

Transmittal 2130, dated December 30, 2010, is being rescinded and replaced by Transmittal 2141 to include the Medicare and Medicaid Extenders Act of 2010 (MMEA) revision to the discussion of hold harmless payments in Section A.-Background, and Section B.-Policy, Item 12 of the Recurring Update Notification, and in section 70.7 of the manual instruction. All other information remains the same.

SUBJECT: January 2011 Update of the Hospital Outpatient Prospective Payment System (OPPS)

I. SUMMARY OF CHANGES: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the January 2011 OPPS update. It affects Chapter 4, Sections 10, 30, 160. CMS is updating information in these sections. The January 2011 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this Change Request (CR).

EFFECTIVE DATE: January 1, 2011
IMPLEMENTATION DATE: January 3, 2011

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
R	4/Table of Contents
R	4/10.2.1/Composite APCs
R	4/30/OPPS Coinsurance
R	4/70.7/Transitional Outpatient Payments (TOPs) for CY 2010
N	4/70.8/TOPs Overpayments
R	4/160.1/Critical Care Services
N	4/180.7/Inpatient-only Services

R	4/230.2/Coding and Payment for Drug Administration
R	4/260.1/Special Partial Hospitalization Billing Requirements for Hospitals, Community Mental Health Centers, and Critical Access Hospitals
R	4/260.1.1/Bill Review for Partial Hospitalization Services Provided in Community Mental Health Centers (CMHC)

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not 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: 2141	Date: January 24, 2011	Change Request: 7271

Transmittal 2130, dated December 30, 2010, is being rescinded and replaced by Transmittal 2141 to include the Medicare and Medicaid Extenders Act of 2010 (MMEA) revision to the discussion of hold harmless payments in Section A.-Background, and Section B.-Policy, Item 12 of the Recurring Update Notification, and in section 70.7 of the manual instruction. All other information remains the same.

SUBJECT: January 2011 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Effective Date: January 1, 2011
Implementation Date: January 3, 2011

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the January 2011 OPPS update. The January 2011 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this Change Request (CR). The Medicare and Medicaid Extenders Act of 2010 (MMEA) extends the Outpatient Hold Harmless Provision for small rural hospitals with 100 or fewer beds and all Sole Community and Essential Access Hospitals and reclassification wage indices originally authorized under section 508 of MMA. This Notification includes instructions addressing hold harmless payment. CMS will issue a separate notification to address the extension of section 508 reclassification wage indices.

The January 2011 revisions to I/OCE data files, instructions, and specifications are provided in CR 7252, Transmittal 2114, "January 2011 Integrated Outpatient Code Editor (I/OCE) Specifications Version 12.0."

B. Policy:

1. Changes to Device Edits for January 2011

Claims for OPPS services must pass two types of device edits to be accepted for processing: procedure-to-device edits and device-to-procedure edits. Procedure-to-device edits, which have been in place for many procedures since 2005, continue to be in place. These edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code. Procedures for which both a Device A and a Device B are specified require that at least one each of Device A and Device B be present on the claim (i.e., there must be some combination of a Device A with a Device B in order to pass the edit). Device B can be reported with any Device A for the same procedural HCPCS code.

Since January 1, 2007, CMS also has required that a claim that contains one of a specified set of device codes be returned to the provider if it fails to contain an appropriate procedure code. CMS has determined that the devices contained in this list cannot be correctly reported without one of the specified procedure codes also being reported on the same claim. Where these devices were billed without an appropriate procedure code prior to January 1, 2007, the cost of the device was being packaged into the median cost for an incorrect procedure code and therefore inflated the payment for the incorrect procedure code. In addition, hospitals billing devices without the appropriate procedure code were being incorrectly paid. The device-to-procedure edits are designed to ensure that the costs of these devices are assigned to the appropriate APC in OPPS ratesetting.

The most current edits for both types of device edits can be found at http://www.cms.gov/HospitalOutpatientPPS/. Failure to pass these edits will result in the claim being returned to the provider.

2. Payment for Multiple Imaging Composite APCs

Effective for services furnished on or after January 1, 2009, multiple imaging procedures performed during a single session using the same imaging modality are paid by applying a composite APC payment methodology. The services are paid with one composite APC payment each time a hospital bills for second and subsequent imaging procedures described by the HCPCS codes in one imaging family on a single date of service. The I/OCE logic determines the assignment of the composite APCs for payment. Prior to January 1, 2009, hospitals received a full APC payment for each imaging service on a claim, regardless of how many procedures were performed during a single session.

The composite APC payment methodology for multiple imaging services utilizes three imaging families (Ultrasound, CT and CTA, and MRI and MRA) and five composite APCs: APC 8004 (Ultrasound Composite); APC 8005 (CT and CTA without Contrast Composite); APC 8006 (CT and CTA with Contrast Composite); APC 8007 (MRI and MRA without Contrast Composite); and APC 8008 (MRI and MRA with Contrast Composite). When a procedure is performed with contrast during the same session as a procedure without contrast, and the two procedures are within the same family, the "with contrast" composite APC (either APC 8006 or 8008) is assigned.

CMS has updated the list of specified HCPCS codes within the three imaging families and five composite APCs to reflect HCPCS coding changes. Specifically, CMS added CPT code 74176 (Computed tomography, abdomen and pelvis; without contrast material), CPT code 74177 (Computed tomography, abdomen and pelvis; with contrast material(s)), and CPT code 74178 (Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions) to the CT and CTA family. These codes are new for CY 2011. CMS also added HCPCS codes C8931 (Magnetic resonance angiography with contrast, spinal canal and contents), C8932 (Magnetic resonance angiography without contrast, spinal canal and contents), C8933 (Magnetic resonance angiography without contrast followed by with contrast, spinal canal and contents), C8934 (Magnetic resonance angiography with contrast, upper extremity), C8935 (Magnetic resonance angiography without contrast, upper extremity), and C8936 (Magnetic resonance angiography without contrast followed by with contrast, upper extremity), to the MRI and MRA family. These codes were recognized for OPPS payment in the October 2010 OPPS Update (Transmittal 2050, Change Request 7117, dated September 17, 2010).

The specified HCPCS codes within the three imaging families and five composite APCs for CY 2011 are provided below:

Table 1 – The Specified HCPCS Codes Within the Three Imaging Families and Five Composite APCs for CY 2011

Family 1 – Ultrasound	
CY 2011 APC 8004 (Ultrasound Composite)	
76604	Us exam, chest
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp

76775	Us exam abdo back wall, lim
76776	Us exam k transpl w/Doppler
76831	Echo exam, uterus
76856	Us exam, pelvic, complete
76870	Us exam, scrotum
76857	Us exam, pelvic, limited
Family 2 - CT and CTA with and without Contrast	
CY 2011 APC 8005 (CT and CTA without Contrast Composite)*	
70450	Ct head/brain w/o dye
70480	Ct orbit/ear/fossa w/o dye
70486	Ct maxillofacial w/o dye
70490	Ct soft tissue neck w/o dye
71250	Ct thorax w/o dye
72125	Ct neck spine w/o dye
72128	Ct chest spine w/o dye
72131	Ct lumbar spine w/o dye
72192	Ct pelvis w/o dye
73200	Ct upper extremity w/o dye
73700	Ct lower extremity w/o dye
74150	Ct abdomen w/o dye
74261	Ct colonography, w/o dye
74176	Ct angio abd & pelvis
CY 2011 APC 8006 (CT and CTA with Contrast Composite)	
70487	Ct maxillofacial w/dye
70460	Ct head/brain w/dye
70470	Ct head/brain w/o & w/dye
70481	Ct orbit/ear/fossa w/dye
70482	Ct orbit/ear/fossa w/o&w/dye
70488	Ct maxillofacial w/o & w/dye
70491	Ct soft tissue neck w/dye
70492	Ct sft tsue nck w/o & w/dye
70496	Ct angiography, head
70498	Ct angiography, neck
71260	Ct thorax w/dye
71270	Ct thorax w/o & w/dye
71275	Ct angiography, chest
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye

72191	Ct angiograph pelv w/o&w/dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o&w/dye
73206	Ct angio upr extrm w/o&w/dye
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o&w/dye
73706	Ct angio lwr extr w/o&w/dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o & w/dye
74175	Ct angio abdom w/o & w/dye
74262	Ct colonography, w/dye
75635	Ct angio abdominal arteries
74177	Ct angio abd&pelv w/contrast
74178	Ct angio abd & pelv 1+ regns
* If a “without contrast” CT or CTA procedure is performed during the same session as a “with contrast” CT or CTA procedure, the I/OCE will assign APC 8006 rather than APC 8005.	
Family 3 - MRI and MRA with and without Contrast	
CY 2011 APC 8007 (MRI and MRA without Contrast Composite)*	
70336	Magnetic image, jaw joint
70540	Mri orbit/face/neck w/o dye
70544	Mr angiography head w/o dye
70547	Mr angiography neck w/o dye
70551	Mri brain w/o dye
70554	Fmri brain by tech
71550	Mri chest w/o dye
72141	Mri neck spine w/o dye
72146	Mri chest spine w/o dye
72148	Mri lumbar spine w/o dye
72195	Mri pelvis w/o dye
73218	Mri upper extremity w/o dye
73221	Mri joint upr extrem w/o dye
73718	Mri lower extremity w/o dye
73721	Mri jnt of lwr extre w/o dye
74181	Mri abdomen w/o dye
75557	Cardiac mri for morph
75559	Cardiac mri w/stress img
C8901	MRA w/o cont, abd
C8904	MRI w/o cont, breast, uni
C8907	MRI w/o cont, breast, bi
C8910	MRA w/o cont, chest

C8913	MRA w/o cont, lwr ext
C8919	MRA w/o cont, pelvis
C8932	MRA, w/o dye, spinal canal
C8935	MRA, w/o dye, upper extr
CY 2011 APC 8008 (MRI and MRA with Contrast Composite)	
70549	Mr angiograph neck w/o&w/dye
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w/dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o&w/dye
70548	Mr angiography neck w/dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
72142	Mri neck spine w/dye
72147	Mri chest spine w/dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o&w/dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o&w/dye
73719	Mri lower extremity w/dye
73720	Mri lwr extremity w/o&w/dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o&w/dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
75561	Cardiac mri for morph w/dye
75563	Card mri w/stress img & dye
C8900	MRA w/cont, abd
C8902	MRA w/o fol w/cont, abd
C8903	MRI w/cont, breast, uni
C8905	MRI w/o fol w/cont, brst, un
C8906	MRI w/cont, breast, bi
C8908	MRI w/o fol w/cont, breast,
C8909	MRA w/cont, chest
C8911	MRA w/o fol w/cont, chest

C8912	MRA w/cont, lwr ext
C8914	MRA w/o fol w/cont, lwr ext
C8918	MRA w/cont, pelvis
C8920	MRA w/o fol w/cont, pelvis
C8931	MRA, w/dye, spinal canal
C8933	MRA, w/o&w/dye, spinal canal
C8934	MRA, w/dye, upper extremity
C8936	MRA, w/o&w/dye, upper extr
* If a "without contrast" MRI or MRA procedure is performed during the same session as a "with contrast" MRI or MRA procedure, the I/OCE will assign APC 8008 rather than 8007.	

