CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3685	**Date: December 22, 2016**
	Change Request 9930

SUBJECT: January 2017 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 2017 OPPS update. The January 2017 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). This Recurring Update Notification applies to Chapter 4, section 50.8.

The January 2017 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming January 2017 I/OCE CR.

EFFECTIVE DATE: January 1, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2017

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	4/Table of Contents
R	4/10.4/Packaging
R	4/10.4.1/Combinations of Packaged Services of Different Types That are Furnished on the Same Claim
R	4/10.7.1/Outlier Adjustments
R	4/20.6.4/ Use of Modifiers for Discontinued Services
N	4/20.6.13/Use of HCPCS Modifier – FX
R	4/60.1/Categories for Use in Coding Devices Eligible for Transitional Pass-Through Payments Under the Hospital OPPS
R	4/60.3/Devices Eligible for Transitional Pass-Through Payments
R	4/60.5/Services Eligible for New Technology APC Assignment and Payments
R	4/61.2/Edits for Claims on Which Specified Procedures are to be Reported With Device Codes and For Which Specific Devices are to be Reported With Procedure Codes
R	4/200.3.1/ Billing Instructions for IMRT Planning and Delivery
R	4/200.3.2/Billing for Multi-Source Photon (Cobalt 60-Based) Stereotactic Radiosurgery (SRS) Planning and Delivery
R	4/231.11/Billing for Allogeneic Stem Cell Transplants
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)
R	4/260.6/Payment for Partial Hospitalization Services
R	16/30.3/Method of Payment for Clinical Laboratory Tests - Place of Service Variation

III. FUNDING:

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:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3685	Date: December 22, 2016	Change Request: 9930

SUBJECT: January 2017 Update of the Hospital Outpatient Prospective Payment System (OPPS)

EFFECTIVE DATE: January 1, 2017
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I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the January 2017 OPPS update. The January 2017 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). This Recurring Update Notification applies to Chapter 4, section 50.8.

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B. Policy: 1. New Device Pass-Through Policies

a. New Device Pass-Through Categories

Section 1833(t)(6)(B) of the Social Security Act requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that we create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

b. Policy

In the CY2017 OPPS/ASC (Outpatient Prospective Payment System/Ambulatory Surgical Center) final rule with comment period that was published in the Federal Register on November 14, 2016, we adopted a policy to revise the pass-through payment time period by having the pass-through start date begin with the date of first payment and by allowing pass-through status to expire on a quarterly basis, such that the duration of device pass-through payment will be as close to three years as possible. In addition, in calculating the pass-through payment, the "Implantable Devices Charged to Patients Cost to Charge Ration (CCR)" will replace the hospital-specific CCR, when available and device offsets will be calculated from the HCPCS payment rate, instead of the APC payment rate (81 FR 79655 through 79657. Refer to the CY 2017 OPPS/ASC final rule with comment period for complete details of these policy changes for device pass-through that will become effective on January 1, 2017. Effective January 1, 2017, there are three device categories eligible for pass-through payment: (1) HCPCS code C2623 (Catheter, transluminal angioplasty, drug-coated, non-laser); (2) HCPCS code C2613 (Lung biopsy plug with delivery system); and (3) HCPCS code C1822 (Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system). Also, refer to https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html for most current device pass-through information.

c. Transitional Pass-Through Payments for Designated Devices

Certain designated new devices are assigned to APCs and identified by the OCE as eligible for payment based on the reasonable cost of the new device reduced by the amount included in the APC for the

procedure that reflects the packaged payment for device(s) used in the procedure. OCE will determine the proper payment amount for these APCs as well as the coinsurance and any applicable deductible. All related payment calculations will be returned on the same APC line and identified as a designated new device.

Refer to https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html for the most current OPPS HCPCS Offset File.

2. Device Intensive Procedures

Effective January 1, 2017, we will assign device- intensive status at the HCPCS code level for all procedures requiring the implantation of a medical device, in which the individual HCPCS level device offset is greater than 40 percent. All new procedures requiring the insertion of an implantable medical device will be assigned a default device offset percentage of at least 41 percent, and be assigned device intensive status, until claims data is available. In certain rare instances, we may to temporarily assign a higher offset percentage if warranted by additional information. Effective January 1, 2017, we will no longer assign device-intensive status based upon the APC level device offset percentage.

In light of this policy change we are modifying Sections 20.6.4 and 61.2 of Chapter 4 of the Medical Claims Processing Manual, Pub.100-04.

3. Argus Retinal Prosthesis Add-on Code (C1842)

Effective January 1, 2017, CMS is creating HCPCS code C1842 (Retinal prosthesis, includes all internal and external components; add-on to C1841) and assigning it a status indicator (SI) of N. HCPCS code C1842 was created to resolve a claims processing issue for ambulatory surgical centers (ASCs) and should not be reported on institutional claims by hospital outpatient department providers.

Additionally, although HCPCS code C1842 was not included in the CY 2017 Annual HCPCS file, the code has been included in the Jan 2017 Integrated Outpatient Code Editor (I/OCE) and therefore, Medicare contractors should add this code to their HCPCS system

4. Services Eligible for New Technology APC Assignment and Payments

Under OPPS, services eligible for payment through New Technology APCs are those codes that are assigned to the series of New Technology APCs published in Addendum A of the latest OPPS update. As of January 1, 2017, the range of New Technology APCs include

- APCs 1491 through 1500
- APCs 1502 through 1537
- APCs 1539 through 1585
- APCs 1589 through 1599, and
- APCs 1901 through 1906

OPPS considers any HCPCS code assigned to the above APCs to be a “new technology procedure or service.”

The application for consideration as a New Technology procedure or service may be found on the CMS Web site, currently at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html. Under the “Downloads” section, refer to the document titled “For a New Technology Ambulatory Payment Classification (APC) Designation Under the Hospital Outpatient Prospective Payment System (OPPS)” for information on the requirements for

submitting an application.

The list of HCPCS codes and payment rates assigned to New Technology APCs can be found in Addendum B of the latest OPPS update regulation each year at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html. Please note that this link may change depending on CMS Web design requirements.

5. Expiration of modifier "L1" for unrelated lab tests in the OPPS

As a result of the CY 2014 OPPS policy to package laboratory services in the hospital outpatient setting, the "L1" modifier was used on type of bill (TOB) 13x to identify unrelated laboratory tests that were ordered for a different diagnosis and by a different practitioner than the other OPPS services on the claim. In the CY 2016 OPPS final rule, we established status indicator "Q4," which conditionally packaged clinical diagnostic laboratory services. Status indicator "Q4" designates packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "J1," "J2," "S," "T," "V," "Q1," "Q2," or "Q3". The "Q4" status indicator was created to identify 13X bill type claims where there are only laboratory HCPCS codes that appear on the clinical laboratory fee schedule (CLFS); automatically change their status indicator to "A"; and pay them separately at the CLFS payment rates. In the CY 2017 OPPS/ASC final rule with comment period, we finalized a policy to eliminate the L1 modifier. Beginning January 1, 2017, we are discontinuing the use of the "L1" modifier to identify unrelated laboratory tests on claims.

6. Conditional packaging change to apply at claim level

When conditional packaging was initially adopted under the OPPS, it was based on the date of service associated with other items and services furnished on the claim. When we established the comprehensive APCs in the CY 2015 OPPS, packaging was applied on a claim basis. To promote consistency and ensure appropriate packaging under OPPS policy, we finalized a change in the CY 2017 OPPS to apply conditional packaging for status indicators "Q1" and "Q2" on a claim basis.

7. Exception for laboratory packaging in the OPPS for Advanced Diagnostic Laboratory Tests (ADLTs)

Beginning in the CY 2014 OPPS, we established that laboratory tests for molecular pathology tests described by CPT codes in the ranges of 81200 through 81383, 81400 through 81408, and 81479 are not packaged in the OPPS. In the CY 2017 OPPS, we are expanding the laboratory packaging exclusion that currently applies to Molecular Pathology tests (described by CPT codes in the ranges of 81200 through 81383, 81400 through 81408, and 81479) to all laboratory tests designated as advanced diagnostic laboratory tests (ADLTs) that meet the criteria of section 1834A(d)(5)(A) of the Act.

8. FX Modifier (X-ray Taken Using Film)

In accordance with provisions allowed under Section 1833(t)(16)(F)(iv) of the Act, we have established a new modifier "FX" to identify imaging services that are X-rays taken using film. Effective January 1, 2017, hospitals are required to use this modifier on claims for imaging services that are X-rays.

The use of this modifier will result in a payment reduction of 20 percent in CY 2017 for the X-ray services taken using film when the service is paid separately. The use of the FX modifier and subsequent reduction in payment under the OPPS is applicable to all imaging services that are X-rays taken using film. All imaging services that are X-rays are listed in Addendum B of the CY 2017 OPPS/ASC Final Rule with comment period (which is available via the Internet on the CMS Web site).

CMS is updating Pub. 100-04, Medicare Claims Processing Manual, chapter 4, section 20.6.13 to include this new modifier.

9. CT Modifier (‘‘Computed tomography services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) XR–29–2013 standard’’)

In accordance with Section 1834(p) of the Act we established modifier "CT" effective January 1, 2016 to identify computed tomography (CT) scans that are furnished on equipment that does not meet the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013, entitled "Standard Attributes on CT Equipment Related to Dose Optimization and Management." Hospitals are required to use this modifier on claims for computed tomography (CT) scans described by applicable HCPCS codes that are furnished on non-NEMA Standard XR-29-2013-compliant equipment. The applicable CT services are identified by HCPCS codes 70450 through 70498; 71250 through 71275; 72125 through 72133; 72191 through 72194; 73200 through 73206; 73700 through 73706; 74150 through 74178; 74261 through 74263; and 75571 through 75574 (and any succeeding codes).

Effective January 1, 2017, the use of this modifier will result in a payment reduction of 15 percent for the applicable computed tomography (CT) services when the service is paid separately. The 15 percent payment reduction will also be applied to the APC payment for the HCPCS codes listed above that are subject to the multiple imaging composite policy. This includes procedures assigned to the two APCs (8005 and 8006) in the computed tomography (CT) and computed tomographic angiography (CTA) imaging family.

10. Billing for Items and Services Furnished at Off-Campus Hospital Outpatient Departments

In accordance with Section 1833(t)(21) of the Act, as added by section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74), we have established a new modifier "PN" *(Nonexcepted service provided at an off-campus, outpatient, provider-based department of a hospital)* to identify and pay nonexcepted items and services billed on an institutional claim. Effective January 1, 2017, non-excepted off-campus provider-based departments of a hospital are required to report this modifier on each claim line for non-excepted items and services. The use of modifier "PN" will trigger a payment rate under the Medicare Physician Fee Schedule. We expect the PN modifier to be reported with each nonexcepted item and service including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services,

Excepted off-campus provider-based departments of a hospital must continue to report existing modifier "PO" *(Services, procedures and/or surgeries provided at off-campus provider-based outpatient departments)* for all excepted items and services furnished. Use of the off-campus PBD modifier became mandatory beginning January 1, 2016.

We would not expect off-campus provider-based departments to report both the PO and PN modifiers on the same claim line. However, if services reported on a claim reflect items and services furnished from both an exceped and a nonexcepted off-campus PBD of the hospital, the PO modifier should be used on the excepted claim lines and the PN modifier should be used on the nonexcepted claim lines.

Neither the PO nor the PN modifier is to be reported by the following hospital departments:

- A dedicated emergency department as defined in existing regulations at 42 CFR 489.24(b);
- A PBD that is "on the campus," or within 250 yards, of the hospital or a remote location of the hospital as defined under 42 CFR 413.65.

11. Partial Hospitalization Program

a. Update to PHP Per Diem Costs

The CY 2017 OPPS/ASC final rule with comment period replaces the existing two-tiered APC structure for PHPs with a single APC by provider type for providing three or more services per day. Specifically, we are

replacing existing CMHC APCs 5851 (Level 1 Partial Hospitalization (3 services)) and 5852 (Level 2 Partial Hospitalization (4 or more services)) with a new CMHC APC 5853 (Partial Hospitalization (3 or More Services Per Day)), and replacing existing hospital-based PHP APCs 5861 (Level 1 Partial Hospitalization (3 services)) and 5862 (Level 2 Partial Hospitalization (4 or more services)) with a new hospital-based PHP APC 5863 (Partial Hospitalization (3 or More Services Per Day)).

b. CMHC Provider-Level Outlier Cap

The CY 2017 OPPS/ASC final rule with comment period implements a CMHC outlier payment cap to be applied at the provider level. In any given year an individual CMHC will receive no more than 8 percent of its CMHC total per diem payments in outlier payments. The provider-level cap on CMHC outlier payments would be managed by the claims processing system. The existing outlier reconciliation process remains in place to adjust outlier payments at final cost report settlement, based on changes in the provider's CCR.

c. PHP Payments under Section 603 (Off-Campus Policy)

Section 1861(ff)(3)(A) of the Act specifies that a PHP is a program furnished by a hospital, to its outpatients, or by a CMHC. Section 1833(t)(1)(B)(i) of the Act provides the Secretary with the authority to designate the outpatient department services to be covered under the OPPS. As a part of the OPPS, HB PHPs are affected by this new legislation. CMHCs are not affected because they are not a hospital or a department/unit of a hospital. The CY 2017 OPPS/ASC final rule with comment adopts payment for non-excepted hospital-based PHPs under the MPFS, paying the CMHC per diem rate for APC 5853, for providing 3 or more PHP services per day.