3. Mental Health Services Composite APC (APC 0034)

Since CY 2009, CMS has set the annual payment rate for the mental health composite APC at the same rate as the maximum partial hospitalization per diem payment. For CY 2011, CMS is adapting a provider-specific two tiered payment approach for partial hospitalization services that distinguishes payment made for services furnished in a community mental health center (CMHC) from payment made for services furnished in a hospital. CMS has modified the titles of APCs 0172 (Level I Partial Hospitalization (3 services) for CMHCs) and 0173 (Level II Partial Hospitalization (4 or more services) for CMHCs) to solely reflect CMHC-based partial hospitalization services. Additionally, CMS has created APCs 0175 (Level I Partial Hospitalization (3 services) for Hospital-Based Partial Hospitalization Programs) and 0176 (Level II Partial Hospitalization (4 or more services) for Hospital-Based PHPs) to pay for hospital-based partial hospitalization services. In accordance with CMS' policy to pay for the mental health composite APC at the same rate as the maximum partial hospitalization per diem payment, for CY 2011, CMS will use the hospital-based partial hospitalization APC 0176 as the daily payment cap for less intensive mental health services provided in hospital outpatient departments and will set the CY 2011 payment rate for APC 0034 at the same rate as APC 0176. CMS is updating Pub. 100-04, Medicare Claims Processing Manual, chapter 4, section 10.2.1 to reflect this change.

The I/OCE will continue to determine whether to pay specified mental health services individually or to make a single payment at the same rate as the APC 0176 per diem rate for partial hospitalization for all of the specified mental health services furnished on that date of service. Through the I/OCE, when the payment for the specified mental health services provided by one hospital to a single beneficiary on one date of service based on the payment rates associated with the APCs for the individual services would exceed the maximum per diem partial hospitalization payment, those specified mental health services would be assigned to APC 0034 (Mental Health Services Composite), which has the same payment rate as APC 0176, and the hospital would be paid one unit of APC 0034.

4. Partial Hospitalization APCs

For CY 2011, CMS is creating four separate PHP per diem payment rates: two for CMHCs (for Level I and Level II PH services based on only CMHC data), and two for hospital-based PHPs (for Level I and Level II services based on only hospital-based data). CMS will be implementing a 2 year transition for the two CMHC PHP per diem rates to mitigate their payment reduction. The APCs for the CMHCs are: APC 0172 (Level I Partial Hospitalization (3 services)) and APC 0173 (Level II Partial Hospitalization (4 or more services)). The APCs for the hospital-based PHPs are: APC 0175 (Level I Partial Hospitalization (3 services)) and APC 0176 (Level Level II Partial Hospitalization (4 or more services)).

When a community mental health center (CMHC) provides three services of partial hospitalization services and meets all other partial hospitalization payment criteria, the CMHCs would be paid through APC 0172. Similarly, when a hospital-based PHP provides three services of partial hospitalization services and meets all

other partial hospitalization payment criteria, the hospital-based PHP would be paid through APC 0175. When the CMHCs provide four or more services of partial hospitalization services and meet all other partial hospitalization payment criteria, the CMHC would be paid through APC 0173 and the hospital-based PHP providing four or more services would be paid through APC 0176.

The tables below provide the updated per diem payment rates:

Table 2 – CY 2011 Median Per Diem Costs for CMHC PHP Services Plus Transition

APC	Group Title	Median Per Diem Costs Plus Transition
0172	Level I Partial Hospitalization (3 services) for CMHCs	$128.25
0173	Level II Partial Hospitalization (4 or more services) for CMHCs	$162.67

Table 3 – CY 2011 Median Per Diem Costs for Hospital-Based PHP Services

APC	Group Title	Median Per Diem Costs
0175	Level I Partial Hospitalization (3 services) for hospital-based PHPs	$202.71
0176	Level II Partial Hospitalization (4 or more services) for hospital-based PHPs	$235.79

a. Changes to Regulations to Incorporate Provisions of HCERA 21010

Section 1301 (a) and (b) of the Health Care and Education Reconciliation Act of 2010 (HCERA 2010) established new requirements for Community Mental Health Centers (CMHCs) and amended the definition of a PHP. Section 1301 (a) of HCERA revised the definition of a CMHC by adding a requirement that the CMHC must provide at least 40 percent of its services to non-Medicare beneficiaries, effective April 1, 2010. Section 1301 (b) of HCERA amends the description of a PHP to specify that the program must be a distinct and organized intensive ambulatory treatment program offering less than 24-hour daily care "other than in an individual's home or in an inpatient or residential setting."

5. Reporting Hospital Critical Care Services Under the OPPS

For CY 2010 and in prior years, the AMA CPT Editorial Panel has defined critical care CPT codes 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes) and 99292 (Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)) to include a wide range of ancillary services such as electrocardiograms, chest X-rays and pulse oximetry. As stated in manual instruction, hospitals should report in accordance with CPT guidance unless CMS instructs otherwise. For critical care in particular, CMS has instructed hospitals that any services that the CPT Editorial Panel indicates are included in the reporting of CPT code 99291 (including those services that would otherwise be reported by and paid to hospitals using any of the CPT codes specified by the CPT Editorial Panel) should not be billed separately. Instead, hospitals should report charges for any services provided as part of the critical care services.

Beginning January 1, 2011, under revised AMA CPT Editorial Panel guidance, hospitals that report in accordance with the CPT guidelines will begin reporting all of the ancillary services and their associated

charges separately when they are provided in conjunction with critical care. CMS will continue to recognize the existing CPT codes for critical care services and is establishing a payment rate based on its historical data, into which the cost of the ancillary services is intrinsically packaged. The I/OCE logic will conditionally package payment for the ancillary services that are reported on the same date of service as critical care services in order to avoid overpayment. The payment status of the ancillary services will not change when they are not provided in conjunction with critical care services. Hospitals may use HCPCS modifier -59 to indicate when an ancillary procedure or service is distinct or independent from critical care when performed on the same day but in a different encounter.

CMS is updating Pub. 100-04, Medicare Claims Processing Manual, chapter 4, section 160.1, to reflect the revised critical care reporting guidelines and OPPS payment policy.

6. Waiver of Cost- Sharing for Preventive Services

The Affordable Care Act waives any copayment and deductible that would otherwise apply for the defined set of preventive services to which the U.S. Preventive Services Task Force (USPSTF) has given a grade of A or B, as well as, the Initial Preventive Physical Examination (IPPE), and the Annual Wellness Visit (AWV) providing Personalized Preventive Plan Services (PPPS). These provisions are effective for services furnished on and after January 1, 2011. CMS is revising Pub. 100-04, Medicare Claims Processing Manual, chapter 4, section 30, which references the 25% copayment for screening colonoscopies and screening flexible sigmoidoscopies, effective prior to January 1, 2011, to reflect this change. Further information on the implementation of waiver of cost- sharing for preventive services as prescribed by the Affordable Care Act can be found in CR 7012, Transmittal 739, issued on July 30, 2010.

7. Billing for Tobacco Cessation Counseling

Effective for claims with dates of service on and after August 25, 2010, CMS will cover tobacco cessation counseling for outpatient and hospitalized Medicare beneficiaries 1) who use tobacco, regardless of whether they have signs or symptoms of tobacco-related disease; 2) who are competent and alert at the time that counseling is provided; and 3) whose counseling is furnished by a qualified physician or other Medicare-recognized practitioner. To implement this recent coverage determination, CMS created new C-codes and G-codes to report tobacco cessation counseling service. The long descriptors for both the C-codes and G-codes appear in Table 4.

Table 4 – Tobacco Cessation Counseling Services

CY 2011 HCPCS Code	CY 2010 HCPCS Code	CY 2011 Long Descriptor	CY 2011 Status Indicator	CY 2011 APC
G0436	C9801	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes	X	0031
G0437	C9802	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes	X	0031

For dates of service between August 25, 2010 through December 31, 2010, hospital outpatient facilities must have reported either HCPCS code C9801 or C9802 for tobacco cessation counseling services. HCPCS codes C9801 and C9802 will be deleted December 31, 2010, and replaced with HCPCS codes G0436 and G0437, respectively, effective January 1, 2011. Both HCPCS codes G0436 and G0437 have been assigned to the same

status indicators and APC assignments as their predecessor C-codes. Further reporting guidelines on tobacco cessation counseling services can be found in Pub. 100-04, Medicare Claims Processing Manual, Chapter 18, Section 150 and in Transmittal 2058, CR 7133 that was published on September 30, 2010.

8. Inpatient-only Services

CMS is adding Section 180.7 Inpatient Only Services to Pub. 100-04, Medicare Claims Processing Manual, chapter 4, to clarify that OPPS does not pay hospitals for an inpatient only procedure and related ancillary services provided on the same day.

9. Billing for Drugs, Biologicals, and Radiopharmaceuticals

a. Reporting HCPCS Codes for All Drugs, Biologicals, and Radiopharmaceuticals

Hospitals are strongly encouraged to 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 codes are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used in the care of the patient.

More complete data from hospitals on the drugs and biologicals provided during an encounter would help improve payment accuracy for separately payable drugs and biologicals in the future. CMS strongly encourages hospitals to report HCPCS codes for all drugs and biologicals furnished, if specific codes are available. CMS realizes that this may require hospitals to change longstanding reporting practices. Precise billing of drug and biological HCPCS codes and units, especially in the case of packaged drugs and biologicals for which the hospital receives no separate payment, is critical to the accuracy of the OPPS payment rates for drugs and biologicals each year.

CMS notes that it makes packaging determinations for drugs and biologicals annually based on charge information reported with specific HCPCS codes on claims, so the accuracy of OPPS payment rates for drugs and biologicals improves when hospitals report charges for all items and services that have HCPCS codes under those HCPCS codes, whether or not payment for the items and services is packaged or not. It is CMS' standard ratesetting methodology to rely on hospital cost and charge information as it is reported to CMS by hospitals through the claims data and cost reports. Precise billing and accurate cost reporting by hospitals allow CMS to most accurately estimate the hospital costs for items and services upon which OPPS payments are based.

CMS reminds hospitals that under the OPPS, if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used in the care of the patient. The mixing together of two or more products does not constitute a "new" drug as regulated by the Food and Drug Administration (FDA) under the New Drug Application (NDA) process. In these situations, hospitals are reminded that 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 the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned.

Unless otherwise specified in the long description, HCPCS descriptions refer to the non-compounded, FDA-approved final product. If a product is compounded and a specific HCPCS code does not exist for the compounded product, the hospital should report an appropriate unlisted code such as J9999 or J3490.

b. New CY 2011 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

For CY 2011, several new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. These new codes are listed in Table 5 below.