12. Changes to Policies related to Allogeneic Hematopoietic Stem Cell Transplantation (HSCT)

a. Allogeneic Hematopoietic Stem Cell Transplantation (HSCT) (C-APC 5244)

Effective January 1, 2017, CMS is assigning procedures described by CPT code 38240 (Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor) to newly established comprehensive APC (C-APC) 5244 (Level 4 Blood Product Exchange and Related Services). CPT code 38240 will be assigned status indicator "J1". The assignment of CPT code 38240 to C-APC 5244 and status indicator "J1" will allow for all other OPPS payable services and items reported on the claim (including donor acquisition costs) to be deemed adjunctive services representing components of a comprehensive service and result in a single prospective payment through C-APC 5244 for the comprehensive service based on the costs of all reported services on the claim.

b. New Revenue Code 0815 for Allogeneic Stem Cell Acquisition Services

Effective January 1, 2017, hospitals are required to report revenue code 0815 when billing donor acquisition costs associated with allogeneic hematopoietic stem cell transplantation (HSCT). CMS is also implementing a code edit (edit 100) effective January 1, 2017 that will require donor acquisition charges for allogeneic HSCT reported with revenue code 0815 to be included on a claim with CPT code 38240 (Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor). Donor acquisition charges for allogeneic HSCT are described in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 4, section 231.11. Revenue code 0819 is no longer required for the reporting of donor acquisition charges for allogeneic HSCT.

CMS is updating Medicare Claims Processing Manual, Pub. 100-04, Chapter 4, section 231.11 and Chapter 3, section 90.3.1 to reflect the new billing guidelines for allogeneic HSCT.

13. Drugs, Biologicals, and Radiopharmaceuticals

a. New CY 2017 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

For CY 2017, 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 1, attachment A.

b. Other Changes to CY 2017 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 2017. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2016, and replaced with permanent HCPCS codes in CY 2017. 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 2017 HCPCS and CPT codes.

Table 2, attachment A, notes those drugs, biologicals, and radiopharmaceuticals that have undergone changes in their HCPCS/CPT code, their long descriptor, or both. Each product's CY 2016 HCPCS/CPT code and long descriptor are noted in the two left hand columns and the CY 2017 HCPCS/CPT code and long descriptor are noted in the adjacent right hand columns.

c. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective January 1, 2017

For CY 2017, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals continues to be made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In addition, in CY 2017, a single payment of ASP + 6 percent continues to be made 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. 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, 2017, payment rates for many drugs and biologicals have changed from the values published in the CY 2017 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 2016. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2017 FISS release. CMS is not publishing the updated payment rates in this Change Request implementing the January 2017 update of the OPPS. However, the updated payment rates effective January 1, 2017 can be found in the January 2017 update of the OPPS Addendum A and Addendum B on the CMS Web site at http://www.cms.gov/HospitalOutpatientPPS/.

d. Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates

Some drugs and biologicals based on ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the CMS Web site on the first date of the quarter at https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html. Providers may resubmit claims that were impacted by adjustments to previous quarter's payment files.

e. Biosimilar Biological Product Payment Policy

Effective January 1, 2017, the payment rate for a biosimilar biological product under the OPPS will continue to be the same as the payment rate in the physician office setting, (i.e., calculated as the average sales price (ASP) of the biosimilar(s) described by the HCPCS code + 6% of the ASP of the reference product). Biosimilar biological products are also be eligible for transitional pass-through payment; however, pass-through payment will be made to the first eligible biosimilar biological product to a reference product. Subsequent biosimilar biological products to a reference product will not meet the newness criterion, and therefore will be ineligible for pass-through payment.

As a reminder, OPPS claims for separately paid biosimilar biological products are required to include a modifier (see table 3, attachment A) that identifies the manufacturer of the specific product. The modifier does not affect payment determination, but is used to distinguish between biosimilar products that appear in the same HCPCS code but are made by different manufacturers.

f. Billing and Payment for New Drugs, Biologicals, or Radiopharmaceuticals Approved by the Food and Drug Administration (FDA) but Before Assignment of a Product-Specific HCPCS Code

Hospital outpatient departments are allowed to bill for new drugs, biologicals, and therapeutic radiopharmaceuticals that are approved by the FDA on or after January 1, 2004 for which pass-through status has not been approved and a C-code and APC payment have not been assigned using the "unclassified" drug/biological HCPCS code C9399 (Unclassified drugs or biological). Drugs, biologicals, and therapeutic radiopharmaceuticals that are assigned to HCPCS code C9399 are contractor priced at 95 percent of AWP.

Diagnostic radiopharmaceuticals and contrast agents are policy packaged under the OPPS unless they have been granted pass-through status. Therefore, new diagnostic radiopharmaceuticals and contrast agents are an exception to the above policy and should not be billed with C9399 prior to the approval of pass-through status but, instead, should be billed with the appropriate "A" NOC code as follows:

1. Diagnostic Radiopharmaceuticals – All new diagnostic radiopharmaceuticals are assigned to either HCPCS code A9597 (Positron emission tomography radiopharmaceutical, diagnostic, for tumor identification, not otherwise classified), HCPCS code A9598 (Positron emission tomography radiopharmaceutical, diagnostic, for non-tumor identification, not otherwise classified), HCPCS code A9599 (Radiopharmaceutical, diagnostic, for beta-amyloid positron emission tomography (PET) imaging, per study dose), or HCPCS code J3490 (Unclassified drugs) (applicable to all new diagnostic radiopharmaceuticals used in non-beta-amyloid PET imaging). HCPCS code A9597, A9598, A9599, or J3490, whichever is applicable, should be used to bill a new diagnostic radiopharmaceutical until the new diagnostic radiopharmaceutical has been granted pass-through status and a C-code has been assigned. HCPCS codes A9597, A9598, A9599, and J3490 are assigned status indicator "N" and, therefore, the payment for a diagnostic radiopharmaceutical assigned to any of these HCPCS codes is packaged into the payment for the associated service.

2. Contrast Agents – All new contrast agents are assigned HCPCS code A9698 (Non-radioactive contrast imaging material, not otherwise classified, per study) or A9700 (Supply of injectable contrast material for use in echocardiography, per study). HCPCS code A9698 or A9700 should be used to bill a new contrast agent until the new contrast agent has been granted pass-through status and a C-code has been assigned. HCPCS code A9698 is assigned status indicator "N" and, therefore, the payment for a drug assigned to HCPCS code A9698 is packaged into the payment for the associated service. The status indicator for A9700 will change from SI=B (Not paid under OPPS) to SI=N (Payment is packaged into payment for other services) and, therefore, the payment for a drug assigned to HCPCS code A9700 is packaged into the payment for the associated service.

g. Skin Substitute Procedure Edits

The payment for skin substitute products that do not qualify for pass-through status will be packaged into the payment for the associated skin substitute application procedure. The skin substitute products are divided into two groups: 1) high cost skin substitute products and 2) low cost skin substitute products for packaging purposes. Table 4, attachment A, lists the skin substitute products and their assignment as either a high cost or a low cost skin substitute product, when applicable. CMS will implement an OPPS edit that requires hospitals to report all high-cost skin substitute products in combination with one of the skin application procedures described by CPT codes 15271-15278 and to report all low-cost skin substitute products in combination with one of the skin application procedures described by HCPCS codes C5271-C5278. All pass-through skin substitute products are to be reported in combination with one of the skin application

procedures described by CPT codes 15271-15278.

h. Reassignment of Skin Substitute Products from the Low Cost Group to the High Cost Group – Retroactive Change

One existing skin substitute product has been reassigned from the low cost skin substitute group to the high cost skin substitute group based on updated pricing information. The start date on this change is retroactive to October 1, 2016. The product is listed in Table 5, attachment A.

14.Changes to OPPS Pricer Logic

a. Rural sole community hospitals and essential access community hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in CY 2017. 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 the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

b. New OPPS payment rates and copayment amounts will be effective January 1, 2017. All copayment amounts will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the CY 2017 inpatient deductible of $1,316. For most OPPS services, copayments are set at 20 percent of the APC payment rate.

c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2017. 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. The fixed-dollar threshold for OPPS outlier payments increases in CY 2017 relative to CY 2016. The estimated cost of a service must be greater than the APC payment amount plus $3,825 in order to qualify for outlier payments.

e. For outliers for Community Mental Health Centers (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2017. This threshold of 3.4 is multiplied by the total line-item APC payment for APC 5853 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 5853 payment x 3.4))/2.

f. Continuing our established policy for CY 2017, 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.

g. Effective January 1, 2017, CMS is adopting the FY 2017 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.

h. Effective January 1, 2014, for claims with APCs, which require implantable devices and have significant device offsets (greater than 40%), a device offset cap will be applied based on the credit amount listed in the "FD" (Credit Received from the Manufacturer for a Replaced Medical Device) value code. The credit amount in value code "FD" which reduces the APC payment for the applicable procedure, will be capped by the device offset amount for that APC. The offset amounts for the above referenced APCs are available on the CMS website.

i. Effective January 1, 2017 conditional packaging for status indicators "Q1" and "Q2" will apply at the claim level rather than the date-of-service level.

j. The Payment Rate field in the Pricer file will be expanded from 7 digits to 8 digits to accommodate APC payment rates greater than or equal to $100,000.

15. Update the Outpatient Provider Specific File (OPSF)

For January 1, 2017, 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 6, attachment A. As always, the OPPS applies the IPPS fiscal year 2017 post-reclassification wage index values to all hospitals and community mental health centers participating in the OPPS for the 2017 calendar year.

Contractors shall do the following to update the OPSF (effective January 1, 2017):

1. Update the CBSA value for each provider in Table 6, attachment A ;

2. For non-IPPS providers who qualify for the 505 adjustment in CY 2017 (Table 6, attachment A);

a) Create a new provider record, effective January 1, 2017 and

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

c) Enter the final wage index value (given for the provider in Table 6, attachment A) in the Special Wage Index field in the OPSF.

3. For non-IPPS providers who received a special wage index in CY 2016, but no longer receive it in CY 2017;

a) Create a new provider record, effective January 1, 2017 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 6, attachment A) 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.

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

Cancer and children's hospitals are held harmless under section 1833(t)(7)(D)(ii) of the Social Security Act and continue to receive hold harmless TOPs permanently. For CY 2017, cancer hospitals will continue to

receive an additional payment adjustment.

b) Updating the OPSF for the Hospital Outpatient Quality Reporting (HOQR) Program 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 HOQR program 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, 2017, contractors shall maintain the accuracy of the provider records in the OPSF by updating the Hospital Quality Indicator field. CMS will release a Technical Direction Letter that lists Subsection (d) hospitals that are subject to and fail to meet the HOQR program 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 HOQR program requirements, FIs/MACs shall update the OPSF. For greater detail regarding updating the OPSF for the HOQR program requirements, see Transmittal 368, CR 6072, issued on August 15, 2008.

c) Updating the OPSF for Cost to Charge Ratios (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 and, when applicable, device department 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.gov/HospitalOutpatientPPS/ under "*Annual Policy Files*."

d) Application of the Out Migration Adjustment for IPPS hospitals that also receive OPPS Payment

For hospitals located in a county eligible for the out migration adjustment, if the hospital is NOT located in a rural county deemed as a Lugar county (only applicable to 1886(d) hospitals), or the hospital has NOT been approved to reclassify as rural under section 1886(d)(8)(E) of the Act (42 CFR 412.103), or the hospital does NOT have an MGCRB reclassification, then MACs shall do the following,

1. Determine if the hospital is located in a county eligible for the out migration adjustment (see attachment B for a list of counties eligible for the out migration adjustment). If the hospital is eligible for the out migration adjustment, then follow steps b-d below.

2. Using the actual geographic CBSA, look up the CBSA wage index on table 3 on the internet at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page-Items/FY2017-IPPS-Final-Rule-Tables.html in the column titled "Wage Index". *Note: if the CBSA is listed more than once and has a wage index value in each of the "Wage Index" columns, then choose the wage index for the hospital based on the state in which the hospital is located as listed in the "State" column.*

3. Add to that wage index value from table 3 on the internet the outmigration adjustment value from Attachment B (the column titled "Out Migration Adjustment").

4. Insert a "1" in the Special Payment Indicator field and insert the wage index value from step b in the Special Wage Index field. ***Note: Hospitals that are LUGAR (and did not waive their LUGAR status) or qualify for MGCRB or 412.103 reclassification are not eligible for the out migration adjustment. Therefore, if the MAC has entered a "Y" in the Special Payment Indicator field and has entered the reclassified CBSA in the "Wage Index Location CBSA" data element, then the***

hospital cannot qualify for the outmigration adjustment.

e) Updating the OPSF for Hospitals Reclassified as Rural Hospitals Under § 412.103 and Hospitals Reclassified under the Medicare Geographic Classification Review Board (MGCRB)

An urban hospital that reclassifies as a rural hospital under § 412.103 is considered rural for all OPPS purposes. Prior to April 21, 2016, the regulations at § 412.230(a)(5)(ii) and § 412.230(a)(5)(iii) prohibited hospitals from simultaneously receiving an urban to rural reclassification under § 412.103 and a reclassification under the MGCRB. Also, the regulations did not allow a LUGAR hospital to keep its LUGAR status if it was approved for an urban to rural reclassification under § 412.103. The court decisions in Geisinger Community Medical Center v. Secretary, United States Department of Health and Human Services, 794 F.3d 383 (3d Cir. 2015) and Lawrence + Memorial Hospital v. Burwell, No. 15-164, 2016 WL 423702 (2d Cir. Feb. 4, 2015) ruled as unlawful the regulation precluding a hospital from maintaining simultaneous MGCRB and § 412.103 reclassifications. Therefore, on April 18, 2016, CMS issued an interim final rule with comment period (CMS-1664-IFC) amending the regulations to conform to the court decisions. The IFC is effective April 21, 2016, and was finalized on August 2, 2016. The IFC allows hospitals nationwide that have an MGCRB reclassification or LUGAR status during FY 2016 and subsequent years the opportunity to simultaneously seek urban to rural reclassification under § 412.103 for IPPS payment and other purposes, and keep their existing MGCRB reclassification or LUGAR status.