Table 5 – New CY 2011 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2011 HCPCS Code	CY 2011 Long Descriptor	CY 2011 SI	CY 2011 APC
C9274	Crotalidae Polyvalent Immune Fab (Ovine), 1 vial	G	9274
C9275	Injection, hexaminolevulinate hydrochloride, 100 mg, per study dose	G	9275
C9276	Injection, cabazitaxel, 1 mg	G	9276
C9277	Injection, alglucosidase alfa (Lumizyme), 1 mg	G	9277
C9278	Injection, incobotulinumtoxin A, 1 unit	G	9278
C9279	Injection, ibuprofen, 100 mg	G	9279
J0638	Injection, canakinumab, 1 mg	K	1311
J1559	Injection, immune globulin (Hizentra), 100 mg	K	1312
J1599	Injection, immune globulin, intravenous, non-lyophilized (e.g., liquid), not otherwise specified, 500 mg	N	N/A
J2358	Injection, olanzapine, long-acting, 1 mg	K	1331
J7196	Injection, antithrombin recombinant, 50 IU	K	1332
J7309	Methyl aminolevulinate (mal) for topical administration, 16.8%, 10 mg	K	1338
Q4118	Matristem micromatrix, 1 mg	K	1342
Q4121	Theraskin, per square centimeter	K	1345

c. Other Changes to CY 2011 HCPCS and CPT Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals

Many HCPCS and CPT codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS and CPT code descriptors that will be effective in CY 2011. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2010, and replaced with permanent HCPCS codes in CY 2011. Hospitals should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the active CY 2011 HCPCS and CPT codes.

Table 6 – Other CY 2011 HCPCS and CPT Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2010 HCPCS/ CPT code	CY 2010 Long Descriptor	CY 2011 HCPCS/ CPT Code	CY 2011 Long Descriptor
90644	Meningococcal conjugate vaccine, serogroups C&Y and Hemophilus influenza b vaccine, tetanus toxoid conjugate (Hib-MenCY-TT), 4-dose schedule, when administered to	90644	Meningococcal conjugate vaccine, serogroups C & Y and Hemophilus influenza b vaccine, tetanus toxoid conjugate (Hib-MenCY-TT), 4 dose schedule, when administered to

CY 2010 HCPCS/ CPT code	CY 2010 Long Descriptor	CY 2011 HCPCS/ CPT Code	CY 2011 Long Descriptor
	children 2-5 months of age, for intramuscular use		children 2-15 months of age, for intramuscular use
90658	Influenza virus vaccine, split virus, when administered to 3 years of age and older, for intramuscular use	Q2035	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (afluria)
90658	Influenza virus vaccine, split virus, when administered to 3 years of age and older, for intramuscular use	Q2036	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (flulaval)
90658	Influenza virus vaccine, split virus, when administered to 3 years of age and older, for intramuscular use	Q2037	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (fluvirin)
90658	Influenza virus vaccine, split virus, when administered to 3 years of age and older, for intramuscular use	Q2038	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (fluzone)
90658	Influenza virus vaccine, split virus, when administered to 3 years of age and older, for intramuscular use	Q2039	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (not otherwise specified)
C9255	Injection, paliperdione palmitate, 1 mg	J2426	Injection, paliperidone palmitate, extended release, 1 mg
C9256	Injection, dexamethasone intravitreal implant, 0.1 mg	J7312	Injection, dexamethasone intravitreal implant, 0.1 mg
C9258	Injection, telavancin, 10 mg	J3095	Injection, telavancin, 10 mg
C9259	Injection, pralatrexate, 1 mg	J9307	Injection, pralatrexate, 1 mg
C9260	Injection, ofatumumab, 10 mg	J9302	Injection, ofatumumab, 10 mg
C9261	Injection, ustekinumab, 1 mg	J3357	Injection, ustekinumab, 1 mg
C9263	Injection, ecallandtide, 1 mg	J1290	Injection, ecallantide, 1 mg
C9264	Injection, tocilizumab, 1 mg	J3262	Injection, tocilizumab, 1 mg
C9265	Injection, romidepsin, 1 mg	J9315	Injection, romidepsin, 1 mg
C9266	Injection, collagenase clostridium histolyticum, 0.1 mg	J0775	Injection, collagenase clostridium histolyticum, 0.01 mg
C9267	Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO	*J7184	Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO
C9268	Capsaicin, patch, 10cm2	J7335	Capsaicin 8% patch, per 10 square centimeters
C9269	Injection, C-1 esterase inhibitor	J0597	Injection, C-1 Esterase inhibitor

CY 2010 HCPCS/ CPT code	CY 2010 Long Descriptor	CY 2011 HCPCS/ CPT Code	CY 2011 Long Descriptor
	(human), Berinert, 10 units		(human), Berinert, 10 units
C9271	Injection, velaglucerase alfa, 100 units	J3385	Injection, velaglucerase alfa, 100 units
J0170	Injection, adrenalin, epinephrine, up to 1 ml ampule	J0171	Injection, adrenalin, epinephrine, 0.1 mg
J0559	Injection, penicillin g benzathine and penicillin g procaine, 2500 units	J0558	Injection, penicillin g benzathine and penicillin g procaine, 100,000 units
J0560	Injection, penicillin g benzathine, up to 600,000 units	J0561	Injection, penicillin g benzathine, 100,000 units
J0570	Injection, penicillin g benzathine, up to 1,200,000 units	J0561	Injection, penicillin g benzathine, 100,000 units
J0580	Injection, penicillin g benzathine, up to 2,400,000 units	J0561	Injection, penicillin g benzathine, 100,000 units
J0970	Injection, estradiol valerate, up to 40 mg	J1380	Injection, estradiol valerate, up to 10 mg
J1390	Injection, estradiol valerate, up to 20 mg	J1380	Injection, estradiol valerate, up to 10 mg
J1470	Injection, gamma globulin, intramuscular, 2 cc	J1460	Injection, gamma globulin, intramuscular, 1 cc
J1480	Injection, gamma globulin, intramuscular, 3 cc	J1460	Injection, gamma globulin, intramuscular, 1 cc
J1490	Injection, gamma globulin, intramuscular, 4 cc	J1460	Injection, gamma globulin, intramuscular, 1 cc
J1500	Injection, gamma globulin, intramuscular, 5 cc	J1460	Injection, gamma globulin, intramuscular, 1 cc
J1510	Injection, gamma globulin, intramuscular, 6 cc	J1460	Injection, gamma globulin, intramuscular, 1 cc
J1520	Injection, gamma globulin, intramuscular, 7 cc	J1460	Injection, gamma globulin, intramuscular, 1 cc
J1530	Injection, gamma globulin, intramuscular, 8 cc	J1460	Injection, gamma globulin, intramuscular, 1 cc
J1540	Injection, gamma globulin, intramuscular, 9 cc	J1460	Injection, gamma globulin, intramuscular, 1 cc
J1550	Injection, gamma globulin, intramuscular, 10 cc	J1460	Injection, gamma globulin, intramuscular, 1 cc
J1785	Injection, imiglucerase, per unit	J1786	Injection, imiglucerase, 10 units
J1825	Injection, interferon beta-1a, 33 mcgunit	J1826	Injection, interferon beta-1a, 33 mcg
J2321	Injection, nandrolone, decanoate, up to 100 mg	J2320	Injection, nandrolone decanoate, up to 50 mg
J2322	Injection, nandrolone decanoate, up to 200 mg	J2320	Injection, nandrolone decanoate, up to 50 mg
J9062	Cisplatin, 50 mg	J9060	Cisplatin, powder or solution, 10 mg

CY 2010 HCPCS/ CPT code	CY 2010 Long Descriptor	CY 2011 HCPCS/ CPT Code	CY 2011 Long Descriptor
J9080	Cyclophosphamide, 200 mg	J9070	Cyclophosphamide, 100 mg
J9090	Cyclophosphamide, 500 mg	J9070	Cyclophosphamide, 100 mg
J9091	Cyclophosphamide, 1.0 gram	J9070	Cyclophosphamide, 100 mg
J9092	Cyclophosphamide, 2.0 gram	J9070	Cyclophosphamide, 100 mg
J9093	Cyclophosphamide, lyophilized, 100 mg	J9070	Cyclophosphamide, 100 mg
J9094	Cyclophosphamide, lyophilized, 200 mg	J9070	Cyclophosphamide, 100 mg
J9095	Cyclophosphamide, lyophilized, 500 mg	J9070	Cyclophosphamide, 100 mg
J9096	Cyclophosphamide, lyophilized, 1.0 gram	J9070	Cyclophosphamide, 100 mg
J9097	Cyclophosphamide, lyophilized, 2.0 gram	J9070	Cyclophosphamide, 100 mg
J9110	Injection, cytarabine, 500 mg	J9100	Injection, cytarabine, 100 mg
J9140	Injection, dacarbazine, 200 mg	J9130	Dacarbazine, 100 mg
J9290	Mitomycin, 20 mg	J9280	Mitomycin, 5 mg
J9291	Mitomycin, 40 mg	J9280	Mitomycin, 5 mg
J9350	Injection, topotecan, 4 mg	J9351	Injection, topotecan, 0.1 mg
J9375	Vincristine sulfate, 2 mg	J9370	Vincristine sulfate, 1 mg
J9380	Vincristine sulfate, 5 mg	J9370	Vincristine sulfate, 1 mg
Q2025	Fludarabine phosphate oral, 1 mg	J8562	Fludarabine phosphate, oral, 10 mg
Q4101	Skin substitute, apligraf, per square centimeter	Q4101	Apligraf, per square centimeter
Q4102	Skin substitute, oasis burn matrix, per square centimeter	Q4102	Oasis wound matrix, per square centimeter
Q4103	Skin substitute, oasis burn matrix, per square centimeter	Q4103	Oasis burn matrix, per square centimeter
Q4104	Skin substitute, integra bilayer matrix wound dressing (bmwd), per square centimeter	Q4104	Integra bilayer matrix wound dressing (BMWD), per square centimeter
Q4105	Skin substitute, integra dermal regeneration template (drt), per square centimeter	Q4105	Integra dermal regeneration template (DRT), per square centimeter
Q4106	Skin substitute, dermagraft, per square centimeter	Q4106	Dermagraft, per square centimeter
Q4107	Skin substitute, graftjacket, per square centimeter	Q4107	Graftjacket, per square centimeter
Q4108	Skin substitute, integra matrix, per square centimeter	Q4108	Integra matrix, per square centimeter

CY 2010 HCPCS/ CPT code	CY 2010 Long Descriptor	CY 2011 HCPCS/ CPT Code	CY 2011 Long Descriptor
Q4110	Skin substitute, primatrix, per square centimeter	Q4110	Primatrix, per square centimeter
Q4111	Skin substitute, gammagraft, per square centimeter	Q4111	Gammagraft, per square centimeter
Q4112	Allograft, cymetra, injectable 1 cc	Q4112	Cymetra, injectable, 1 cc
Q4113	Allograft, graftjacket express, injectable 1 cc	Q4113	Graftjacket express, injectable, 1 cc
Q4115	Skin substitute, alloskin, per square centimeter	Q4115	Alloskin, per square centimeter
Q4116	Skin substitute, alloderm, per square centimeter	Q4116	Alloderm, per square centimeter

*Note: HCPCS code J7184 is identified as a blood clotting factor and, as such, is subject to the CY 2011 blood clotting factor furnishing fee.

d. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective January 1, 2011

For CY 2011, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 5 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2011, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. CMS notes that for the first quarter of CY 2011, payment for drugs and biologicals with pass-through status is not made at the Part B Drug Competitive Acquisition Program (CAP) rate, as the CAP program was postponed beginning January 1, 2009. Should the Part B Drug CAP program be reinstituted sometime during CY 2011, CMS would again use the Part B drug CAP rate for pass-through drugs and biologicals if they are a part of the Part B drug CAP program, as required by the statute.

In the CY 2011 OPPS/ASC final rule with comment period, CMS stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Effective January 1, 2011, payment rates for many drugs and biologicals have changed from the values published in the CY 2011 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2010. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2011 release of the OPPS Pricer. CMS is not publishing the updated payment rates in this Change Request implementing the January 2011 update of the OPPS. However, the updated payment rates effective January 1, 2011, can be found in the January 2011 update of the OPPS Addendum A and Addendum B on the CMS Web site at http://www.cms.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage.

e. Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2010 through September 30, 2010

The payment rates for several HCPCS codes were incorrect in the July 2010 OPPS Pricer. The corrected payment rates are listed below and have been installed in the January 2011 OPPS Pricer, effective for services furnished on July 1, 2010, through implementation of the October 2010 update.

Table 7 – Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2010 through September 30, 2010

CY 2010 HCPCS Code	CY 2010 SI	CY 2010 APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
A9543	K	1643	Y90 ibritumomab, rx	$30,581.01	$6,116.20
J0150	K	0379	Injection adenosine 6 MG	$13.74	$2.75
J0641	G	1236	Levoleucovorin injection	$0.73	$0.14
J2430	K	0730	Pamidronate disodium /30 MG	$15.61	$3.12
J2850	K	1700	Inj secretin synthetic human	$26.97	$5.39
J9065	K	0858	Inj cladribine per 1 MG	$24.12	$4.82
J9178	K	1167	Inj, epirubicin hcl, 2 mg	$2.06	$0.41
J9185	K	0842	Fludarabine phosphate inj	$112.61	$22.52
J9200	K	0827	Floxuridine injection	$42.31	$8.46
J9206	K	0830	Irinotecan injection	$4.23	$0.85
J9208	K	0831	Ifosfomide injection	$30.95	$6.19
J9209	K	0732	Mesna injection	$4.96	$0.99
J9211	K	0832	Idarubicin hcl injection	$40.09	$8.02
J9263	K	1738	Oxaliplatin	$4.37	$0.87
J9293	K	0864	Mitoxantrone hydrochl / 5 MG	$44.07	$8.81

f. New Vaccine CPT Codes

One new vaccine code is effective for services provided beginning January 1, 2011. Table 8 lists this new vaccine code, its OPPS status indicator and APC, as appropriate.

Table 8 – New Vaccine Codes

CY 2011 HCPCS Code	CY 2011 Long Descriptor	CY 2011 SI	CY 2011 APC
90654	Influenza virus vaccine, split virus, preservative free, for intradermal use	E	-

g. Correct Reporting of Biologicals When Used As Implantable Devices

When billing for biologicals where the HCPCS code describes a product that is solely surgically implanted or inserted, whether the HCPCS code is identified as having pass-through status or not, hospitals are to report the appropriate HCPCS code for the product. Units should be reported in multiples of the units included in the HCPCS descriptor. Providers and hospitals should not bill the units based on the way the implantable biological is packaged, stored, or stocked. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the implantable biological. Therefore, before submitting Medicare claims for

biologicals that are used as implantable devices, it is extremely important to review the complete long descriptors for the applicable HCPCS codes. In circumstances where the implanted biological has pass-through status, either as a biological or a device, a separate payment for the biological or device is made. In circumstances where the implanted biological does not have pass-through status, the OPPS payment for the biological is packaged into the payment for the associated procedure.

When billing for biologicals where the HCPCS code describes a product that may either be surgically implanted or inserted or otherwise applied in the care of a patient, hospitals should not separately report the biological HCPCS codes, with the exception of biologicals with pass-through status, when using these items as implantable devices (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures. Under the OPPS, hospitals are provided a packaged APC payment for surgical procedures that includes the cost of supportive items, including implantable devices without pass-through status. When using biologicals during surgical procedures as implantable devices, hospitals may include the charges for these items in their charge for the procedure, report the charge on an uncoded revenue center line, or report the charge under a device HCPCS code (if one exists) so these costs would appropriately contribute to the future median setting for the associated surgical procedure.

h. Correct Reporting of Units for Drugs

Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor. For example, if the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be 1. As another example, if the description for the drug code is 50 mg, but 200 mg of the drug was administered to the patient, the units billed should be 4. Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, hospitals should bill 10 units, even though only 1 vial was administered. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

As discussed in Pub.100-04, Medicare Claims Processing Manual, chapter 17, section 40, CMS encourages hospitals to use drugs efficiently and in a clinically appropriate manner. However, CMS also recognizes that hospitals may discard some drug and biological product when administering from a single use vial or package. In that circumstance, Medicare pays for the amount of drug or biological discarded *as well as* the *dose* administered, up to the amount of the drug or biological as indicated on the vial or package label. Multi-use vials are not subject to payment for discarded amounts of drug or biological.

i. Payment for Therapeutic Radiopharmaceuticals

Beginning in CY 2010, nonpass-through separately payable therapeutic radiopharmaceuticals are paid under the OPPS based upon the ASP. If ASP data are unavailable, payment for therapeutic radiopharmaceuticals will be provided based on the most recent hospital mean unit cost data. Therefore, for January 1, 2011, the status indicator for separately payable therapeutic radiopharmaceuticals is “K” to reflect their separately payable status under the OPPS. Similar to payment for other separately payable drugs and biologicals, the payment rates for nonpass-through separately payable therapeutic radiopharmaceuticals will be updated on a quarterly basis.

Table 9 – Nonpass-Through Separately Payable Therapeutic Radiopharmaceuticals for January 1, 2011

CY 2011 HCPCS Code	CY 2011 Long Descriptor	Final CY 2011 APC	Final CY 2011 SI
A9517	Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie	1064	K
A9530	Iodine I-131 sodium iodide solution, therapeutic, per millicurie	1150	K
A9543	Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries	1643	K
A9545	Iodine I-131 tositumomab, therapeutic, per treatment dose	1645	K
A9563	Sodium phosphate P-32, therapeutic, per millicurie	1675	K
A9564	Chromic phosphate P-32 suspension, therapeutic, per millicurie	1676	K
A9600	Strontium Sr-89 chloride, therapeutic, per millicurie	0701	K
A9604	Samarium SM-153 lexidronam, therapeutic, per treatment dose, up to 150 millicuries	1295	K

j. Reporting of Outpatient Diagnostic Nuclear Medicine Procedures

With the specific exception of HCPCS code C9898 (Radiolabeled product provided during a hospital inpatient stay) to be reported by hospitals on outpatient claims for nuclear medicine procedures to indicate that a radiolabeled product that provides the radioactivity necessary for the reported diagnostic nuclear medicine procedure was provided during a hospital inpatient stay, hospitals should only report HCPCS codes for products they provide in the hospital outpatient department and should not report a HCPCS code and charge for a radiolabeled product on the nuclear medicine procedure-to-radiolabeled product edit list solely for the purpose of bypassing those edits present in the I/OCE.

As CMS stated in the October 2009 OPPS update, in the rare instance when a diagnostic radiopharmaceutical may be administered to a beneficiary in a given calendar year prior to a hospital furnishing an associated nuclear medicine procedure in the subsequent calendar year, hospitals are instructed to report the date the radiolabeled product is furnished to the beneficiary as the same date that the nuclear medicine procedure is performed. CMS believes that this situation is extremely rare and expects that the majority of hospitals will not encounter this situation.

Where a hospital or a nonhospital location, administers a diagnostic radiopharmaceutical product for a different hospital providing the nuclear medicine scan, hospitals should comply with the OPPS policy that requires that radiolabeled products be reported and billed with the nuclear medicine scan. In these cases, the first hospital or nonhospital location may enter into an arrangement under section 1861(w)(1) of the Act, and as discussed in 42 CFR 410.28(a)(1) and defined in 42 CFR 409.3, where the second hospital that administers the nuclear medicine scan both bills Medicare for the administration of the nuclear medicine scan with diagnostic radiopharmaceutical and pays the first hospital or nonhospital location that administers the diagnostic radiopharmaceutical some amount for administration of the diagnostic radiopharmaceutical. CMS notes that it considers the radiolabeled product and the nuclear medicine scan to be part of one procedure and would expect both services to be performed together.

k. Implementation of the FB modifier for Diagnostic Radiopharmaceuticals

As discussed in the CY 2011 OPPS/ASC final rule with comment period, beginning on January 1, 2011, CMS is extending the use of the "FB" modifier ("Item Provided Without Cost to Provider, Supplier or Practitioner, or Credit Received for Replacement Device (Examples, but not limited to: Covered Under Warranty, Replaced Due to Defect, Free Samples)" to diagnostic radiopharmaceuticals received free of charge or with full credit. Hospitals should report diagnostic radiopharmaceuticals received free of charge (including free samples or trial diagnostic radiopharmaceuticals received free of charge) by reporting the "FB" modifier on the line with the procedure code for the nuclear medicine scan in the APCs listed in Table 10 below. In addition, hospitals should report a token charge of less than $1.01 for diagnostic radiopharmaceuticals received free of charge or with full credit. The payment amount for the procedures in the APCs listed in Table 10 below will be reduced by the full "policy-packaged" offset amount appropriate for diagnostic radiopharmaceuticals.

l. Payment Offset for Pass-Through Diagnostic Radiopharmaceuticals

Effective for nuclear medicine services furnished on and after April 1, 2009, CMS implemented a payment offset for pass-through diagnostic radiopharmaceuticals under the OPPS. As discussed in the April 2009 OPPS CR 6416, Transmittal 1702, pass-through payment for a diagnostic radiopharmaceutical is the difference between the payment for the pass-through product and the payment for the predecessor product that, in the case of diagnostic radiopharmaceuticals, is packaged into the payment for the nuclear medicine procedure in which the diagnostic radiopharmaceutical is used.

Effective April 1, 2009, the diagnostic radiopharmaceutical reported with HCPCS code A9582 (Iobenguane, I-123, diagnostic, per study dose, up to 15 millicuries) was granted pass-through status under the OPPS and assigned status indicator "G." HCPCS code A9582 will continue on pass-through status for CY 2011 and therefore, when HCPCS code A9582 is billed on the same claim with a nuclear medicine procedure, CMS will reduce the amount of payment for the pass-through diagnostic radiopharmaceutical reported with HCPCS code A9582 by the corresponding nuclear medicine procedure's portion of its APC payment associated with "policy-packaged" drugs (offset amount) so no duplicate radiopharmaceutical payment is made.

The "policy-packaged" portions of the CY 2011 APC payments for nuclear medicine procedures may be found on the CMS Web site at: http://www.cms.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage in the download file labeled 2011 OPPS Offset Amounts by APC.

CY 2011 APCs to which nuclear medicine procedures are assigned and for which CMS expects a diagnostic radiopharmaceutical payment offset could be applicable in the case of a pass-through diagnostic radiopharmaceutical are displayed in Table 10 below.