At any point during a calendar year, MACs may be notified by the CMS Regional Offices of hospitals located in an urban CBSA that are approved to reclassify as rural under section 1886(d)(8)(E) of the Act (§ 412.103). The regulations at § 412.103(a)(c) provide the CMS Regional Offices with up to 60 days to review and approve an urban to rural reclassification request. If the request is approved by CMS Regional Office, the approval is effective as of the filing date of the request (typically specified in the CMS Regional Office's approval letter).

Instructions for Updating the OPSF if a Hospital is Approved for an Urban to Rural Reclassification Under Section 1886(d)(8)(E) of the Act (§ 412.103) with an Effective Date of April 21, 2016 and After for CY 2016

(i) If the hospital does not have an existing MGCRB or Lugar reclassification in the OPSF (meaning the data element for the "Wage Index Location CBSA" field is blank), MACs shall ensure that the data elements for the "Specialty Payment Indicator" and "Special Wage Index" fields are blank. MACs shall also ensure that the rural CBSA (two digit state code) is specified in the Wage Index Location CBSA field with an effective date in the OPSF that is the effective date of the hospital's rural reclassification (typically specified in the Regional Office's approval letter).

(ii) If the hospital had an existing MGCRB reclassification or is deemed LUGAR for CY 2016 and was approved by the CMS Regional Office for a 412.103 reclassification with an effective date of April 21, 2016 and after, MACs shall do the following:

1. Update all quarterly records in CY 2016 for after the submission of the request to reclassify from urban to rural status, for these hospitals.

2. Enter an effective date in the PSF of the later of April 21, 2016 or the effective date of the hospital's rural reclassification (typically specified in the Regional Office's approval letter).

3. Enter a value of "2" in the Special Payment Indicator field.

4. Enter the hospital's rural CBSA associated with the 412.103 reclassification in the Wage Index Location CBSA field.

5. Enter the final CY 2016 wage index value associated with the MGCRB reclassification in the Special Wage Index field in the OPSF.

6. Ensure claims are paid correctly. If necessary, the MAC may need to reprocess claims from the effective date in the OPSF until the date of reprocessing to ensure that claims are paid correctly.

Instructions for Updating the OPSF for Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals Under §412.103 in CY 2017 but with no other Reclassifications

An urban hospital that reclassifies as a rural hospital under §412.103 is considered rural. In order to ensure correct payment under the OPPS, the rural CBSA (2-digit State code) in the Wage Index Location CBSA and the special payment indicator field must be updated.

MACs shall do the following to update the OPSF (effective January 1, 2017):

1. Create a new provider record, effective January 1, 2017, and

2. Enter a value of "Y" in the Special Payment Indicator field on the OPSF; and

3. Enter the rural CBSA (2-digit State code) in the Wage Index Location CBSA field for each provider marked "Y" in the column "Hospital Reclassified as Rural Under Section 1886(d)(8)(E) of the Act (412.103)" found in Table 2 of the FY 2017 IPPS Final rule.

Instructions for Updating the OPSF if a Hospital is Approved for an Urban to Rural Reclassification Under Section 1886(d)(8)(E) of the Act (§ 412.103) with an Effective Date of January 1, 2017 and After for CY 2017

(i) If the hospital does not have an existing MGCRB or Lugar reclassification, MACs shall ensure that the data elements for the "Specialty Payment Indicator" and "Special Wage Index" fields are blank. MACs shall also ensure that the rural CBSA (two digit state code) is specified in the Wage Index Location CBSA field with an effective date in the OPSF that is the effective date of the hospital's rural reclassification (typically specified in the Regional Office's approval letter).

(ii) For hospitals listed in table 7, attachment A, that maintain both a MGCRB reclassification/LUGAR status and a 412.103 urban to rural reclassification in CY 2017, MACs shall do the following:

1. Create a new provider record, effective January 1, 2017.

2. Enter a value of "2" in the Special Payment Indicator field.

3. Enter the Wage Index Location CBSA (given for the provider in Table 7, attachment A) in the Wage Index Location CBSA field.

4. Enter the CY 2017 Special Wage Index value (given for the provider in Table 7, attachment A) in the Special Wage Index field.

5. We note that at any point in the year, MACs may be notified by the CMS Regional Offices of a hospital that is approved for Urban to Rural Reclassification under section 1886(d)(8)(E) of the Act (§ 412.103). For hospitals that are approved for these reclassifications mid fiscal year and already have an approved MGCRB reclassification for CY 2017, MACs shall perform steps 1 through 3 and enter in the Special Wage Index field, with an effective date in the OPSF that is the date that the CMS Regional Office Received the hospital's application (typically specified in the Regional Office's approval letter).

Instructions for Updating the OPSF if a Hospital Cancels an Urban to Rural Reclassification Under Section 1886(d)(8)(E) of the Act (§ 412.103)

If a hospital notifies the CMS Regional Office that it wishes to cancel its urban to rural reclassification under section 1886(d)(8)(E) of the Act (42 CFR 412.103), MACs shall do the following:

(i) If the hospital does not have an existing MGCRB or Lugar reclassification, then do the following:

1. Delete the rural CBSA from the data element for the "Wage Index Location CBSA" field effective with the beginning of the hospital's next full cost reporting period (or if the hospital is a Rural Referral Center, effective with the beginning of the Federal fiscal year following the 12-month cost reporting period in which it was paid as rural).The effective date of this change must follow the rules of section 412.103(g).

2. If the hospital is located in a county eligible for the out migration adjustment, follow the instruction in section d of this CR.

3. Ensure claims are paid correctly. If necessary, the MAC may need to reprocess claims from the effective date in the OPSF until the date of reprocessing to ensure that claims are paid correctly.

(ii) For hospitals that have both a MGCRB reclassification/LUGAR status and a 412.103 urban to rural reclassification and cancel their Urban to Rural reclassification under section 1886 (d)(8)(E) of the Act (412.103) in the middle of the Fiscal Year, do the following:

1. Replace the rural CBSA in the Wage Index Location CBSA field with the Post Reclassification CBSA, effective with the beginning of the hospital's next full cost reporting period (or if the hospital is a Rural Referral Center, effective with the beginning of the Federal fiscal year following the 12-month cost reporting period in which it was paid as rural). If the Post Reclassification CBSA is equal to the Actual Geographic Location CBSA field, delete the existing value in the Wage Index Location CBSA field and leave it blank. The effective date of this change must follow the rules of section 412.103(g).

2. Enter a blank in the Special Payment Indicator field.

3. Enter zeroes in the special wage index field.

4. Ensure claims are paid correctly. If necessary, the MAC may need to reprocess claims from the effective date in the OPSF until the date of reprocessing to ensure that claims are paid correctly.

16. Coverage Determinations

As a reminder, 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. Medicare Administrative Contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, 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

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9930 - 04.1	Medicare contractors shall install the January 2017 OPPS Pricer.	X		X		X				
9930 - 04.2	Medicare contactors shall manually add to their systems: • HCPCS code C1842, listed in section I.B.3, effective January 1, 2017; **Note:** This HCPCS code will be included with the January 2017 I/OCE update. Status and payment indicator for this HCPCS code will be listed in the January 2017 update of the OPPS Addendum A and Addendum B on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html	X		X						
9930 - 04.3	As specified in chapter 4, section 50.1, Medicare contractors shall maintain the accuracy of the data and update the OPSF file as changes occur in data element values. For CY 2017, this includes all changes to the OPSF identified in Section 15 of this Change Request.	X		X						
9930 - 04.4	Medicare contractors shall adjust, as appropriate, claims brought to their attention with any retroactive changes that were received prior to implementation of January 2017 OPPS Pricer.	X		X						
9930 - 04.5	Medicare system maintainers shall make any needed updates to their systems to accommodate APC rates >= 100,000.					X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9930 - 04.6	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-	X		X		

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	Network-MLN/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 sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

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

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 2

Attachment A − Tables for the Policy Section

Table 1 − New CY 2017 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2017 HCPCS Code	CY 2017 Long Descriptor	CY 2017 SI	CY 2017 APC
90682	Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use	L	
90750	Zoster (shingles) vaccine (HZV), recombinant, sub-unit, adjuvanted, for intramuscular injection	E1	
A9587	Gallium ga-68, dotatate, diagnostic, 0.1 millicurie	G	9056
A9588	Fluciciovine f-18, diagnostic, 1 millicurie	G	9052
A9597	Positron emission tomography radiopharmaceutical, diagnostic, for tumor identification, not otherwise classified	N	
A9598	Positron emission tomography radiopharmaceutical, diagnostic, for non-tumor identification, not otherwise classified	N	
C9140	Injection, Factor VIII (antihemophilic factor, recombinant) (Afstyla), 1 I.U.	G	9043
J0570	Buprenorphine implant, 74.2 mg	G	9058
J1130	Injection, diclofenac sodium, 0.5 mg	E2	
J7175	Injection, factor x, (human), 1 i.u.	K	1857
J7179	Injection, von willebrand factor (recombinant), (Vonvendi), 1 i.u. vwf:rco	G	9059
J9034	Injection, bendamustine hcl (Bendeka), 1 mg	G	1861
Q4166	Cytal, per square centimeter	N	
Q4167	Truskin, per square centimeter	N	
Q4168	Amnioband, 1 mg	N	
Q4169	Artacent wound, per square centimenter	N	
Q4170	Cygnus, per square centimenter	N	
Q4171	Interfyl, 1 mg	N	
Q4173	Palingen or palingen xplus, per square centimenter	N	
Q4174	Palingen or promatrx, 0.36 mg per 0.25 cc	N	
Q4175	Miroderm, per square centimeter	N	

Table 2 − Other CY 2017 HCPCS and CPT Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2016 HCPCS /CPT Code	CY 2016 Long Descriptor	CY 2017 HCPCS /CPT Code	CY 2017 Long Descriptor
C9461	Choline C 11, diagnostic, per study dose	A9515	Choline c-11, diagnostic, per study dose up to 20 millicuries
A9599	Radiopharmaceutical, diagnostic, for beta-amyloid positron emission tomography (pet) imaging, per study dose	A9599	Radiopharmaceutical, diagnostic, for beta-amyloid positron emission tomography (pet) imaging, per study dose, not otherwise specified
C9121	Injection, argatroban, per 5 mg	J0883	Injection, argatroban, 1 mg (for non-esrd use)
C9121	Injection, argatroban, per 5 mg	J0884	Injection, argatroban, 1 mg (for esrd on dialysis)
C9137	Injection, Factor VIII (antihemophilic factor, recombinant) PEGylated, 1 I.U.	J7207	Injection, factor viii, (antihemophilic factor, recombinant), pegylated, 1 i.u.
C9138	Injection, Factor VIII (antihemophilic factor, recombinant) (Nuwiq), 1 I.U.	J7209	Injection, factor viii, (antihemophilic factor, recombinant), (nuwiq), 1 i.u.
C9139	Injection, factor ix, albumin fusion protein (recombinant), idelvion, 1 i.u.	J7202	Injection, factor ix, albumin fusion protein, (recombinant), idelvion, 1 i.u.
C9349	Puraply, and puraply antimicrobial, any type, per square centimeter	Q4172	Puraply or puraply am, per square centimeter
C9470	Injection, aripiprazole lauroxil, 1 mg	J1942	Injection, aripiprazole lauroxil, 1 mg
C9471	Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg	J7322	Hyaluronan or derivative, hymovis, for intra-articular injection, 1 mg
C9472	Injection, talimogene laherparepvec, 1 million plaque forming units (PFU)	J9325	Injection, talimogene laherparepvec, per 1 million plaque forming units
C9473	Injection, mepolizumab, 1 mg	J2182	Injection, mepolizumab, 1 mg
C9474	Injection, irinotecan liposome, 1 mg	J9205	Injection, irinotecan liposome, 1 mg
C9475	Injection, necitumumab, 1 mg	J9295	Injection, necitumumab, 1 mg
C9476	Injection, daratumumab, 10 mg	J9145	Injection, daratumumab, 10 mg
C9477	Injection, elotuzumab, 1 mg	J9176	Injection, elotuzumab, 1 mg
C9478	Injection, sebelipase alfa, 1 mg	J2840	Injection, sebelipase alfa, 1 mg
C9479	Instillation, ciprofloxacin otic suspension, 6 mg	J7342	Installation, ciprofloxacin otic suspension, 6 mg
C9480	Injection, trabectedin, 0.1 mg	J9352	Injection, trabectedin, 0.1 mg
C9481	Injection, reslizumab, 1 mg	J2786	Injection, reslizumab, 1 mg
J0571	Buprenorphine, oral, 1 mg	J0571	Buprenorphine oral 1 mg
J0573	Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 3.1 to 6 mg	J0573	Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg buprenorphine
J3357	Injection, ustekinumab, 1 mg	J3357	Ustekinumab, for subcutaneous injection, 1 mg
J1745	Injection, infliximab, 10 mg	J1745	Injection, infliximab, excludes biosimilar, 10 mg
J7201	Injection, factor ix, fc fusion protein (recombinant), per iu	J7201	Injection, factor ix, fc fusion protein (recombinant), Alprolix, per iu

CY 2016 HCPCS /CPT Code	CY 2016 Long Descriptor	CY 2017 HCPCS /CPT Code	CY 2017 Long Descriptor
J7340	Carbidopa 5 mg/levodopa 20 mg enteral suspension	J7340	Carbidopa 5 mg/levodopa 20 mg enteral suspension, 100 ml
Q9981	Rolapitant, oral, 1 mg	J8670	Rolapitant, oral, 1 mg
Q4105	Integra dermal regeneration template (drt), per square centimeter	Q4105	Integra dermal regeneration template (drt) or integra omnigraft dermal regeneration matrix, per square centimeter
Q4131	Epifix, per square centimeter	Q4131	Epifix or epicord, per square centimeter
Q2039	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (not otherwise specified)	Q2039	Influenza virus vaccine, not otherwise specified