Table 10 – APCs to Which Nuclear Medicine Procedures are Assigned for CY 2011

CY 2011 APC	CY 2011 APC Title
0307	Myocardial Positron Emission Tomography (PET) imaging
0308	Non-Myocardial Positron Emission Tomography (PET) imaging
0377	Level II Cardiac Imaging
0378	Level II Pulmonary Imaging
0389	Level I Non-imaging Nuclear Medicine
0390	Level I Endocrine Imaging
0391	Level II Endocrine Imaging
0392	Level II Non-imaging Nuclear Medicine
0393	Hematologic Processing & Studies
0394	Hepatobiliary Imaging
0395	GI Tract Imaging
0396	Bone Imaging
0397	Vascular Imaging
0398	Level I Cardiac Imaging
0400	Hematopoietic Imaging
0401	Level I Pulmonary Imaging
0402	Level II Nervous System Imaging
0403	Level I Nervous System Imaging
0404	Renal and Genitourinary Studies
0406	Level I Tumor/Infection Imaging
0408	Level III Tumor/Infection Imaging
0414	Level II Tumor/Infection Imaging

m. Payment Offset for Pass-Through Contrast Agents

Effective for contrast-enhanced procedures furnished on or after January 1, 2010, CMS implemented a payment offset for pass-through contrast agents, for when a contrast-enhanced procedure that is assigned to a procedural APC with a "policy-packaged" drug amount greater than $20 (that is not an APC containing nuclear medicine procedures) is billed on the same claim with a pass-through contrast agent on the same date of service. As discussed in the January 2010 OPPS CR 6751, Transmittal 1882, CMS will reduce the amount of payment for the contrast agent by the corresponding contrast-enhanced procedure's portion of its APC payment associated with "policy-packaged" drugs (offset amount) so no duplicate contrast agent payment is made.

CY 2011 procedural APCs for which CMS expects a contrast agent payment offset could be applicable in the case of a pass-through contrast agent are identified in Table 11 below. Pass-through payment for a contrast agent is the difference between the payment for the pass-through product and the payment for the predecessor product that, in the case of a contrast agent, is packaged into the payment for the contrast-enhanced procedure in which the contrast agent is used. For CY 2011, when a contrast agent with pass-through status is billed with a contrast-enhanced procedure assigned to any procedural APC listed in Table 11 on the same date of service, a specific pass-through payment offset determined by the procedural APC to which the contrast-enhanced procedure is assigned will be applied to payment for the contrast agent to ensure that duplicate payment is not made for the contrast agent.

For CY 2011, HCPCS code A9583 (Injection, gadofosveset trisodium, 1 ml) will continue on pass-through status and will be subject to the payment offset methodology for contrast agents. In addition,

HCPCS code C9275 (Injection, hexaminolevulinate hydrochloride, 100 mg, per study dose) describes a contrast agent that has been granted pass-through status beginning January 1, 2011, and will be subject to the payment offset methodology for contrast agents. Both HCPCS codes A9583 and C9275 will be assigned status indicator "G". Therefore, in CY 2011, CMS will reduce the payment for HCPCS code A9583 and C9275 by the estimated amount of payment that is attributable to the predecessor contrast agent that is packaged into payment for the associated contrast-enhanced procedure reported on the same claim on the same date as HCPCS code A9583 or C9275 if the contrast-enhanced procedure is assigned to one of the APCs listed in Table 11 below. The "policy-packaged" portions of the CY 2011 APC payments that are the offset amounts may be found on the CMS Web site at: http://www.cms.gov/HospitalOutpatientPPS/04_passthrough_payment.asp#TopOfPage in the download file labeled 2011 OPPS Offset Amounts by APC.

When HCPCS code A9583 or C9275 is billed on a claim on the same date of service as one or more procedures assigned to an APC listed in Table 11, the OPPS Pricer will identify the offset amount or amounts that apply to the contrast-enhanced procedures that are reported on the claim. Where there is a single contrast-enhanced procedure reported on the claim with a single occurrence of either HCPCS code A9583 or C0275, the OPPS Pricer will identify a single offset amount for the procedure billed and adjust the offset by the wage index value that applies to the hospital submitting the claim. Where there are multiple contrast procedures on the claim with a single occurrence of the pass-through contrast agent, the OPPS Pricer will select the contrast-enhanced procedure with the single highest offset amount and adjust the selected offset amount by the wage index value of the hospital submitting the claim. When a claim has more than one occurrence of either HCPCS code A9583 or C9275, the OPPS Pricer will rank potential offset amounts associated with the units of contrast-enhanced procedures on the claim and identify a total offset amount that takes into account the number of occurrences of the pass-through contrast agent on the claim and adjust the total offset amount by the wage index value of the hospital submitting the claim. The adjusted offset amount will be subtracted from the APC payment for the pass-through contrast agent reported with either HCPCS code A9583 or C9275. The offset will cease to apply when each of these contrast agents expires from pass-through status.

Table 11 – APCs to Which a Pass-Through Contrast Agent Offset May Be Applicable for CY 2011

CY 2011 APC	CY 2011 APC Title
0080	Diagnostic Cardiac Catheterization
0082	Coronary or Non-Coronary Atherectomy
0083	Coronary or Non-Coronary Angioplasty and Percutaneous Valvuloplasty
0093	Vascular Reconstruction/Fistula Repair without Device
0104	Transcatheter Placement of Intracoronary Stents
0128	Echocardiogram with Contrast
0152	Level I Percutaneous Abdominal and Biliary Procedures
0229	Transcatheter Placement of Intravascular Shunts
0278	Diagnostic Urography
0279	Level II Angiography and Venography
0280	Level III Angiography and Venography
0283	Computed Tomography with Contrast
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast
0333	Computed Tomography without Contrast followed by Contrast
0337	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast followed by Contrast
0375	Ancillary Outpatient Services When Patient Expires

CY 2011 APC	CY 2011 APC Title
0383	Cardiac Computed Tomographic Imaging
0388	Discography
0418	Insertion of Left Ventricular Pacing Elect.
0442	Dosimetric Drug Administration
0653	Vascular Reconstruction/Fistula Repair with Device
0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents
0662	CT Angiography
0668	Level I Angiography and Venography
8006	CT and CTA with Contrast Composite
8008	MRI and MRA with Contrast Composite

10. Clarification of Coding for Drug Administration Services

CMS revised Pub. 100-04, Medicare Claims Processing Manual, chapter 4, section 230.2, to clarify the correct coding of drug administration services. Drug administration services are to be reported with a line-item date of services on the day they are provided. In addition, beginning in CY 2007, hospitals should report 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. Although new CPT guidance has been issued for reporting initial drug administration services, Medicare contractors are to continue to follow the guidance given in this manual.

11. Changes to OPPS Pricer Logic

a. Rural sole community hospitals (SCHs) and essential access community hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in CY 2011. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with section 1833(t)(13)(B) of the Act, as added by section 411 of Pub. L. 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

b. New OPPS payment rates and copayment amounts will be effective January 1, 2011. All copayments amounts will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the CY 2011 inpatient deductible.

c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2011. This threshold of 1.75 is multiplied by the total line-item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount. The payment formula is (cost-(APC payment x 1.75))/2.

d. However, there will be a change in the fixed-dollar threshold in CY 2011. The estimated cost of a service must be greater than the APC payment amount plus $2,025 in order to qualify for outlier payments. The previous fixed-dollar threshold for CY 2010 was $2,175.

e. For outliers for Community Mental Health Centers (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2011. This threshold of 3.4 is multiplied by the total line-item APC payment for APC 0173 to determine eligibility for outlier payments. This multiple amount is also used

to determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment formula is (cost-(APC 0173 payment x 3.4))/2.

f. Effective January 1, 2011, 1 device is eligible for pass-through payment in the OPPS Pricer logic. Category C1749 for new Endoscope, retrograde imaging/illumination colonoscope device (implantable) has an offset amount of $0 because CMS is not able to identify a portion of the APC payment amount associated with the cost of the device. For outlier purposes, when C1749 is billed with a service included in APC 0143 or APC 0158 it will be associated with specific HCPCS in those APCs for outlier eligibility and payment.

g. Effective January 1, 2011, the OPPS Pricer will apply a reduced update ratio of 0.980 to the payment and copayment for hospitals that fail to meet their hospital outpatient quality data reporting requirements or that fail to meet CMS validation edits. The reduced payment amount will be used to calculate outlier payments.

h. Effective January 1, 2011, there will be 1 diagnostic radiopharmaceutical receiving pass-through payment in the OPPS Pricer logic. For APCs containing nuclear medicine procedures, Pricer will reduce the amount of the pass-through diagnostic radiopharmaceutical payment by the wage-adjusted offset for the APC with the highest offset amount when the radiopharmaceutical with pass-through appears on a claim with a nuclear procedure. The offset will cease to apply when the diagnostic radiopharmaceutical expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals are the "policy-packaged" portions of the CY 2011 APC payments for nuclear medicine procedures and may be found on the CMS Web site.

i. Effective January 1, 2011, there will be 2 contrast agents receiving pass-through payments in the OPPS Pricer logic. For a specific set of APCs identified elsewhere in this update, Pricer will reduce the amount of the pass-through contrast agent by the wage-adjusted offset for the APC with the highest offset amount when the contrast agent with pass-through status appears on a claim on the same date of service with a procedure from the identified list of APCs with procedures using contrast agents. The offset will cease to apply when the contrast agent expires from pass-through status. The offset amounts for contrast agents are the "policy-packaged" portions of the CY 2011 APC payments for procedures using contrast agents and may be found on the CMS Web site.

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

k. Effective January 1, 2011, CMS is adopting the FY 2011 IPPS post-reclassification wage index values with application of out-commuting adjustment authorized by Section 505 of the MMA to non-IPPS hospitals discussed below.

12. Update the Outpatient Provider Specific File (OPSF)

For January 1, 2011, contractors shall maintain the accuracy of the provider records in the Outpatient Provider Specific File (OPSF) as changes occur in data element values.

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

This includes updating the CBSA in the provider records, as well as updating the "special wage index" value for those providers who qualify for the Section 505 adjustment as annotated in Table 12. As always, the OPPS applies the IPPS fiscal year 2011 post-reclassification wage index values to all hospitals and community mental

health centers participating in the OPPS for the 2011 calendar year. Section 102 of the Medicare and Medicaid Extenders Act of 2010 extends the reclassification wage index values under Section 508 of MMA through September 30, 2011.

Contractors shall do the following to update the OPSF (effective January 1, 2011):

1. Update the CBSA value for each provider in Table 12;

2. For non-IPPS providers who qualify for the 505 adjustment in CY 2011 (Table 12);

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

   b) Enter the final wage index value (given for the provider in Table 12) in the Special Wage Index field in the OPSF.

3. For non-IPPS providers who received a special wage index in CY -2010, but no longer receive it in CY 2011;

   a) Create a new provider record, effective January 1, 2011; and

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

   c) Enter zeroes in the special wage index field.

NOTE: Although the Section 505 adjustment is static for each qualifying county for 3 years, the special wage index will need to be updated (using the final wage index in Table 12.) because the post-reclassification CBSA wage index has changed.