Table 3 – Biosimilar Biological Product Payment and Required Modifiers

HCPCS Code	Short Descriptor	Long Descriptor	SI	APC	FDA Approval Dates	HCPCS Modifier	HCPCS Modifier Effective Date
Q5101	Inj filgrastim g-csf biosim	Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram	G	1822	03/06/2015	ZA-Novartis/ Sandoz	01/01/2016
Q5102	Inj., infliximab biosimilar	Injection, Infliximab, Biosimilar, 10 mg	K	1847	04/05/2016	ZB-Pfizer/ Hospira	04/01/2016

Table 4 – Skin Substitute Product Assignment to High Cost/Low Cost Status for CY 2016

CY 2017 HCPCS Code	CY 2017 Short Descriptor	CY 2017 SI	Low/High Cost Skin Substitute
C9363	Integra Meshed Bil Wound Mat	N	High
Q4100	Skin Substitute, NOS	N	Low
Q4101	Apligraf	N	High
Q4102	Oasis Wound Matrix	N	Low
Q4103	Oasis Burn Matrix	N	High
Q4104	Integra BMWD	N	High
Q4105	Integra DRT	N	High
Q4106	Dermagraft	N	High

CY 2017 HCPCS Code	CY 2017 Short Descriptor	CY 2017 SI	Low/High Cost Skin Substitute
Q4107	GraftJacket	N	High
Q4108	Integra Matrix	N	High
Q4110	Primatrix	N	High
Q4111	Gammagraft	N	Low
Q4115	Alloskin	N	Low
Q4116	Alloderm	N	High
Q4117	Hyalomatrix	N	Low
Q4121	Theraskin	N	High
Q4122	Dermacell	N	High
Q4123	Alloskin	N	High
Q4124	Oasis Tri-layer Wound Matrix	N	Low
Q4126	Memoderm/derma/tranz/integup	N	High
Q4127	Talymed	N	High
Q4128	Flexhd/Allopatchhd/Matrixhd	N	High
Q4131	Epifix	N	High
Q4132	Grafix Core	N	High
Q4133	Grafix Prime	N	High
Q4134	hMatrix	N	Low
Q4135	Mediskin	N	Low
Q4136	Ezderm	N	Low
Q4137	Amnioexcel or Biodexcel, 1cm	N	High
Q4138	Biodfence DryFlex, 1cm	N	High
Q4140	Biodfence 1cm	N	High
Q4141	Alloskin ac, 1cm	N	High
Q4143*	Repriza, 1cm	N	High
Q4146*	Tensix, 1CM	N	High
Q4147	Architect ecm, 1cm	N	High
Q4148	Neox 1k, 1cm	N	High
Q4150	Allowrap DS or Dry 1 sq cm	N	High
Q4151	AmnioBand, Guardian 1 sq cm	N	High
Q4152	Dermapure 1 square cm	N	High
Q4153	Dermavest 1 square cm	N	High
Q4154	Biovance 1 square cm	N	High
Q4156	Neox 100 1 square cm	N	High
Q4157*	Revitalon 1 square cm	N	High
Q4158*	MariGen 1 square cm	N	High
Q4159	Affinity 1 square cm	N	High
Q4160	NuShield 1 square cm	N	High
Q4161	Bio-Connekt per square cm	N	Low
Q4162	Amnio bio and woundex flow	N	Low
Q4163*	Amnion bio and woundex sq cm	N	High
Q4164	Helicoll, per square cm	N	High
Q4165	Keramatrix, per square cm	N	Low
Q4166*	Cytal, per square cm	N	Low

CY 2017 HCPCS Code	CY 2017 Short Descriptor	CY 2017 SI	Low/High Cost Skin Substitute
Q4167*	Truskin, per square cm	N	Low
Q4168*	Amnioband, 1 mg	N	Low
Q4169*	Artacent wound, per square cm	N	Low
Q4170*	Cygnus, per square cm	N	Low
Q4171*	Interfyl, 1 mg	N	Low
Q4172	PuraPly, PuraPly antimic	G	High
Q4173*	Palingen or palingen xplus, per sq cm	N	Low
Q4175*	Miroderm, per square cm	N	Low

*HCPCS codes Q4166, Q4167, Q4168, Q4169, Q4170, Q4171, Q4173, and Q4175 were assigned to the low cost group in the CY 2017 OPPS/ASC final rule with comment period. Upon submission of updated pricing information, Q4143, Q4146, Q4157, Q4158, and Q4163 are assigned to the high cost group for CY 2017.

Table 5 – Updated Skin Substitute Product Assignment to High Cost Status Retroactive to October 1, 2016

HCPCS Code	Short Descriptor	Status Indicator	Low/High Cost Status
Q4158	MariGen 1 square cm	N	High

Table 6 – 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 2017
013027	19300	YES	0.7482
013032	23460	YES	0.7195
014006	23460	YES	0.7195
014009	19460	YES	0.7087
014015	01	YES	0.6968
014016	01	YES	0.7248
014017	19300	YES	0.7482
042007	38220	YES	0.8038
042011	04	YES	0.7492
052055	33700	YES	1.3157
052034	36084	YES	1.7229
052048	33700	YES	1.3157
053036	33700	YES	1.3157
053301	36084	YES	1.7229
054074	46700	YES	1.7042
054110	36084	YES	1.7229
054122	34900	YES	1.5827

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2017
054123	44700	YES	1.4625
054141	46700	YES	1.7042
054146	36084	YES	1.7229
054149	36084	YES	1.7229
054151	42220	YES	1.6033
063033	24540	YES	0.9887
064007	14500	YES	1.0051
072003	35300	YES	1.2313
074003	25540	YES	1.2016
074007	25540	YES	1.2016
074011	35300	YES	1.2313
082000	48864	YES	1.0962
083026	48864	YES	1.0962
083300	48864	YES	1.0962
084001	48864	YES	1.0962
084002	48864	YES	1.0962
084003	48864	YES	1.0962
084004	20100	YES	1.0815
102019	36100	YES	0.8502
102028	45540	YES	0.8585
103032	42680	YES	0.8755
103043	36100	YES	0.8502
104068	36100	YES	0.8502
114018	11	YES	0.7640
132001	17660	YES	1.0033
133027	17660	YES	1.0033
134010	13	YES	0.7788
144037	20994	YES	1.0337
152012	23844	YES	0.9528
152017	29020	YES	0.9097
152024	23844	YES	0.9528
152025	34620	YES	1.0063
152028	23844	YES	0.9528
153027	29020	YES	0.9097
153039	29020	YES	0.9097
153040	15	YES	0.8585
154013	23844	YES	0.9528
154014	15	YES	0.8325
154017	18020	YES	0.9927
154020	23844	YES	0.9528
154021	15	YES	0.8227
154031	21140	YES	0.9095
154035	15	YES	0.8218
154047	15	YES	0.8585
154048	18020	YES	0.9927

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2017
154053	34620	YES	1.0063
154058	15	YES	0.8585
162002	16300	YES	0.8729
183028	21060	YES	0.7989
184012	21060	YES	0.7989
192022	19	YES	0.7321
192034	19	YES	0.7388
193036	19	YES	0.7388
193052	19	YES	0.7755
193055	19	YES	0.7335
193067	19	YES	0.7319
193069	19	YES	0.7401
193073	19	YES	0.7388
193075	19	YES	0.7360
193084	19	YES	0.7332
194074	19	YES	0.7321
194075	19	YES	0.7319
194077	19	YES	0.7321
194081	19	YES	0.7268
194082	19	YES	0.7319
194083	19	YES	0.7401
194087	19	YES	0.7321
194092	19	YES	0.7317
194095	19	YES	0.7388
194111	19	YES	0.7388
194112	19	YES	0.7536
212002	25180	YES	0.9048
213029	43524	YES	0.9831
214001	12580	YES	0.9494
214003	25180	YES	0.9048
214013	43524	YES	0.9831
214019	21	YES	0.9253
222000	15764	YES	1.1904
222003	15764	YES	1.1904
222043	39300	YES	1.1869
223026	15764	YES	1.1904
223032	12700	YES	1.2783
224001	39300	YES	1.1869
224007	15764	YES	1.1904
224021	39300	YES	1.1869
224028	39300	YES	1.1869
224031	12700	YES	1.2783
224038	15764	YES	1.1904
224041	39300	YES	1.1869
232019	19804	YES	0.9193

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2017
232025	35660	YES	0.8516
232027	19804	YES	0.9193
232028	12980	YES	0.9980
232031	19804	YES	0.9193
232032	19804	YES	0.9193
232035	12980	YES	0.9980
232036	27100	YES	0.9357
232038	19804	YES	0.9193
233025	12980	YES	0.9980
233027	19804	YES	0.9193
233300	19804	YES	0.9193
234028	19804	YES	0.9193
234034	19804	YES	0.9193
234035	19804	YES	0.9193
234038	19804	YES	0.9193
234040	19804	YES	0.9193
252008	25	YES	0.7442
252011	25	YES	0.7526
264005	26	YES	0.8130
303026	40484	YES	1.1726
304001	40484	YES	1.1726
312020	35084	YES	1.1715
312024	35084	YES	1.1715
313025	35084	YES	1.1715
313027	45940	YES	1.1571
314010	35084	YES	1.1715
314013	45940	YES	1.1571
314016	35084	YES	1.1715
314018	15804	YES	1.1370
314020	35084	YES	1.1715
314025	45940	YES	1.1571
334004	35614	YES	1.3014
334055	35614	YES	1.3014
344001	39580	YES	0.9580
344004	34	YES	0.8872
344011	39580	YES	0.9580
344014	39580	YES	0.9580
344027	34	YES	0.8872
344029	34	YES	0.8400
362016	15940	YES	0.8274
362027	10420	YES	0.8394
362032	15940	YES	0.8274
362039	48260	YES	0.8223
363026	49660	YES	0.8270
363035	10420	YES	0.8394

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2017
363303	10420	YES	0.8394
364011	10420	YES	0.8394
364031	15940	YES	0.8274
364040	44220	YES	0.8718
364042	36	YES	0.8219
364043	36	YES	0.8248
364047	36	YES	0.8248
364054	36	YES	0.8453
372014	37	YES	0.7849
372017	37	YES	0.7845
372019	37	YES	0.8220
372022	37	YES	0.7849
373032	37	YES	0.7845
374017	37	YES	0.7939
384008	41420	YES	1.0746
392031	27780	YES	0.9122
392034	10900	YES	1.1585
392040	29540	YES	0.9423
392048	33874	YES	1.0159
393025	33874	YES	1.0159
393032	33874	YES	1.0425
393050	10900	YES	1.1585
393052	33874	YES	1.0159
393054	29540	YES	0.9423
394001	33874	YES	1.0425
394006	33874	YES	1.0425
394031	33874	YES	1.0425
394033	33874	YES	1.0425
394034	33874	YES	1.0425
394043	39	YES	0.8097
394049	33874	YES	1.0425
422004	43900	YES	0.8306
423031	43900	YES	0.8306
424013	42	YES	0.8148
442016	28700	YES	0.7249
443027	28700	YES	0.7249
443030	44	YES	0.7267
444005	44	YES	0.7267
444008	44	YES	0.7711
444019	17300	YES	0.8518
452018	23104	YES	0.9407
452019	23104	YES	0.9407
452028	23104	YES	0.9407
452041	43300	YES	0.8894
452084	33260	YES	0.8966

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2017
452088	23104	YES	0.9407
452099	23104	YES	0.9407
452110	23104	YES	0.9407
452117	33260	YES	0.8966
453040	23104	YES	0.9407
453041	23104	YES	0.9407
453042	23104	YES	0.9407
453057	33260	YES	0.8966
453089	45	YES	0.7825
453094	23104	YES	0.9407
453095	33260	YES	0.8966
453300	23104	YES	0.9407
454012	23104	YES	0.9407
454049	33260	YES	0.8966
454101	45	YES	0.7866
454110	33260	YES	0.8966
454113	23104	YES	0.9407
454124	23104	YES	0.9407
454128	23104	YES	0.9407
462005	39340	YES	0.9440
463027	36260	YES	0.9122
464001	36260	YES	0.9122
464014	39340	YES	0.9440
474001	47	YES	0.9958
474002	47	YES	0.9741
474003	47	YES	0.9741
474004	47	YES	0.9741
513027	37620	YES	0.7428
522005	39540	YES	0.9450
523302	36780	YES	0.9359
524002	36780	YES	0.9359
524025	22540	YES	0.9477
673035	23104	YES	0.9407
673037	43300	YES	0.8894
673041	43300	YES	0.8894
673044	23104	YES	0.9407
673048	23104	YES	0.9407
673060	23104	YES	0.9407

Table 7 – CY 2017 Wage Index for Providers with both a MGCRB reclassification and LUGAR status in CY 2017

Provider Number	Actual Geographic Location CBSA	Wage Index Location CBSA	Post Reclassification CBSA	CY 2017 Special Wage Index	Section 401 Hospital with a LUGAR or MGCRB Wage Index Reclassification	Special Pay Indicator
130003	30300	13	47460	1.0042	YES	2
170137	29940	17	28140	0.9194	YES	2
180038	36980	18	21780	0.8625	YES	2
180051	17300	18	34980	0.8933	YES	2
290009	39900	29	16180	1.0018	YES	2
330011	13780	33	27060	0.8868	YES	2
330175	33	33	27060	0.8868	YES	2
330235	33	33	45060	0.9524	YES	2
340010	24140	34	39580	0.9202	YES	2
360125	36	36	17460	0.8885	YES	2
370054	36420	37	36420	0.8961	YES	2
390138	16540	39	16540	1.0726	YES	2
390183	39	39	39740	0.9632	YES	2
390233	49620	39	23900	0.9075	YES	2
420030	42	42	16700	0.8743	YES	2
420053	42	42	17900	0.8135	YES	2
490018	44420	49	16820	0.9135	YES	2
500030	13380	50	13380	1.2927	YES	2

SSA State County Code	County Name	Out Migration Adjustment	Year of Adjustment
01010	BALDWIN	0.0150	FY2017
01060	BUTLER	0.0177	FY2017
01090	CHEROKEE	0.0038	FY2017
01120	CLARKE	0.0166	FY2017
01150	COFFEE	0.0071	FY2015
01200	CRENSHAW	0.0120	FY2017
01210	CULLMAN	0.0400	FY2017
01220	DALE	0.0141	FY2015
01240	DE KALB	0.0447	FY2017
01260	ESCAMBIA	0.0251	FY2016
01270	ETOWAH	0.0074	FY2017
01310	GREENE	0.0963	FY2015
01350	JACKSON	0.0585	FY2017
01400	LEE	0.0176	FY2017
01470	MARSHALL	0.0530	FY2017
01510	MORGAN	0.0238	FY2015
01540	PIKE	0.0067	FY2016
01550	RANDOLPH	0.0875	FY2017
01590	SUMTER	0.0137	FY2017
01600	TALLADEGA	0.0321	FY2017
01610	TALLAPOOSA	0.0285	FY2016
01660	WINSTON	0.0408	FY2017
04130	COLUMBIA	0.0348	FY2017
04210	DREW	0.0135	FY2016
04270	GREENE	0.0111	FY2017
04280	HEMPSTEAD	0.0117	FY2016
04290	HOT SPRING	0.0561	FY2017
04340	JEFFERSON	0.0001	FY2017
04350	JOHNSON	0.0041	FY2016
04460	MISSISSIPPI	0.0212	FY2016
04530	PHILLIPS	0.0003	FY2016
04600	RANDOLPH	0.0147	FY2017
04720	WHITE	0.0126	FY2017
05000	ALAMEDA	0.0023	FY2017
05020	AMADOR	0.0918	FY2017
05380	NAPA	0.0473	FY2017
05390	NEVADA	0.0756	FY2017
05490	SAN JOAQUIN	0.0618	FY2016
05510	SAN MATEO	0.0050	FY2017
05580	SOLANO	0.0070	FY2017
05590	SONOMA	0.0096	FY2015
05600	STANISLAUS	0.0392	FY2017
05620	TEHAMA	0.0226	FY2017
05680	YUBA	0.0973	FY2017
06060	BOULDER	0.0032	FY2017

SSA State County Code	County Name	Out Migration Adjustment	Year of Adjustment
06210	FREMONT	0.0025	FY2017
06610	WELD	0.0112	FY2016
07020	LITCHFIELD	0.0677	FY2016
07030	MIDDLESEX	0.0317	FY2016
07040	NEW HAVEN	0.0101	FY2016
08000	KENT	0.0099	FY2016
08010	NEW CASTLE	0.0070	FY2015
10070	CHARLOTTE	0.0161	FY2017
10080	CITRUS	0.0078	FY2017
10110	COLUMBIA	0.0294	FY2016
10170	FLAGLER	0.0223	FY2017
10300	INDIAN RIVER	0.0025	FY2016
10370	LEVY	0.0011	FY2017
10410	MARION	0.0205	FY2016
10520	POLK	0.0076	FY2016
10530	PUTNAM	0.0749	FY2017
10590	SUMTER	0.0392	FY2015
11030	BALDWIN	0.0224	FY2017
11080	BERRIEN	0.0082	FY2016
11140	BULLOCH	0.0179	FY2016
11170	CAMDEN	0.0594	FY2016
11340	CRISP	0.0364	FY2016
11360	DECATUR	0.0202	FY2016
11380	DODGE	0.0099	FY2016
11430	ELBERT	0.0550	FY2016
11441	EVANS	0.0226	FY2017
11450	FANNIN	0.0167	FY2016
11462	FRANKLIN	0.0195	FY2016
11471	GILMER	0.0237	FY2017
11500	GORDON	0.0368	FY2017
11510	GRADY	0.0125	FY2016
11540	HABERSHAM	0.0335	FY2017
11581	HART	0.0686	FY2016
11600	HOUSTON	0.0517	FY2016
11610	JACKSON	0.0871	FY2017
11620	JEFFERSON	0.0580	FY2017
11861	STEPHENS	0.0191	FY2016
11870	SUMTER	0.0277	FY2016
11910	TROUP	0.0258	FY2016
13050	BINGHAM	0.0316	FY2016
13270	KOOTENAI	0.0354	FY2017
13320	MADISON	0.0395	FY2016
13340	NEZ PERCE	0.0294	FY2017
14370	FULTON	0.0150	FY2017
14460	IROQUOIS	0.0379	FY2017

SSA State County Code	County Name	Out Migration Adjustment	Year of Adjustment
14530	KANE	0.0038	FY2015
14540	KANKAKEE	0.0296	FY2016
14560	KNOX	0.0059	FY2016
14580	LA SALLE	0.0333	FY2017
14610	LIVINGSTON	0.0101	FY2017
14640	MC HENRY	0.0023	FY2016
14770	MORGAN	0.0184	FY2017
14970	STEPHENSON	0.0565	FY2017
14982	VERMILION	0.0047	FY2016
15020	BARTHOLOMEW	0.0026	FY2017
15080	CASS	0.0146	FY2017
15170	DELAWARE	0.0087	FY2016
15190	ELKHART	0.0024	FY2016
15260	GRANT	0.0155	FY2016
15320	HENRY	0.0859	FY2017
15330	HOWARD	0.0108	FY2016
15340	HUNTINGTON	0.0346	FY2017
15350	JACKSON	0.0338	FY2016
15420	KOSCIUSKO	0.0253	FY2017
15440	LAKE	0.0146	FY2016
15490	MARSHALL	0.0514	FY2017
15530	MONTGOMERY	0.0460	FY2017
15740	STARKE	0.0498	FY2017
16220	CLINTON	0.0191	FY2017
16560	LINN	0.0277	FY2016
16630	MARSHALL	0.0159	FY2016
16690	MUSCATINE	0.0646	FY2017
17050	BOURBON	0.0045	FY2016
17100	CHEROKEE	0.0110	FY2017
17170	COWLEY	0.0114	FY2017
17180	CRAWFORD	0.0039	FY2016
17220	DOUGLAS	0.0183	FY2015
17290	FRANKLIN	0.0316	FY2015
17300	GEARY	0.0398	FY2015
17550	LYON	0.0073	FY2016
17620	MONTGOMERY	0.0058	FY2017
18040	BARREN	0.0085	FY2017
18100	BOYLE	0.0163	FY2016
18460	HARDIN	0.0105	FY2017
18470	HARLAN	0.0019	FY2016
18480	HARRISON	0.0264	FY2017
18660	LETCHER	0.0015	FY2016
18700	LOGAN	0.0358	FY2017
18750	MADISON	0.0547	FY2017
18860	MONTGOMERY	0.0198	FY2017

SSA State County Code	County Name	Out Migration Adjustment	Year of Adjustment
18890	NELSON	0.0323	FY2015
19040	AVOYELLES	0.0321	FY2017
19050	BEAUREGARD	0.0053	FY2017
19100	CALDWELL	0.0120	FY2015
19130	CLAIBORNE	0.0161	FY2015
19190	EVANGELINE	0.0165	FY2016
19200	FRANKLIN	0.0102	FY2017
19260	JEFFRSON DAVIS	0.0104	FY2017
19290	LASALLE	0.0217	FY2017
19300	LINCOLN	0.0106	FY2017
19330	MOREHOUSE	0.0186	FY2017
19410	RICHLAND	0.0145	FY2016
19420	SABINE	0.0266	FY2016
19480	ST. LANDRY	0.0173	FY2017
19500	ST. MARY	0.0117	FY2016
19580	WASHINGTON	0.0540	FY2016
20000	ANDROSCOGGIN	0.0234	FY2017
20040	HANCOCK	0.0253	FY2017
20070	LINCOLN	0.0231	FY2016
21010	ANNE ARUNDEL	0.0043	FY2015
21110	GARRETT	0.0025	FY2016
21130	HOWARD	0.0072	FY2015
21140	KENT	0.0579	FY2016
21150	MONTGOMERY	0.0386	FY2016
21180	ST. MARYS	0.0316	FY2015
21200	TALBOT	0.0157	FY2016
21210	WASHINGTON	0.0259	FY2017
22000	BARNSTABLE	0.0084	FY2017
22020	BRISTOL	0.0047	FY2016
22090	MIDDLESEX	0.0082	FY2016
23100	BERRIEN	0.0221	FY2017
23110	BRANCH	0.0266	FY2017
23120	CALHOUN	0.0019	FY2017
23170	CLARE	0.0044	FY2016
23280	GRATIOT	0.0204	FY2015
23290	HILLSDALE	0.0372	FY2017
23310	HURON	0.0142	FY2016
23370	JACKSON	0.0284	FY2017
23430	LAPEER	0.0291	FY2017
23450	LENAWEE	0.0138	FY2017
23530	MECOSTA	0.0234	FY2017
23550	MIDLAND	0.0059	FY2017
23570	MONROE	0.0471	FY2017
23610	NEWAYGO	0.0135	FY2015
23640	OGEMAW	0.0195	FY2016

SSA State County Code	County Name	Out Migration Adjustment	Year of Adjustment
23740	ST. JOSEPH	0.0557	FY2017
23770	SHIAWASSEE	0.1106	FY2017
23810	WAYNE	0.0158	FY2016
24020	BECKER	0.0185	FY2017
24240	GOODHUE	0.0238	FY2017
24300	ITASCA	0.0166	FY2017
24420	MC LEOD	0.0265	FY2016
24490	MOWER	0.0780	FY2017
24650	RICE	0.0711	FY2017
24730	STEELE	0.0523	FY2017
24840	WINONA	0.0069	FY2017
25190	GEORGE	0.0022	FY2015
25330	JONES	0.0054	FY2016
25420	LINCOLN	0.0098	FY2016
25450	MARION	0.0109	FY2016
25530	PANOLA	0.0130	FY2017
25540	PEARL RIVER	0.0320	FY2017
25640	SMITH	0.0121	FY2017
25740	WARREN	0.0046	FY2016
26030	AUDRAIN	0.0058	FY2017
26500	JOHNSON	0.0462	FY2017
26520	LACLEDE	0.0037	FY2017
26630	MARION	0.0102	FY2016
26730	NODAWAY	0.0213	FY2016
26870	RANDOLPH	0.0156	FY2016
26911	ST. CLAIR	0.0142	FY2016
26930	ST. FRANCOIS	0.0116	FY2017
26988	TANEY	0.0044	FY2016
28260	DODGE	0.0182	FY2017
30050	HILLSBOROUGH	0.0360	FY2015
30070	ROCKINGHAM	0.0816	FY2015
31160	CAMDEN	0.0026	FY2015
31180	CAPE MAY	0.0086	FY2016
31200	ESSEX	0.0372	FY2017
31260	MERCER	0.0227	FY2015
31300	MORRIS	0.0371	FY2016
32190	RIO ARRIBA	0.0204	FY2015
32230	SAN MIGUEL	0.0291	FY2015
33040	CATTARAUGUS	0.0258	FY2017
33050	CAYUGA	0.0272	FY2017
33200	COLUMBIA	0.0625	FY2017
33210	CORTLAND	0.0196	FY2017
33340	LEWIS	0.0185	FY2015
33580	PUTNAM	0.0980	FY2015
33590	QUEENS	0.0078	FY2016

SSA State County Code	County Name	Out Migration Adjustment	Year of Adjustment
33710	SULLIVAN	0.1225	FY2017
33740	ULSTER	0.1041	FY2017
33750	WARREN	0.0004	FY2016
33900	WYOMING	0.0264	FY2017
34000	ALAMANCE	0.0680	FY2017
34030	ANSON	0.0237	FY2015
34060	BEAUFORT	0.0540	FY2017
34150	CARTERET	0.0106	FY2015
34170	CATAWBA	0.0075	FY2015
34190	CHEROKEE	0.0006	FY2016
34220	CLEVELAND	0.0203	FY2017
34230	COLUMBUS	0.0052	FY2017
34300	DUPLIN	0.0082	FY2016
34380	GRANVILLE	0.0808	FY2016
34410	HALIFAX	0.0196	FY2017
34420	HARNETT	0.0336	FY2017
34520	LEE	0.0330	FY2017
34530	LENOIR	0.0165	FY2017
34550	MC DOWELL	0.0079	FY2016
34580	MARTIN	0.0545	FY2015
34620	MOORE	0.0160	FY2016
34770	ROBESON	0.0152	FY2016
34800	RUTHERFORD	0.0024	FY2016
34810	SAMPSON	0.0188	FY2017
34850	SURRY	0.0184	FY2016
34910	WAKE	0.0148	FY2015
34970	WILSON	0.0341	FY2017
36020	ASHLAND	0.0059	FY2015
36030	ASHTABULA	0.0261	FY2017
36110	CLARK	0.0187	FY2017
36130	CLINTON	0.0228	FY2017
36140	COLUMBIANA	0.0058	FY2017
36150	COSHOCTON	0.0230	FY2016
36190	DARKE	0.0221	FY2017
36220	ERIE	0.0202	FY2017
36270	GALLIA	0.0048	FY2016
36330	HANCOCK	0.0163	FY2016
36400	HURON	0.0071	FY2015
36420	JEFFERSON	0.0030	FY2016
36430	KNOX	0.0601	FY2017
36470	LOGAN	0.0283	FY2016
36520	MARION	0.0293	FY2016
36610	MUSKINGUM	0.0164	FY2016
36730	SANDUSKY	0.0105	FY2017
36740	SCIOTO	0.0046	FY2016