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

Table 12 - Wage Index by CBSA for Non-IPPS Hospitals that are Eligible for the Section 505 Out-Commuting Adjustment

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2011
013027	01	YES	0.7589
013032	23460	YES	0.7497
014006	23460	YES	0.7497
042007	38220	YES	0.8339
042011	04	YES	0.7640
052034	36084	YES	1.5907
052035	42044	YES	1.1967
052037	40140	YES	1.1881
052039	42044	YES	1.1967

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2011
052040	40140	YES	1.1881
052053	42044	YES	1.1967
053034	42044	YES	1.1967
053037	40140	YES	1.1881
053301	36084	YES	1.5907
053304	42044	YES	1.1967
053306	42044	YES	1.1967
053308	42044	YES	1.1967
054074	46700	YES	1.4801
054093	40140	YES	1.1881
054110	36084	YES	1.5907
054111	40140	YES	1.1881
054122	34900	YES	1.4602
054135	42044	YES	1.1967
054141	46700	YES	1.4801
054146	36084	YES	1.5907
063033	24540	YES	0.9757
064007	14500	YES	1.0168
082000	48864	YES	1.0767
083300	48864	YES	1.0767
084001	48864	YES	1.0767
084002	48864	YES	1.0767
084003	48864	YES	1.0767
092002	47894	YES	1.0561
092003	47894	YES	1.0561
093025	47894	YES	1.0561
093300	47894	YES	1.0561
094001	47894	YES	1.0561
094004	47894	YES	1.0561
114018	11	YES	0.7956
132001	17660	YES	0.9535
134010	13	YES	0.8581
153040	15	YES	0.8654
154014	15	YES	0.8569
154035	15	YES	0.8451
154047	15	YES	0.8654
183028	21060	YES	0.8428
184012	21060	YES	0.8428
192022	19	YES	0.7968
192026	19	YES	0.8192
192034	19	YES	0.8070
192036	19	YES	0.8151
192040	19	YES	0.8151
192050	19	YES	0.8129
193036	19	YES	0.8070

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2011
193044	19	YES	0.8151
193047	19	YES	0.8070
193049	19	YES	0.8070
193055	19	YES	0.7989
193058	19	YES	0.7988
193063	19	YES	0.8151
193067	19	YES	0.8021
193068	19	YES	0.8151
193069	19	YES	0.7988
193073	19	YES	0.8070
193079	19	YES	0.8151
193081	19	YES	0.8129
193088	19	YES	0.8129
193091	19	YES	0.7984
194047	19	YES	0.8192
194065	19	YES	0.7968
194075	19	YES	0.8021
194077	19	YES	0.7968
194081	19	YES	0.7970
194082	19	YES	0.8021
194083	19	YES	0.7988
194085	19	YES	0.8129
194087	19	YES	0.7968
194091	19	YES	0.8151
194092	19	YES	0.7944
194095	19	YES	0.8070
194097	19	YES	0.8070
212002	25180	YES	0.9553
214001	12580	YES	1.0188
214003	25180	YES	0.9553
214015	21	YES	0.9446
222000	15764	YES	1.1675
222003	15764	YES	1.1675
222024	15764	YES	1.1675
222026	37764	YES	1.1273
222044	37764	YES	1.1273
222047	37764	YES	1.1273
222048	49340	YES	1.1225
223026	15764	YES	1.1675
223028	37764	YES	1.1273
223029	49340	YES	1.1225
223033	49340	YES	1.1225
224007	15764	YES	1.1675
224026	49340	YES	1.1225
224032	49340	YES	1.1225

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2011
224033	37764	YES	1.1273
224038	15764	YES	1.1675
224039	37764	YES	1.1273
232019	19804	YES	0.9781
232020	13020	YES	0.9433
232023	47644	YES	0.9697
232025	35660	YES	0.9104
232027	19804	YES	0.9781
232028	12980	YES	0.9776
232030	47644	YES	0.9700
232031	19804	YES	0.9781
232032	19804	YES	0.9781
232036	27100	YES	0.9419
232038	19804	YES	0.9781
233025	12980	YES	0.9776
233027	19804	YES	0.9781
233028	47644	YES	0.9700
233300	19804	YES	0.9781
234011	47644	YES	0.9700
234021	47644	YES	0.9697
234023	47644	YES	0.9700
234028	19804	YES	0.9781
234034	19804	YES	0.9781
234035	19804	YES	0.9781
234038	19804	YES	0.9781
234039	47644	YES	0.9697
252011	25	YES	0.8130
264005	26	YES	0.8213
303026	40484	YES	1.1078
304001	40484	YES	1.1078
312018	20764	YES	1.1485
312020	35084	YES	1.1491
313025	35084	YES	1.1607
313300	20764	YES	1.1485
314010	35084	YES	1.1607
314011	20764	YES	1.1485
314016	35084	YES	1.1491
314020	35084	YES	1.1607
323025	32	YES	0.9443
334017	39100	YES	1.1875
334049	10580	YES	0.8680
334061	39100	YES	1.1875
362016	15940	YES	0.8587
362032	15940	YES	0.8587
363026	49660	YES	0.8608

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2011
364031	15940	YES	0.8587
364040	44220	YES	0.9051
364043	36	YES	0.8629
372019	37	YES	0.8261
392030	39	YES	0.9112
392031	27780	YES	0.8527
392034	10900	YES	0.9587
393026	39740	YES	0.9089
393050	10900	YES	0.9587
394014	39740	YES	0.9089
394020	30140	YES	0.8790
394052	39740	YES	0.9089
422004	43900	YES	0.9194
423028	16740	YES	0.9255
423029	11340	YES	0.8940
424011	11340	YES	0.8940
442016	28700	YES	0.7972
443027	28700	YES	0.7972
444006	27740	YES	0.7996
444008	44	YES	0.8269
452018	23104	YES	0.9438
452019	23104	YES	0.9438
452028	23104	YES	0.9438
452088	23104	YES	0.9438
452099	23104	YES	0.9438
452110	23104	YES	0.9438
453040	23104	YES	0.9438
453041	23104	YES	0.9438
453042	23104	YES	0.9438
453089	45	YES	0.8007
453094	23104	YES	0.9438
453300	23104	YES	0.9438
453303	23104	YES	0.9438
454009	45	YES	0.8029
454012	23104	YES	0.9438
454051	23104	YES	0.9438
454052	23104	YES	0.9438
454061	23104	YES	0.9438
454072	23104	YES	0.9438
454086	23104	YES	0.9438
454101	45	YES	0.8115
462005	39340	YES	0.9204
493026	49	YES	0.8240
494029	49	YES	0.8025
523302	36780	YES	0.9488

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2011
524002	36780	YES	0.9488
524025	22540	YES	0.9423
673035	23104	YES	0.9438

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

Section 5105 of the Deficit Reduction Act of 2005 (DRA) extended hold harmless transitional outpatient payments (TOPs) through December 31, 2008, for rural hospitals having 100 or fewer beds that are not sole community hospitals (SCHs). Hospitals received 95 percent of the hold harmless amount for services furnished in CY 2006, 90 percent in CY 2007, and 85 percent in CY 2008. Section 147 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) extended the hold harmless provision for small rural hospitals with 100 or fewer beds through December 31, 2009, at 85 percent of the hold harmless amount. Section 147 also provided 85 percent of the hold harmless amount from January 1, 2009 through December 31, 2009, to SCHs with 100 or fewer beds, per CR 6320, Transmittal 1657.

Section 3121 of the Affordable Care Act extended the hold harmless provision for small rural hospitals with 100 or fewer beds through December 31, 2010, at 85 percent of the hold harmless amount. Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs) are no longer limited to those with 100 or fewer beds effective January 1, 2010 through December 31, 2010, and these providers will receive TOPs payments at 85 percent of the hold harmless amount through December 31, 2010. **(Note:** EACHs are considered SCHs for purposes of the TOPs adjustment.) Cancer and children's hospitals are permanently held harmless under section 1833(t)(7)(D)(ii) of the Social Security Act and continue to receive TOPs payments in CY 2010.

Section 108 of the Medicare and Medicaid Extenders Act of 2010 (MEA) extends the Outpatient Hold Harmless provision from January 1, 2011 through December 31, 2011 for rural hospitals with 100 or fewer beds at 85 percent of the hold harmless amount, and to all SCHs and EACHs regardless of bed size at 85 percent of the hold harmless amount from January 1, 2011 through December 31, 2011. Cancer and children's hospitals are permanently held harmless under section 1833(t)(7)(D)(ii) of the Social Security Act and continue to receive TOPs payments through CY 2011.

For CY 2011, small rural hospitals with 100 or fewer beds and all sole community hospitals (and essential access community hospitals) remain eligible for a TOPS adjustment, so the TOPS indicator for these hospitals must be set to ‘Y’. Cancer and children's hospitals continue to receive hold harmless TOPs permanently.

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

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

For January 1, 2011, contractors shall maintain the accuracy of the provider records in the OPSF by updating the Hospital Quality Indicator field. CMS will release a Joint Signature Memorandum/Technical Direction

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

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

As stated in Pub 100-04, Medicare Claims Processing Manual, chapter 4, section 50.1, contractors must maintain the accuracy of the data and update the OPSF as changes occur in data element values, including changes to provider cost–to-charge ratios. The file of OPPS hospital upper limit CCRs and the file of Statewide CCRs are located on the CMS Web site at www.cms.hhs.gov/HospitalOutpatientPPS/ under "*Annual Policy Files*." A spreadsheet listing the Statewide CCRs also can be found in the file containing the preamble tables that appears in the most recent OPPS/ASC final rule.

13. Coverage Determinations

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

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7271-04.1	Medicare contractors shall install the January 2011 OPPS Pricer.	X		X		X	X				COBC
7271-04.2	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service that fall on or after July 1, 2010, but prior to October 1, 2010; 2) Contain HCPCS code listed in Table 7; and 3) Were originally processed prior to the installation of the January 2011 OPPS Pricer.	X		X		X					COBC
7271-04.3	As specified in Chapter 4, Section 50.1, Medicare contractors shall maintain the accuracy of the data and	X		X		X					COBC

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	update the OPSF file as changes occur in data element values. For CY 2011, this includes all changes to the OPSF identified in Section 12 of this Change Request.										

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7271.4	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in 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.	X		X		X					COBC

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:
	None

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

V. CONTACTS

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

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

VI. FUNDING

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

No additional funding will be provided by CMS; 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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(Rev. 2141, 01-24-11)

10.2.1 - Composite APCs

(Rev. 2141, Issued: 01-24-11, Effective: 01-01-11, Implementation: 01-03-11)

Composite APCs provide a single payment for a comprehensive diagnostic and/or treatment service that is defined, for purposes of the APC, as a service typically reported with multiple HCPCS codes. When HCPCS codes that meet the criteria for payment of the composite APC are billed on the same date of service, CMS makes a single payment for all of the codes as a whole, rather than paying individually for each code.