SSA State County Code	County Name	Out Migration Adjustment	Year of Adjustment
36760	SHELBY	0.0254	FY2017
36770	STARK	0.0015	FY2015
36780	SUMMIT	0.0201	FY2016
36790	TRUMBULL	0.0077	FY2016
36800	TUSCARAWAS	0.0026	FY2017
36820	VAN WERT	0.0055	FY2017
36860	WAYNE	0.0137	FY2017
37060	BRYAN	0.0320	FY2017
37110	CHOCTAW	0.0021	FY2015
37170	CRAIG	0.0017	FY2017
37200	DELAWARE	0.0214	FY2016
37240	GARVIN	0.0214	FY2017
37370	KIOWA	0.0050	FY2017
37450	MCINTOSH	0.0036	FY2017
37480	MAYES	0.0030	FY2017
37500	MUSKOGEE	0.0025	FY2016
37510	NOBLE	0.0205	FY2016
37570	OTTAWA	0.0115	FY2016
37620	POTTAWATOMIE	0.0397	FY2017
37680	STEPHENS	0.0029	FY2017
37690	TEXAS	0.0023	FY2016
37730	WASHINGTON	0.0025	FY2016
38160	JOSEPHINE	0.0075	FY2016
38210	LINN	0.0138	FY2017
38230	MARION	0.0115	FY2016
39100	BEDFORD	0.0573	FY2017
39130	BRADFORD	0.0065	FY2015
39160	CAMBRIA	0.0188	FY2017
39210	CHESTER	0.0223	FY2015
39220	CLARION	0.0076	FY2016
39230	CLEARFIELD	0.0456	FY2017
39240	CLINTON	0.0110	FY2015
39370	GREENE	0.0085	FY2017
39380	HUNTINGDON	0.0531	FY2017
39390	INDIANA	0.0133	FY2016
39440	LANCASTER	0.0042	FY2015
39450	LAWRENCE	0.0119	FY2017
39520	MC KEAN	0.0049	FY2016
39550	MONROE	0.1095	FY2017
39560	MONTGOMERY	0.0489	FY2015
39590	NORTHAMPTON	0.0241	FY2015
39600	NORTHUMBERLND	0.0646	FY2015
39650	SCHUYLKILL	0.0370	FY2016
39680	SOMERSET	0.0135	FY2016
39710	TIOGA	0.0026	FY2015

SSA State County Code	County Name	Out Migration Adjustment	Year of Adjustment
39720	UNION	0.0270	FY2015
39760	WAYNE	0.0274	FY2016
40070	ARECIBO	0.0060	FY2016
40280	GUAYAMA	0.0079	FY2016
40400	LARES	0.0106	FY2016
42100	CHEROKEE	0.0125	FY2017
42120	CHESTERFIELD	0.0110	FY2016
42140	COLLETON	0.0120	FY2017
42210	GEORGETOWN	0.0011	FY2015
42240	HAMPTON	0.0041	FY2015
42350	NEWBERRY	0.0050	FY2017
42360	OCONEE	0.0167	FY2016
42370	ORANGEBURG	0.0040	FY2017
42410	SPARTANBURG	0.0130	FY2017
42420	SUMTER	0.0010	FY2015
44010	BEDFORD	0.0715	FY2017
44050	BRADLEY	0.0217	FY2017
44120	CLAIBORNE	0.0086	FY2016
44150	COFFEE	0.0205	FY2017
44270	GILES	0.0311	FY2015
44290	GREENE	0.0012	FY2015
44340	HARDEMAN	0.0476	FY2017
44490	LAWRENCE	0.0612	FY2015
44510	LINCOLN	0.0205	FY2016
44530	MC MINN	0.0240	FY2016
44540	MC NAIRY	0.0025	FY2017
44610	MONROE	0.0093	FY2016
44620	MONTGOMERY	0.0635	FY2017
44810	SULLIVAN	0.0013	FY2015
44880	WARREN	0.0202	FY2016
44910	WEAKLEY	0.0031	FY2016
45000	ANDERSON	0.0058	FY2017
45113	BEE	0.0104	FY2016
45160	BOSQUE	0.0188	FY2017
45340	COOKE	0.0705	FY2017
45392	DEAF SMITH	0.0049	FY2016
45420	DE WITT	0.0134	FY2017
45564	GRAYSON	0.0222	FY2016
45582	HALE	0.0099	FY2017
45620	HARRISON	0.0164	FY2017
45640	HENDERSON	0.0376	FY2017
45651	HILL	0.0415	FY2017
45654	HOPKINS	0.0308	FY2017
45690	JASPER	0.0094	FY2017
45743	KLEBERG	0.0161	FY2017

SSA State County Code	County Name	Out Migration Adjustment	Year of Adjustment
45758	LIMESTONE	0.0028	FY2016
45794	MIDLAND	0.0053	FY2016
45795	MILAM	0.0445	FY2017
45800	MONTAGUE	0.0574	FY2017
45820	NAVARRO	0.0566	FY2016
45822	NOLAN	0.0119	FY2016
45841	PALO PINTO	0.0452	FY2015
45842	PANOLA	0.0185	FY2017
45890	SHELBY	0.0056	FY2016
45910	TARRANT	0.0089	FY2017
45942	TYLER	0.0104	FY2017
45947	VAN ZANDT	0.0563	FY2017
45949	WALKER	0.0407	FY2017
45954	WHARTON	0.0636	FY2016
46240	UTAH	0.0022	FY2016
46280	WEBER	0.0037	FY2016
47010	BENNINGTON	0.0503	FY2016
47110	WASHINGTON	0.0156	FY2016
47120	WINDHAM	0.0373	FY2016
49070	AUGUSTA	0.0162	FY2017
49520	LEE	0.0021	FY2017
49600	MONTGOMERY	0.0203	FY2017
50130	GRAYS HARBOR	0.0160	FY2016
50170	KITSAP	0.0083	FY2017
50200	LEWIS	0.0112	FY2017
50280	SKAGIT	0.0148	FY2017
50330	THURSTON	0.0176	FY2017
51220	LOGAN	0.0119	FY2016
51240	MARION	0.0287	FY2017
51260	MASON	0.0316	FY2017
51330	NICHOLAS	0.0115	FY2016
51510	WETZEL	0.0115	FY2016
51530	WOOD	0.0171	FY2016
52130	DODGE	0.0305	FY2017
52190	FOND DU LAC	0.0128	FY2015
52270	JEFFERSON	0.0445	FY2017
52350	MANITOWOC	0.0066	FY2016
52370	MARINETTE	0.0038	FY2016
52430	OUTAGAMIE	0.0001	FY2016
52500	RACINE	0.0101	FY2015
52520	ROCK	0.0147	FY2015
52550	SAUK	0.0219	FY2017
52580	SHEBOYGAN	0.0090	FY2017
52630	WALWORTH	0.0296	FY2017
52690	WINNEBAGO	0.0010	FY2017

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

Table of Contents

(Rev. 3685, Issued: 12-22-16)

10.4 - Packaging

(Rev. 3685, Issued: 12-22-16, Effective: 01-01-17, Implementation: 01-03-17)

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

A. Packaging for Claims Resulting in APC Payments

If a claim contains services that result in an APC payment but also contains packaged services, separate payment for the packaged services is not made since payment is included in the APC. However, charges related to the packaged services are used for outlier and Transitional Corridor Payments (TOPs) as well as for future rate setting.
Therefore, it is extremely important that hospitals report all HCPCS codes consistent with their descriptors; CPT and/or CMS instructions and correct coding principles, and all charges for all services they furnish, whether payment for the services is made separately paid or is packaged.

B. Packaging for Claims Resulting in No APC Payments

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

C. Packaging Types Under the OPPS

1. Unconditionally packaged services are services for which separate payment is never made because the payment for the service is always packaged into the payment for other services. Unconditionally packaged services are identified in the OPPS Addendum B with status indictor of N. See the OPPS Web site at http://www.cms.hhs.gov/HospitalOutpatientPPS/ for the most recent Addendum B (HCPCS codes with status indicators). In general, the charges for unconditionally packaged services are used to calculate outlier and TOPS payments when they appear on a claim with a service that is separately paid under the OPPS because the packaged service is considered to be part of the package of services for which payment is being made through the APC payment for the separately paid service.

2. STV-packaged services are services for which separate payment is made only if there is no service with status indicator S, T, *or* V reported on the same claim. If a claim includes a service that is assigned status indicator S, T, *or* V reported on the same *claim* as the STV- packaged service, the payment for the STV-packaged service is packaged into the payment for the service(s) with status indicator S, T, V and no separate payment is made for the STV-packaged service. STV-packaged services are assigned status indicator Q1. See the OPPS Webpage at http://www.cms.hhs.gov/HospitalOutpatientPPS/ for identification of STV-packaged codes.

3. T-packaged services are services for which separate payment is made only if there is no service with status indicator T reported on the same claim. When there is a claim that includes a service that is assigned status indicator T reported on the same *claim* as the T-packaged service, the payment for the T-packaged service is packaged into the payment for the service(s) with status indicator T and no separate payment is

made for the T-packaged service. T-packaged services are assigned status indicator Q2. See the OPPS Web site at http://www.cms.hhs.gov/HospitalOutpatientPPS/ for identification of T-packaged codes.

4. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Services mapped to composite APCs are assigned status indicator Q3. See the discussion of composite APCs in section 10.2.1.

5. J1 services are assigned to comprehensive APCs. Payment for all adjunctive services reported on the same claim as a J1 service is packaged into payment for the primary J1 service. See the discussion of comprehensive APCs in section 10.2.3.

6. J2 services are assigned to comprehensive APCs when a specific combination of services are reported on the claim. Payment for all adjunctive services reported on the same claim as a J2 service is packaged into payment for the J2 service when certain conditions are met. See the discussion of comprehensive APCs in section 10.2.3.

10.4.1 - Combinations of Packaged Services of Different Types That are Furnished on the Same *Claim*

(Rev. 3685, Issued: 12-22-16, Effective: 01-01-17, Implementation: 01-03-17)

Where a claim contains multiple codes that are STV-packaged codes and does not contain a procedure with status indicator S, T, *or* V on the same *claim*, separate payment is made for the STV-packaged code that is assigned to the highest paid APC and payment for the other STV-packaged codes on the claim is packaged into the payment for the highest paid STV-packaged code.
Where a claim contains multiple codes that are T-packaged codes and does not contain a procedure with status indicator T on the same *claim*, separate payment is made for the T-packaged code assigned to the highest paid APC and payment for the other T-packaged codes on the claim is packaged into the payment for the highest paid T-packaged code.
Where a claim contains a combination of STV-packaged and T-packaged codes and does not contain a procedure with status indicator S, T, *or* V, separate payment is made for the STV-packaged or T-packaged code with the highest payment rate and payment for the other STV-packaged and T-packaged codes is packaged into the payment for the highest paid STV-packaged or T-packaged procedure.
Where a claim contains a combination of STV-packaged and T-packaged codes and codes that could be paid through composite APCs, payment for the STV-packaged and/or T-packaged services is packaged into separate payment for the composite APC.

10.7.1 - Outlier Adjustments

(Rev. 3685, Issued: 12-22-16, Effective: 01-01-17, Implementation: 01-03-17)

The OPPS incorporates an outlier adjustment to ensure that outpatient services with variable and potentially significant costs do not pose excessive financial risk to providers. Section 419.43(f) of the Code of Federal Regulations excludes drugs, biologicals and items and services paid at charges adjusted to cost from outlier payments. The OPPS determines eligibility for outliers using either a “multiple” threshold, which is the product of a multiplier and the APC payment rate, or a combination of a multiple and fixed-dollar threshold. A service or group of services becomes eligible for outlier payments when the cost of the service or group of services estimated using the hospital’s most recent overall cost-to-charge ratio (CCR) separately exceeds each relevant threshold. For community mental health centers (CMHCs), CMS determines whether billed partial hospitalization services are eligible for outlier payments using a multiple threshold specific to CMHCs. The outlier payment is a percentage of the difference between the cost estimate and the multiple threshold. The CMS OPPS Web site at www.cms.hhs.gov/HospitalOutpatientPPS/ under “Annual Policy Files” includes a table depicting the specific hospital and CMHC outlier thresholds and the payment percentages in place for each year of the OPPS.

Beginning in CY 2000, CMS determined outlier payments on a claim basis. CMS determined a claim’s

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

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

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

The current outlier payment is determined by:

- Calculating the cost related to an OPPS line-item service, including a pro rata portion of the total cost of packaged services on the claim and adding payment for any device with pass- through status to payment for the associated procedure, by multiplying the total charges for OPPS services by each hospital's overall CCR (see §10.11.8 of this chapter); and

- Determining whether the total cost for a service exceeds 1.75 times the OPPS payment and separately exceeds the fixed-dollar threshold determined each year; and

- If total cost for the service exceeds both thresholds, the outlier payment is 50 percent of the amount by which the cost exceeds 1.75 times the OPPS payment.

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

To illustrate, assume the total cost of all packaged services and revenue codes on the claim is $100, and the three APC payment amounts paid for OPPS services on the claim are $200, $300, and $500 (total APC payments of $1000). The first OPPS service or line-item is allocated $20 or 20 percent of the total cost of packaged services, because the APC payment for that service/line-item represents 20 percent ($200/$1000) of total APC payments on the claim. The second OPPS service is allocated $30 or 30 percent of the total cost of packaged services, and the third OPPS service is allocated $50 or 50 percent of the total cost of packaged services.

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

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

claim.

In accordance with Section 1833(t)(5)(A)(i) of the Act, if a claim includes a device receiving pass-through payment, the payment for the pass-through device is added to the payment for the associated procedure, less any offset, in determining the associated procedure's eligibility for outlier payment, and the outlier payment amount. The estimated cost of the device, which is equal to payment, also is added to the estimated cost of the procedure to ensure that cost and payment both contain the procedure and device costs when determining the procedure's eligibility for an outlier payment.

CMHC Outlier Payment Cap

Beginning for services provided on or after January 1, 2017, outlier payments made to CMHCs are subject to a cap, applied at the individual CMHC level, so that each CMHC's total outlier payments for the calendar year do not exceed 8 percent of that CMHC's total per diem payments for the calendar year. Total per diem payments are total Medicare per diem payments plus the total beneficiary share of those per diem payments.

Future updates will be issued in a Recurring Update Notification.

20.6.4 - Use of Modifiers for Discontinued Services

(Rev. 3685, Issued: 12-22-16, Effective: 01-01-17, Implementation: 01-03-17)

A. General

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

Modifier -73 is used by the facility to indicate that a procedure requiring anesthesia was terminated due to extenuating circumstances or to circumstances that threatened the well being of the patient after the patient had been prepared for the procedure (including procedural pre-medication when provided), and been taken to the room where the procedure was to be performed, but prior to administration of anesthesia. For purposes of billing for services furnished in the hospital outpatient department, anesthesia is defined to include local, regional block(s), moderate sedation/analgesia ("conscious sedation"), deep sedation/analgesia, or general anesthesia. This modifier code was created so that the costs incurred by the hospital to prepare the patient for the procedure and the resources expended in the procedure room and recovery room (if needed) could be recognized for payment even though the procedure was discontinued.

Modifier -74 is used by the facility to indicate that a procedure requiring anesthesia was terminated after the induction of anesthesia or after the procedure was started (e.g., incision made, intubation started, scope inserted) due to extenuating circumstances or circumstances that threatened the well being of the patient. This modifier may also be used to indicate that a planned surgical or diagnostic procedure was discontinued, partially reduced or cancelled at the physician's discretion after the administration of anesthesia. For purposes of billing for services furnished in the hospital outpatient department, anesthesia is defined to include local, regional block(s), moderate sedation/analgesia ("conscious sedation"), deep sedation/analgesia, and general anesthesia. This modifier code was created so that the costs incurred by the hospital to initiate the procedure (preparation of the patient, procedure room, recovery room) could be recognized for payment even though the procedure was discontinued prior to completion.

Coinciding with the addition of the modifiers -73 and -74, modifiers -52 and -53 were revised. Modifier -52 is used to indicate partial reduction, cancellation, or discontinuation of services for which anesthesia is not planned. The modifier provides a means for reporting reduced services without disturbing the identification of the basic service. Modifier -53 is used to indicate discontinuation of physician services and is not approved for use for outpatient hospital services.

The elective cancellation of a procedure should not be reported.

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

B. Effect on Payment

Procedures that are discontinued after the patient has been prepared for the procedure and taken to the procedure room but before anesthesia is provided will be paid at 50 percent of the full OPPS payment amount. Modifier -73 is used for these procedures. As of January 1, 2016, for *device-intensive* procedures that append modifier -73, we will reduce the APC payment amount for the discontinued device-intensive procedure, by 100 percent of the device offset amount prior to applying the additional payment adjustments that apply when the procedure is discontinued as modified by means of a final rule with comment period and published in the November 13, 2015 "Federal Register" (80 FR 70424). *Beginning January 1, 2017, device-intensive procedures are defined as those procedures requiring the insertion of an implantable device, that also have a HCPCS- level device offset greater than 40 percent. From January 1, 2016 through December 31, 2016 device-intensive procedures were defined as those procedures that involve implantable devices that are assigned to a device-intensive APC (defined as those APCs with a device offset greater than 40 percent).*

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

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

20.6.13 - Use of HCPCS Modifier – FX

(Rev. 3685, Issued: 12-22-16, Effective: 01-01-17, Implementation: 01-03-17)

Effective January 1, 2017, the definition of modifier – FX is "X-ray taken using film". This modifier is required to be reported on claims for imaging services that are X-rays taken using film.

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

(Rev. 3685, Issued: 12-22-16, Effective: 01-01-17, Implementation: 01-03-17)

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 requires establishing categories for purposes of determining transitional pass-through payment for devices, effective April 1, 2001. Each category is defined as a separate code in the C series or occasionally a code in another series (e.g., certain codes in the L series) of HCPCS. C-codes are assigned by CMS for this purpose when other HCPCS codes for the eligible item do not exist. Only devices specifically described by the long descriptions associated with the currently payable pass-through category codes are qualified for transitional pass-through payments. The complete list of currently and previously payable pass-through category codes can be viewed and/or downloaded from the CMS Web site, currently at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html

Each item that qualifies for transitional pass-through payments fits in one of the device categories currently active for pass-through payments. Devices may be billed using the currently active category codes for pass-through payments, as long as they:

- Meet the definition of a device that qualifies for transitional pass-through payments and other requirements and definitions put forth below in §60.3.

- Are described by the long descriptor associated with a currently active pass-through device category HCPCS code assigned by CMS and

- Are described according to the definitions of terms and other general explanations issued by CMS to accompany coding assignments in program instructions. The current definitions and explanations are located with the latest complete list of currently payable and previously payable pass-through device categories, found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html. Please note that this link may change depending on CMS Web design requirements.

If a device does not meet the description and other coding instructions for currently payable categories, even though it appears to meet the other requirements in this section, it may not be billed using one of the HCPCS codes for currently payable categories for transitional pass-through payments unless an applicable category is established by CMS, as discussed in section 60.3 below.

Transitional pass-through payment for a device is based on the charge on the individual provider's bill, *and the amount by which the hospital's charges for a device, adjusted to cost (the cost of the device), exceeds the portion of the otherwise applicable Medicare outpatient department fee schedule amount associated with the device.*

The OCE software determines the reduction to cost and the deduction for similar devices.

The eligibility of a device category for transitional pass-through payments is temporary, lasting for at least 2 but no more than 3 years. (The initial categories expired on January 1, 2003 or on January 1, 2004. The underlying provision is permanent, and categories established later have expired or will expire in successive years.) At the time of expiration, APC payment rates are adjusted to reflect the costs of devices (and drugs and biologicals) that received transitional pass-through payments. These adjustments are based on claims data that reflect the use of transitional pass-through devices, drugs and biologicals in conjunction with the associated procedures.

60.3 - Devices Eligible for Transitional Pass-Through Payments

(Rev. 3685, Issued: 12-22-16, Effective: 01-01-17, Implementation: 01-03-17)

The definition of and criteria for devices eligible for establishment of new categories for transitional pass-through payments was discussed and defined in a final rule with comment period published in the "Federal Register" on November 1, 2002, (67 FR 66781). Two of the criteria were also modified by means of a final rule with comment period published in the "Federal Register" on November 10, 2005 (70 FR 68628). As of January 1, 2010, implantable biologicals that are surgically inserted or implanted (through a surgical incision or natural orifice) are being evaluated for device pass-through payment as modified by means of a final rule with comment period and published in the November 20, 2009 "Federal Register" (74 FR 60471). As of January 1, 2015, skin substitutes are being evaluated for device pass-through payment as modified by means of a final rule with comment period and published in the November 10, 2015 "Federal Register" (79 FR 66885). As of January 1, 2016, the application process for device pass-through payments will add a rulemaking component to the existing quarterly process and a requirement will ensure that medical devices seeking pass-through payments are "new," as modified by means of a final rule with comment period and published in the November 13, 2015 "Federal Register (80 FR 70417*). As of January 1, 2017, the pass-through payment time period has been refined by having the pass-through start date begin with the date of first payment and by allowing pass-through status to expire quarterly as modified by means of a final rule with comment period and published in the November 14, 2016 "Federal Register (81 FR 79655). Also, in calculating the pass-through payment, the "Implantable Devices Charged to Patients Cost to Charge Ration*

(CCR)" will replace the hospital-specific CCR, when available and device offsets will be calculated from the HCPCS payment rate, instead of the APC payment rate (81 FR 79655 through 79656). The regulations regarding transitional pass-through payment for devices are compiled at 42 CFR 419.66. Additionally, the eligibility criteria for CMS to establish a new category for pass-through payment are discussed on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html.

60.5 - Services Eligible for New Technology APC Assignment and Payments

(Rev. 3685, Issued: 12-22-16, Effective: 01-01-17, Implementation: 01-03-17)

Under OPPS, services eligible for payment through New Technology APCs are those codes that are assigned to the series of New Technology APCs published in Addendum A of the latest OPPS update. *As of January 1, 2017, the range of New Technology APCs include*

- *APCs 1491 through 1500*
- *APCs 1502 through 1537*
- *APCs 1539 through 1585*
- *APCs 1589 through 1599, and*
- *APCs 1901 through 1906*

OPPS considers any HCPCS code assigned to the *above* APCs to be a "new technology procedure or service."

Application procedures for consideration as a New Technology procedure or service may be found on the CMS Web site, currently at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html. *Under the "Downloads" section, refer to the document titled "For a New Technology Ambulatory Payment Classification (APC) Designation under the Hospital Outpatient Prospective Payment System (OPPS)" for information on the requirements for submitting an application.*

The list of HCPCS codes *and payment rates* assigned *to New Technology APCs* can be found in Addendum B of the latest OPPS update regulation each year at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html. Please note that this link may change depending on CMS Web design requirements

61.2 - Edits for Claims on Which Specified Procedures are to be Reported With Device Codes and For Which Specific Devices are to be Reported With Procedure Codes

(Rev. 3685, Issued: 12-22-16, Effective: 01-01-17, Implementation: 01-03-17)

The OCE will return to the provider any claim that reports a HCPCS code for a *device-intensive* procedure that does not also report at least one device HCPCS code required for that procedure. If the claim is returned to the provider for failure to pass the edit, the hospital will need to modify the claim by either correcting the procedure code or ensuring that one of the required device codes is on the claim before resubmission. While all devices that have device HCPCS codes and that were used in a given procedure should be reported on the claim, only one of the possible device codes is required to be on the claim for payment to be made, unless otherwise specified.

The device edit does not apply to the specified procedure code if the provider reports one of the following modifiers with the procedure code:

52 - Reduced Services;
73 -- Discontinued outpatient procedure prior to anesthesia administration; and

74 -- Discontinued outpatient procedure after anesthesia administration.

Where a procedure that normally requires a device is interrupted, either before or after the administration of anesthesia if anesthesia is required or at any point if anesthesia is not required, and the device is not used, hospitals should report modifier 52, 73 or 74 as applicable. The device edit is not applied in these cases.

The OCE will also return to the provider claims for which specified devices are billed without the procedure code that is necessary for the device to have therapeutic benefit to the patient. If the claim is returned to the provider for failure to pass the edit, the hospital will need to modify the claim by either correcting the device code or ensuring that one of the required procedure codes is on the claim before resubmission.

200.3.1 - Billing Instructions for IMRT Planning and Delivery

(Rev. 3685, Issued: 12-22-16, Effective: 01-01-17, Implementation: 01-03-17)

Payment for the services identified by CPT codes 77014, 77280, 77285, 77290, 77295, 77306 through 77321, 77331, and 77370 are included in the APC payment for CPT code 77301 (IMRT planning). These codes should not be reported in addition to CPT code 77301 when provided prior to or as part of the development of the IMRT plan. *In addition, CPT codes 77280-77290 (simulation-aided field settings) should not be reported for verification of the treatment field during a course of IMRT.*

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

(Rev. 3685, Issued: 12-22-16, Effective: 01-01-17, Implementation: 01-03-17)

Effective for services furnished on or after January 1, 2014, hospitals must report SRS planning and delivery services using only the CPT codes that accurately describe the service furnished. For the delivery services, hospitals must report CPT code 77371, 77372, or 77373.

CPT Code	Long Descriptor
77371	Radiation treatment delivery, stereotactic radiosurgery (srs), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source cobalt 60 based
77372	Radiation treatment delivery, stereotactic radiosurgery (srs), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions

As instructed in the CY 2014 OPPS/ASC final rule, CPT code 77371 is to be used only for single session cranial SRS cases performed with a Cobalt-60 device, and CPT code 77372 is to be used only for single session cranial SRS cases performed with a linac- based device. The term “cranial” means that the pathological lesion(s) that are the target of the radiation is located in the patient’s cranium or head. The term “single session” means that the entire intracranial lesion(s) that comprise the patient’s diagnosis are treated in their entirety during a single treatment session on a single day. CPT code 77372 is never to be used for the first fraction or any other fraction of a fractionated SRS treatment. CPT code 77372 is to be used only for single session cranial linac-based SRS treatment. Fractionated SRS treatment is any SRS delivery service requiring more than a single session of SRS treatment for a cranial lesion, up to a total of no more than five fractions, and one to five sessions (but no more than five) for non-cranial lesions. CPT code 77373 is to be used for any fraction (including the first fraction) in any series of fractionated treatments, regardless of the anatomical location of the lesion or lesions being radiated. Fractionated cranial SRS is any cranial SRS that exceeds one treatment session

and fractionated non-cranial SRS is any non-cranial SRS, regardless of the number of fractions but never more than five. Therefore, CPT code 77373 is the exclusive code (and the use of no other SRS treatment delivery code is permitted) for any and all fractionated SRS treatment services delivered anywhere in the body, including, but not limited to, the cranium or head. 77372 is not to be used for the first fraction of a fractionated cranial SRS treatment series and must only be used in cranial SRS when there is a single treatment session to treat the patient's entire condition.

In addition, for the planning services, hospitals must report the specific CPT code that accurately describes the service provided. The planning services may include but are not limited to CPT code 77290, 77295, 77300, 77334, or 77370.

CPT Code	**Long Descriptor**
77290	Therapeutic radiology simulation-aided field setting; complex
77295	Therapeutic radiology simulation-aided field setting; 3-dimensional
77300	Basic radiation dosimetry calculation, central axis depth dose calculation, tdf, nsd, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician
77334	Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)
77370	Special medical radiation physics consultation

Effective for cranial single session stereotactic radiosurgery procedures (CPT code 77371 or 77372) furnished on or after January 1, 2016 until December 31, 2017, costs for certain adjunctive services (e.g., planning and preparation) are not factored into the APC payment rate for APC 5627 (Level 7 Radiation Therapy). Rather, the ten planning and preparation codes listed in table below, will be paid according to their assigned status indicator when furnished 30 days prior or 30 days post SRS treatment delivery.