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

Composite APC	Composite APC Title	Criteria for Composite Payment
8000	Cardiac Electrophysiologic Evaluation and Ablation Composite	At least one unit of CPT code 93619 or 93620 and at least one unit of CPT code 93650, 93651 or 93652 on the same date of service.
8001	Low Dose Rate Prostate Brachytherapy Composite	One or more units of CPT codes 55875 and 77778 on the same date of service.
8002	Level I Extended Assessment and Management Composite	1) Eight or more units of HCPCS code G0378 are billed-- • On the same day as HCPCS code G0379*; or • On the same day or the day after CPT codes 99205 or 99215; and 2) There is no service with SI=T on the claim on the same date of service or 1 day earlier than HCPCS code G0378.
8003	Level II Extended Assessment and Management Composite	1) Eight or more units of HCPCS code G0378** are billed on the same date of service or the date of service after CPT codes 99284, 99285, G0384, or 99291; and 2) There is no service with SI=T on the claim

Composite APC	Composite APC Title	Criteria for Composite Payment
		on the same date of service or 1 day earlier.
0034	Mental Health Services Composite	Payment for any combination of mental health services with the same date of service exceeds the payment for APC 0173 *in years prior to 2011 or APC 0176 after January 1, 2011*. For the list of mental health services to which this composite applies, see the I/OCE supporting files for the pertinent period.
8004	Ultrasound Composite	Payment for any combination of designated imaging procedures within the Ultrasound imaging family on the same date of service. For the list of imaging services included in the Ultrasound imaging family, see the I/OCE specifications document for the pertinent period.
8005	Computed Tomography (CT) and Computed Tomographic Angiography (CTA) without Contrast Composite	Payment for any combination of designated imaging procedures within the CT and CTA imaging family on the same date of service. If a "without contrast" CT or CTA procedure is performed on the same date of service as a "with contrast" CT or CTA procedure, the IOCE will assign APC 8006 rather than APC 8005. For the list of imaging services included in the CT and CTA imaging family, see the I/OCE specifications document for the pertinent period.
8006	CT and CTA with Contrast Composite	
8007	Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA) without Contrast Composite	Payment for any combination of designated imaging procedures within the MRI and MRA imaging family on the same date of service. If a "without contrast" MRI or MRA procedure is performed on the same date of service as a "with contrast" MRI or MRA

Composite APC	Composite APC Title	Criteria for Composite Payment
8008	MRI and MRA with Contrast Composite	procedure, the I/OCE will assign APC 8008 rather than APC 8007. For the list of imaging services included in the MRI and MRA imaging family, see the I/OCE specifications document for the pertinent period.

*Payment for direct admission to observation care (HCPCS code G0379) is made either under APC 604 (Level 1 Hospital Clinic Visits) or APC 8002 (Level I Extended Management and Assessment Composite) or is packaged into payment for other separately payable services. See §290.5.2 for additional information and the criteria for payment of HCPCS code G0379.

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

Future updates will be issued in a Recurring Update Notification.

30 - OPPS Coinsurance

(Rev. 2141, Issued: 01-24-11, Effective: 01-01-11, Implementation: 01-03-11)

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*, prior to January 1, 2011*. *Coinsurance does not apply to screening colonoscopies, screening sigmoidoscopies, and other specified services furnished on or after January 1, 2011.*

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

See §30.2 below for more detail.

Future updates will be issued in a Recurring Update Notification.

70.7 - *Transitional Outpatient Payments (TOPs) for CY 2010 and CY 2011*

(Rev. 2141, Issued: 01-24-11, Effective: 01-01-11, Implementation: 01-03-11)

Hold harmless transitional outpatient payments (TOPs) to small rural hospitals and rural sole community hospitals were scheduled to expire December 31, 2009. Section 3121 of the Affordable Care Act extended the hold harmless provision for small rural hospitals with 100 or fewer beds through December 31, 2010, at 85 percent of the hold harmless amount. Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs) are no longer limited to those with 100 or fewer beds effective January 1, 2010 through December 31, 2010 and these providers will receive TOPs payments at 85 percent of the hold harmless amount until December 31, 2010. Cancer and children's hospitals are permanently held harmless under section 1833(t)(7)(D)(ii) of the Social Security Act and continue to receive TOPs payments in CY 2010. Section 108 of the Medicare and Medicaid Extenders Act of 2010 (MMEA) further extended the hold harmless provision for rural hospitals with 100 or fewer beds and to all SCHs (and EACHs) regardless of bed size through December 31, 2011 at 85 percent of the hold harmless amount. Cancer and children's hospitals are permanently held harmless under section 1833(t)(7)(D)(ii) of the Social Security Act and continue to receive TOPs payments in both CY 2010 and CY 2011.

Monthly TOPs calculations that contractors are required to calculate are described below. This calculation is effective for services provided between January 1, 2010, and December 31, 2011.

Step 1 – Compute 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 (including reconciled outlier payments and the time value of money) 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 4. No transitional payment is due this month.

Step 3 - If the hospital is a children's hospital, a cancer hospital, a rural hospital with 100 or fewer beds, or a sole community hospital (including EACHs), subtract the result of step 2 from the result of step 1 and pay .85 times this amount. If the hospital is not one of the hospital types listed above, no payment is made.

Step 4 - When the result of step 2 is greater than the result of step 1 for the final month of a provider's cost report period, do nothing more. When the result of step 2 is greater than the result of step 1 for any other month, store all step 1 and step 2 totals and include these totals with the totals for the next month's TOP calculation.

70.8 - TOPs Overpayments

(Rev. 2141, Issued: 01-24-11, Effective: 01-01-11, Implementation: 01-03-11)

Because the revised TOP calculations are often implemented in the system after their effective date, overpayments or underpayments in interim TOPs to providers are expected.

Unless directed by CMS, retroactive calculations of monthly interim TOP amounts are not necessary because any difference in interim TOP payments and actual TOP amounts determined on the cost report will be taken into account in the cost report settlement process, including tentative settlements.

If mutually agreed upon by both the contractor and the provider, the contractor can pay less than 85 percent of the monthly TOP payment to that provider, to avoid significant overpayments throughout the year that must be paid back to the contractor at cost report settlement.

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

160.1 - Critical Care Services

(Rev. 2141, Issued: 01-24-11, Effective: 01-01-11, Implementation: 01-03-11)

Hospitals should separately report all HCPCS codes in accordance with correct coding principles, CPT code descriptions, and any additional CMS guidance, when available. Specifically with respect to CPT code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes), hospitals must follow the CPT instructions related to reporting that CPT code. Prior to January 1, 2011, any services that CPT indicates are included in the reporting of CPT code 99291 (including those services that would otherwise be reported by and paid to hospitals using any of the CPT codes specified by CPT) should not be billed separately by the hospital. Instead,

hospitals should report charges for any services provided as part of the critical care services. In establishing payment rates for critical care services, and other services, CMS packages the costs of certain items and services separately reported by HCPCS codes into payment for critical care services and other services, according to the standard OPPS methodology for packaging costs.

Beginning January 1, 2011, in accordance with revised CPT guidance, hospitals that report in accordance with the CPT guidelines will begin reporting all of the ancillary services and their associated charges separately when they are provided in conjunction with critical care. CMS will continue to recognize the existing CPT codes for critical care services and will establish payment rates based on historical data, into which the cost of the ancillary services is intrinsically packaged. The I/OCE conditionally packages payment for the ancillary services that are reported on the same date of service as critical care services in order to avoid overpayment. The payment status of the ancillary services does not change when they are not provided in conjunction with critical care services. Hospitals may use HCPCS modifier -59 to indicate when an ancillary procedure or service is distinct or independent from critical care when performed on the same day but in a different encounter.

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.

- Beginning 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.)

- Beginning 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.

Future updates will be issued in a Recurring Update Notification.

180.7 - Inpatient-only Services

(Rev. 2141, Issued: 01-24-11, Effective: 01-01-11, Implementation: 01-03-11)

Section 1833(t)(1)(B)(i) of the Act allows CMS to define the services for which payment under the OPPS is appropriate and the Secretary has determined that the services designated to be "inpatient only" services are not appropriate to be furnished in a hospital outpatient department. "Inpatient only" services are generally, but not always, surgical services that require inpatient care because of the nature of the procedure, the typical underlying physical condition of patients who require the service, or the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged. An example of an "inpatient only" service is CPT code 33513, "Coronary artery bypass, vein only; four coronary venous grafts." The designation of

services to be "inpatient-only" is open to public comment each year as part of the annual rulemaking process.

There is no payment under the OPPS for services that CMS designates to be "inpatient-only" services. These services have OPPS status indicator "C" in OPPS Addendum B and are listed together in Addendum E of each year's OPPS/ASC final rule. For the most current Addendum B and for Addendum E published with the OPPS notices and regulations, see www.cms.gov/HospitalOutpatientPPS.

Excluding the handful of exceptions discussed below, CMS does not pay for an "inpatient-only" service furnished to a person who is registered in the hospital as an outpatient and reports the service on the outpatient hospital bill type (TOB 13X). CMS also does not pay for all other services on the same day as the "inpatient only" procedure.

There are two exceptions to the policy of not paying for outpatient services furnished on the same day with an "inpatient-only" service that would be paid under the OPPS if the inpatient service had not been furnished:

Exception 1: If the "inpatient-only" service is defined in CPT to be a "separate procedure" and the other services billed with the "inpatient-only" service contain a procedure that can be paid under the OPPS and that has an OPPS SI=T on the same date as the "inpatient-only" procedure, then the "inpatient-only" service is denied but CMS makes payment for the separate procedure and any remaining payable OPPS services. The list of "separate procedures" is available with the Integrated Outpatient Code Editor (I/OCE) documentation. See www.cms.gov/OutpatientCodeEdit.

Exception 2: If an "inpatient-only" service is furnished but the patient expires before inpatient admission or transfer to another hospital and the hospital reports the "inpatient only" service with modifier "CA", then CMS makes a single payment for all services provided on that day, including the "inpatient only" procedure, through one unit of APC 0375, (Ancillary outpatient services when the patient expires.) Hospitals should report modifier CA on only one procedure.

230.2 - Coding and Payment for Drug Administration

(Rev. 2141, Issued: 01-24-11, Effective: 01-01-11, Implementation: 01-03-11)

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) (96360-96549 beginning in CY 2009) 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: Pub.100-02, Medicare Benefit Policy Manual, Chapter 6, §20.4.)

Drug administration services are to be reported with a line item date of service on the day they are provided. In addition, only one initial drug administration service is to be reported per vascular access site per encounter, including during an encounter where observation services span more *than* 1 calendar day.

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, *hospitals should report* 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. *Although new CPT guidance has been issued for reporting initial drug administration services, Medicare contractors shall continue to follow the guidance given in this manual.*

(**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.

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

(Rev. 2141, Issued: 01-24-11, Effective: 01-01-11, Implementation: 01-03-11)

Medicare Part B coverage is available for hospital outpatient partial hospitalization services.

A. Billing Requirement

Section 1861 of the Act defines the services under the partial hospitalization benefit in a hospital.

Section 1866(e)(2) of the Act recognizes CMHCs as "providers of services" but only for furnishing partial hospitalization services. See §261.1.1 for CMHC partial hospitalization bill review directions.

Hospitals and CAHs report condition code 41 in FLs 18-28 (or electronic equivalent) to indicate the claim is for partial hospitalization services. They must also report a revenue code and the charge for each individual covered service furnished. In addition, hospital outpatient departments are required to report HCPCS codes. CAHs are not required to *report* HCPCS code for this benefit.

Under component billing, hospitals are required to report a revenue code and the charge for each individual covered service furnished under a partial hospitalization program. In addition, hospital outpatient departments are required to report HCPCS codes. Component billing assures that only those partial hospitalization services covered under §1861(ff) of the Act are paid by the Medicare program.

All hospitals are required to report condition code 41 in FLs 18-28 to indicate the claim is for partial hospitalization services. Hospitals use bill type 13X and CAHs use bill type 85X. The following special procedures apply.

Bills must contain an acceptable revenue code. They are as follows:

Revenue Code	Description
0250	Drugs and Biologicals
043X	Occupational Therapy
0900	Behavioral Health Treatment/Services
0904	Activity Therapy
0910	Psychiatric/Psychological Services (Dates of Service prior to October

Revenue Code	Description
	16, 2003)
0914	Individual Therapy
0915	Group Therapy
0916	Family Therapy
0918	Testing
0942	Education Training

Hospitals other than CAHs are also required to report appropriate HCPCS codes as follows:

Revenue Code	Description	HCPCS Code
043X	Occupational Therapy	*G0129
0900	Behavioral Health Treatment/Services	90801 or 90802
0904	Activity Therapy (Partial Hospitalization)	**G0176
0910	Psychiatric General Services (Dates of Service prior to October 16, 2003)	90801, 90802, 90899
0914	Individual Psychotherapy	90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829 90845, 90865, or 90880
0915	Group Therapy	G0410 or G0411
0916	Family Psychotherapy	90846 or 90847
0918	Psychiatric Testing	96101, 96102, 96103, 96116, 96118, 96119, or 96120
0942	Education Training	***G0177

The FI will edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. The FI will not edit for matching the revenue code to HCPCS.

*The definition of code G0129 is as follows:

> Occupational therapy services requiring skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per session (45 minutes or more).

**The definition of code G0176 is as follows:

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

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

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

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

Code G0177 may be used in both partial hospitalization program and outpatient mental health settings.

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

Edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. Do not edit for the matching of revenue code to HCPCS.

B. Professional Services

The professional services listed below when provided in all hospital outpatient departments are separately covered and paid as the professional services of physicians and other practitioners. These professional services are unbundled and these practitioners (other than physician assistants (PA) bill the Medicare Part B carrier directly for the professional services furnished to hospital outpatient partial hospitalization patients. The hospital can also serve as a billing agent for these professionals by billing the Part B carrier on their behalf under their billing number for their professional services. The professional services of a PA can be billed to the carrier only by the PAs employer. The employer of a PA may be such entities or individuals as a physician, medical group, professional corporation, hospital, SNF, or nursing facility. For example, if a physician is the employer of the PA and the PA renders services in the hospital, the physician and not the hospital would be responsible for billing the carrier on Form CMS-1500 for the

services of the PA. The following direct professional services are unbundled and not paid as partial hospitalization services.

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

The services of other practitioners (including clinical social workers and occupational therapists), are bundled when furnished to hospital patients, including partial hospitalization patients. The hospital must bill *the contractor* for such nonphysician practitioner services as partial hospitalization services. Make payment for the services to the hospital.

C. Outpatient Mental Health Treatment Limitation

The outpatient mental health treatment limitation may apply to services to treat mental, psychoneurotic, and personality disorders when furnished by physicians, clinical psychologists, NPs, CNSs, and PAs to partial hospitalization patients. However, the outpatient mental health treatment limitation does not apply to such mental health treatment services billed to the intermediary by a CMHC or hospital outpatient department as partial hospitalization services.

D. Reporting of Service Units

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

NOTE: Service units are not required to be reported for drugs and biologicals (Revenue Code 250).

E. Line Item Date of Service Reporting

Hospitals other than CAHs are required to report line item dates of service per revenue code line for partial hospitalization claims. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are reported in FL 45 "Service Date" (MMDDYY). See §260.5 for a detailed explanation.

F. Payment

Beginning with services provided on or after August 1, 2000, for hospital outpatient departments and *CMHCs*, make payment under the hospital outpatient prospective payment system for partial hospitalization services. Effective *January 1, 2011*, there are *four* separate APC payment rates for PHP: *two for CMHCs (for Level 1 and Level II services based on only CMHC data) and two for hospital-based PHPs (for Level I and Level II services based on only hospital-based data). The following chart displays the CMHC and hospital-based PHP APCs:*

Community Mental Health Center PHP APCs

APC	***Group Title***
0172	*Level I Partial Hospitalization (3 services) for CMHCs*
0173	*Level II Partial Hospitalization (4 or more services) for CMHCs*

Hospital-based PHP APCs

APC	***Group Title***
0175	*Level I Partial Hospitalization (3 services) for hospital-based PHPs*
0176	*Level II Partial Hospitalization (4 or more services) for hospital-based PHPs*

Apply Part B deductible, if any, and coinsurance.

G. Data for CWF and PS&R

Include revenue codes, HCPCS/CPT codes, units, and covered charges in the financial data section (fields 65a - 65j), as appropriate. Report the billed charges in field 65h, "Charges," of the CWF record.

Include in the financial data portion of the PS&R UNIBILL, revenue codes, HCPCS/CPT codes, units, and charges, as appropriate.

Future updates will be issued in a Recurring Update Notification.

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

(Rev. 2141, Issued: 01-24-11, Effective: 01-01-11, Implementation: 01-03-11)

A. General

Medicare Part B coverage for partial hospitalization services provided by CMHCs is available effective for services provided on or after October 1, 1991.

B. Special Requirements

Section 1866(e)(2) of the Act recognizes CMHCs as "providers of services" but only for furnishing partial hospitalization services. Applicable provider ranges are 1400-1499, 4600-4799, and 4900-4999.

C. Billing Requirements

The CMHCs bill for partial hospitalization services on Form CMS-1450 or electronic equivalent under bill type 76X. The FIs follow bill review instructions in chapter 25 *of this manual,* except for those listed below.

The acceptable revenue codes are as follows:

Code	Description
0250	Drugs and Biologicals
043X	Occupational Therapy
0900	Behavioral Health Treatments/Services
0904	Activity Therapy
0910	Psychiatric/Psychological Services (Dates of Service prior to October 16, 2003)
0914	Individual Therapy
0915	Group Therapy
0916	Family Therapy
0918	Testing
0942	Education Training

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

Revenue Codes	Description	HCPCS Code
043X	Occupational Therapy (Partial Hospitalization)	*G0129

Revenue Codes	Description	HCPCS Code
0900	Behavioral Health Treatments/Services	90801 or 90802
0904	Activity Therapy (Partial Hospitalization)	**G0176
0910	Psychiatric General Services (Dates of Service prior to October 16, 2003)	90801, 90802, 90899
0914	Individual Psychotherapy	90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829, 90845, 90865, or 90880
0915	Group Psychotherapy	G0410 or G0411
0916	Family Psychotherapy	90846 or 90847
0918	Psychiatric Testing	96101, 96102, 96103, 96116, 96118, 96119, or 96120
0942	Education Training	***G0177

The FIs edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. They do not edit for the matching of revenue codes to HCPCS.

*The definition of code G0129 is as follows:

> Occupational therapy services requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per session (45 minutes or more).

**The definition of code G0176 is as follows:

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

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

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

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

Code G0177 may be used in both partial hospitalization program and outpatient mental health settings.

Revenue code 0250 does not require HCPCS coding. However, drugs that can be self-administered are not covered by Medicare.

HCPCS includes CPT-4 codes. CMHCs report HCPCS codes in FL44, "HCPCS/Rates." HCPCS code reporting is effective for claims with dates of service on or after April 1, 2000.

The FIs are to advise their CMHCs of these requirements. CMHCs should complete the remaining items on Form CMS-1450 in accordance with the bill completion instructions in chapter 25 *of this manual*.

The professional services listed below are separately covered and are paid as the professional services of physicians and other practitioners. These professional services are unbundled and these practitioners (other than physician assistants (PAs)) bill the Medicare Part B carrier directly for the professional services furnished to CMHC partial hospitalization patients. The CMHC can also serve as a billing agent for these professionals by billing the Part B carrier on their behalf for their professional services. The professional services of a PA can be billed to the carrier only by the PAs employer. The employer of a PA may be such entities or individuals as a physician, medical group, professional corporation, hospital, SNF, or nursing facility. For example, if a physician is the employer of the PA and the PA renders services in the CMHC, the physician and not the CMHC would be responsible for billing the carrier on Form CMS-1500 for the services of the PA.

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

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

The services of other practitioners (including clinical social workers and occupational therapists) are bundled when furnished to CMHC patients. The CMHC must bill the FI for such nonphysician practitioner services as partial hospitalization services. The FI makes payment for the services to the CMHC.

D. Outpatient Mental Health Treatment Limitation

The outpatient mental health treatment limitation **may apply** to services to treat mental, psychoneurotic, and personality disorders when furnished by physicians, clinical psychologists, NPs, CNSs, and PAs to partial hospitalization patients. However, the outpatient mental health treatment limitation **does not** apply to such mental health treatment services billed to the FI as partial hospitalization services.

E. Reporting of Service Units

Visits should no longer be reported as units. Instead, CMHCs report in the field, "Service Units," the number of times the service or procedure, as defined by the HCPCS code, was performed when billing for partial hospitalization services identified by revenue code in subsection C.

EXAMPLE: A beneficiary received psychological testing (HCPCS code 96100, which is defined in 1 hour intervals) for a total of 3 hours during one day. The CMHC reports revenue code 0918, HCPCS code 96100, and "3".

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

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

NOTE: Information regarding the claim form locators that correspond with these fields and a table to crosswalk the CMS-1450 form locators to the 837 transaction is found in chapter 25 *of this manual*.

F. Line Item Date of Service Reporting

Dates of service per revenue code line for partial hospitalization claims that span two or more dates. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are reported in "Service Date". See examples below of reporting line item dates of service. These examples are for group therapy services provided twice during a billing period.

For claims, report as follows:

Revenue Code	HCPCS	Dates of Service	Units	Total Charges
0915	G0176	20090505	1	$80
0915	G0176	20090529	2	$160

NOTE: Information regarding the claim form locators that correspond with these fields and a table to crosswalk the CMS-1450 form locators to the 837 transaction is found in chapter 25 *of this manual*.

The FIs return to provider claims that span two or more dates if a line item date of service is not entered for each HCPCS code reported or if the line item dates of service reported are outside of the statement covers period. Line item date of service reporting is effective for claims with dates of service on or after June 5, 2000.

G. Payment

Section 1833(a)(2)(B) of the Act provides the statutory authority governing payment for partial hospitalization services provided by a CMHC. FIs made payment on a reasonable cost basis until OPPS was implemented. The Part B deductible and coinsurance applied.

Payment principles applicable to partial hospitalization services furnished in CMHCs are contained in §2400 of the Medicare Provider Reimbursement Manual.

The FIs make payment on a per diem basis under the hospital outpatient prospective payment system for partial hospitalization services. CMHCs must continue to maintain documentation to support medical necessity of each service provided, including the beginning and ending time.

Effective *January 1, 2011*, there are *four* separate APC payment rates for PHP: *two for CMHCs (for Level I and Level II services based on only CMHC data) and two for hospital-based PHPs (for Level I and Level II services based on only hospital-based PHP data). The following chart displays the CMHC APCs:*

Community Mental Health Center PHP APCs

APC	*Group Title*
0172	*Level I Partial Hospitalization (3 services) for CMHCs*
0173	*Level II Partial Hospitalization (4 or more services) for CMHCs*

NOTE: Occupational therapy services provided to partial hospitalization patients are not subject to the prospective payment system for outpatient rehabilitation

services, and therefore the financial limitation required under §4541 of the Balanced Budget Act (BBA) does not apply.

H. Medical Review

The FIs follow medical review guidelines in Pub. 100-08, Medicare Program Integrity Manual.

I. Coordination With CWF

See chapter 27 *of this manual*. All edits for bill type 74X apply, except provider number ranges 4600-4799 are acceptable only for services provided on or after October 1, 1991.