In addition, hospitals must report modifier "CP" (Adjunctive service related to a procedure assigned to a comprehensive ambulatory payment classification [C-APC] procedure) on TOB 13X claims for any other services (excluding the ten codes in table below) that are adjunctive or related to SRS treatment but billed on a different claim and within either 30 days prior or 30 days after the date of service for either CPT code 77371 (Radiation treatment delivery, stereotactic radiosurgery, complete course of treatment cranial lesion(s) consisting of 1 session; multi-source Cobalt 60-based) or CPT code 77372 (Linear accelerator based). The "CP" modifier need not be reported with the ten planning and preparation CPT codes table below. Adjunctive/related services include but are not necessarily limited to imaging, clinical treatment planning/preparation, and consultations. Any service related to the SRS delivery should have the CP modifier appended. We would not expect the "CP" modifier to be reported with services such as chemotherapy administration as this is considered to be a distinct service that is not directly adjunctive, integral, or dependent on delivery of SRS treatment.

Excluded Planning and Preparation CPT Codes

CPT Code	CY *2017* Short Descriptor	CY *2017* OPPS Status Indicator
70551	Mri brain stem w/o dye	Q3
70552	Mri brain stem w/dye	Q3
70553	Mri brain stem w/o & w/dye	Q3
77011	Ct scan for localization	N
77014	Ct scan for therapy guide	N
77280	Set radiation therapy field	S
77285	Set radiation therapy field	S

77290	Set radiation therapy field	S
77295	3-d radiotherapy plan	S
77336	Radiation physics consult	S

231.11 - Billing for Allogeneic Stem Cell Transplants

(Rev. 3685, Issued: 12-22-16, Effective: 01-01-17, Implementation: 01-03-17)

1. Definition of Acquisition Charges for Allogeneic Stem Cell Transplants

Acquisition charges for allogeneic stem cell transplants include, but are not limited to, charges for the costs of the following services:

- National Marrow Donor Program fees, if applicable, for stem cells from an unrelated donor;
- Tissue typing of donor and recipient;
- Donor evaluation;
- Physician pre-procedure donor evaluation services;
- Costs associated with harvesting procedure (e.g., general routine and special care services, procedure/operating room and other ancillary services, apheresis services, etc.);
- Post-operative/post-procedure evaluation of donor; and
- Preparation and processing of stem cells.

Payment for these acquisition services is included in the OPPS *C*-APC payment for the allogeneic stem cell transplant when the transplant occurs in the hospital outpatient setting, and in the MS-DRG payment for the allogeneic stem cell transplant when the transplant occurs in the inpatient setting. The Medicare contractor does not make separate payment for these acquisition services, because hospitals may bill and receive payment only for services provided to the Medicare beneficiary who is the recipient of the stem cell transplant and whose illness is being treated with the stem cell transplant. Unlike the acquisition costs of solid organs for transplant (e.g., hearts and kidneys), which are paid on a reasonable cost basis, acquisition costs for allogeneic stem cells are included in prospective payment. Recurring update notifications describing changes to and billing instructions for various payment policies implemented in the OPPS are issued annually.

Acquisition charges for stem cell transplants apply only to allogeneic transplants, for which stem cells are obtained from a donor (other than the recipient himself or herself). Acquisition charges do not apply to autologous transplants (transplanted stem cells are obtained from the recipient himself or herself), because autologous transplants involve services provided to the beneficiary only (and not to a donor), for which the hospital may bill and receive payment (see Pub. 100-04, chapter 3, §90.3.1 and §231.10 of this chapter for information regarding billing for autologous stem cell transplants).

2. Billing for Acquisition Services

The hospital bills and shows acquisition charges for allogeneic stem cell transplants based on the status of the patient (i.e., inpatient or outpatient) when the transplant is furnished. See Pub. 100-04, chapter 3, §90.3.1 for instructions regarding billing for acquisition services for allogeneic stem cell transplants that are performed in the inpatient setting.

Effective January 1, 2017, when the allogeneic stem cell transplant occurs in the outpatient setting, the hospital identifies stem cell acquisition charges for allogeneic bone marrow/stem cell transplants separately in FL 42 of Form CMS-1450 (or electronic equivalent) by using revenue code *0815 (Other Organ Acquisition).* Revenue code *0815* charges should include all services required to acquire stem cells from a donor, as defined above, and should be reported on the same date of service as the transplant procedure in order to be appropriately packaged for payment purposes.

The transplant hospital keeps an itemized statement that identifies the services furnished, the charges, the person receiving the service (donor/recipient), and whether this is a potential transplant donor or recipient. These charges will be reflected in the transplant hospital's stem cell/bone marrow acquisition cost center. For allogeneic stem cell acquisition services in cases that do not result in transplant, due to death of the intended recipient or other causes, hospitals include the costs associated with the acquisition services on the Medicare cost report.

In the case of an allogeneic transplant in the hospital outpatient setting, the hospital reports the transplant itself with the appropriate CPT code, and a charge under revenue center code 0362 or another appropriate cost center. Selection of the cost center is up to the hospital.

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

(Rev. 3685, Issued: 12-22-16, Effective: 01-01-17, Implementation: 01-03-17)

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

A. Billing Requirement

Section 1861 (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act defines the services under the partial hospitalization benefit in a hospital.

Section 1866(e)(2) of the Act (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm)recognizes CMHCs as "providers of services" but only for furnishing partial hospitalization services. See §261.1.1 of this chapter 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.*

Effective January 1, 2017, non-excepted off-campus provider-based departments of a hospital are required to report a "PN" modifier on each claim line for non-excepted items and services. The use of modifier "PN" will trigger a payment rate under the Medicare Physician Fee Schedule. We expect the PN modifier to be reported with each non-excepted item and service including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services.

Excepted off-campus provider-based departments of a hospital must continue to report existing modifier "PO"

(Services, procedures and/or surgeries provided at off-campus provider-based outpatient departments) for all excepted items and services furnished. Use of the off-campus PBD modifier became mandatory beginning January 1, 2016.

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 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	****90791 or***** 90792
0904	Activity Therapy (Partial Hospitalization)	**G0176
0914	Individual Psychotherapy	90785, 90832, 90833, 90834, 90836, 90837, 90838, 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 A/B MAC (A) will edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. The A/B MAC (A) 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).

****The definition of code 90791 is as follows:

> Psychiatric diagnostic evaluation (no medical services) completed by a non-physician.

*****The definition of code 90792 is as follows:

Psychiatric diagnostic evaluation (with medical services) completed by a physician.

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 A/B MAC (B) 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 A/B MAC (B) on their behalf under their billing number for their professional services. The professional services of a PA can be billed to the A/B MAC (B) 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 A/B MAC (B) 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 A/B MAC (A) 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

Starting in CY 2017 and subsequent years, the payment structure for partial hospitalization services provided in hospital outpatient departments and CMHCs has been reduced from four APCs (two for CMHCs and two for hospital-based PHPs) to a single APC by provider type. Effective January 2, 2017, we are replacing existing CMHC APCs 5851 (Level 1 Partial Hospitalization (3 services)) and 5852 (Level 2 Partial Hospitalization (4 or more services)) with a new CMHC APC 5853 (Partial Hospitalization (3 or More Services Per Day)), and replacing existing hospital-based PHP APCs 5861 (Level 1 Partial Hospitalization (3 services)) and 5862 (Level 2 Partial Hospitalization (4 or more services)) with a new hospital-based PHP APC 5863 (Partial Hospitalization (3 or More Services Per Day)). The following chart displays the CMHC and hospital-based PHP APCs:

Hospital-Based and Community Mental Health Center PHP APCs

CY 2017 APC	*Group Title*
5853	*Partial Hospitalization (3 or more services per day) for CMHCs*
5863	*Partial Hospitalization (3 or more services per day) 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. 3685, Issued: 12-22-16, Effective: 01-01-17, Implementation: 01-03-17)

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) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) 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 under bill type 76X. The A/B MACs (A) 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

Code	Description
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
0900	Behavioral Health Treatments/Services	****90791 or***** 90792
0904	Activity Therapy (Partial Hospitalization)	**G0176
0914	Individual Psychotherapy	90785, 90832, 90833, 90834, 90836, 90837, 90838, 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 A/B MAC(s) (A) 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.
Definitions each of the asterisked HCPCS codes follows:

*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).

****The definition of code 90791 is as follows:
Psychiatric diagnostic evaluation (no medical services) completed by a non-physician.

*****The definition of code 90792 is as follows:
Psychiatric diagnostic evaluation (with medical services) completed by a physician.

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. See the ASC X12 837 institutional claim guide for how to report HCPCS electronically. CMHCs report HCPCS codes on Form CMS-1450 in FL44, "HCPCS/Rates." HCPCS code reporting is effective for claims with dates of service on or after April 1, 2000.

The A/B MACs (A) are to advise their CMHCs of these requirements. CMHCs should complete the remaining items on the claim in accordance with the ASC X12 837 Institutional Claim implementation guide and the Form CMS-1450 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 A/B MAC (B) directly for the professional services furnished to CMHC partial hospitalization patients. The ASC X12 837 professional claim format or the paper form 1500 is used. The CMHC can also serve as a billing agent for these professionals by billing the A/B MAC (B) on their behalf for their professional services. The professional services of a PA can be billed to the A/B MAC (B) 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 A/B MAC (B) 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) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act;

- Nurse practitioner and clinical nurse specialist services, as defined in §1861(s)(2)(K)(ii) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act; and,

- Clinical psychologist services, as defined in §1861(ii) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) 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 A/B MAC (A) for such nonphysician practitioner services as partial hospitalization services. The A/B MAC (A) 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 A/B MAC (A) 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 Form CMS-1450 form locators that correspond with these fields is found in Chapter 25 of this manual. See the ASC X12 837 Institutional Claim implementation guide for related guidelines for the electronic claim.

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 Form CMS-1450 form locators that correspond with these fields is found in Chapter 25 of this manual. See the ASC X12 837 Institutional Claim Implementation Guide for related guidelines for the electronic claim.

The A/B MACs (A) 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) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act provides the statutory authority governing payment for partial hospitalization services provided by a CMHC. A/B MAC(s) (A) 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 A/B MACs (A) 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 were 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 two CMHC APCS for providing partial hospitalization services were: APC 5851 (Level 1 Partial Hospitalization (3 services)) and APC 5852 (Level 2 Partial Hospitalization (4 or more services)). Effective January 1, 2017, we are combining APCs 5851 and 5852 into one new APC 5853 (Partial Hospitalization (3 or more services) for CMHCs).

Community Mental Health Center PHP APC

APC	*Group Title*
5853	*Partial Hospitalization (3 or more services per day) 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 A/B MACs (A) 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.

260.6 - Payment for Partial Hospitalization Services

(Rev. 3685, Issued: 12-22-16, Effective: 01-01-17, Implementation: 01-03-17)

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

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

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

In CY 2017, payment for non-excepted off-campus hospital-based PHPs will be made under the MPFS, paying the CMHC per diem rate for APC 5853, for providing 3 or more PHP services per day.

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

Medicare Claims Processing Manual

Chapter 16 - Laboratory Services

30.3 - Method of Payment for Clinical Laboratory Tests - Place of Service Variation

(Rev. 3685, Issued: 12-22-16, Effective: 01-01-17, Implementation: 01-03-17)

The following apply in determining the amount of Part B payment for clinical laboratory tests:

Laboratory tests not payable on the Clinical Diagnostic Laboratory Fee Schedule (CLFS) will be based on OPPS (for hospitals subject to OPPS) and current methodology for hospitals not subject to OPPS.
Independent laboratory or a physician or medical group - Payment to an independent laboratory or a physician or medical group is the lesser of the actual charge, the fee schedule amount or the national limitation amount. Part B deductible and coinsurance do not apply.
Reference laboratory - For tests performed by a reference laboratory, the payment is the lesser of the actual charge by the billing laboratory, the fee schedule amount, or the national limitation amount (NLA). (See §50.5 for A/B MAC (B) jurisdiction details.) Part B deductible and coinsurance do not apply.
Outpatient of **OPPS** hospital - For hospitals paid under the OPPS, beginning January 1, 2014 outpatient laboratory tests are generally packaged as ancillary services and do not receive separate payment. Only in the following circumstance are lab tests eligible for separate payment under the CLFS.

(1) Outpatient lab tests only - If the hospital only provides outpatient laboratory tests to the patient (directly or under arrangement) and the patient does not also receive other hospital outpatient services on that day.

Payment to a hospital for laboratory tests payable on the Clinical Diagnostic Laboratory Fee Schedule, furnished to an outpatient of the hospital, is the lesser of the actual charge, fee schedule amount, or the NLA. Part B deductible and coinsurance do not apply. Laboratory tests not payable on the Clinical Diagnostic Laboratory Fee Schedule will be based on OPPS (for hospitals subject to OPPS) and current methodology for hospitals not subject to OPPS.
Exception: Reasonable cost reimbursement has been provided for outpatient clinical laboratory tests furnished by hospitals with fewer than 50 beds in qualified rural areas for cost reporting periods beginning on July 1, 2004 through 2008 (per the following legislation: Section 416 of the Medicare Modernization Act (MMA) of 2003, Section 105 of the Tax Relief and Health Care Act (TRHCA) of 2006, and Section 107 of the Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Extension Act of 2007). Section 3122 of the Patient Protection and Affordable Care Act re-institutes the above reasonable cost provisions for cost reporting periods beginning on or after July 1, 2010, through June 30, 2011. Section 109 of the Medicare and Medicaid Extenders Act extends the above reasonable cost provisions for cost reporting periods beginning on or after July 1, 2011, through June 30, 2012.

Non-Patient (Referred) Laboratory Specimen- A non-patient is defined as a beneficiary that is neither an inpatient nor an outpatient of a hospital, but that has a specimen that is submitted for analysis to a hospital and the beneficiary is not physically present at the hospital. All hospitals (including Maryland waiver hospitals and CAHs) bill non-patient lab tests on TOB 14X. They are paid under the clinical laboratory fee schedule at the lesser of the actual charge, the fee schedule amount, or the NLA (including CAH and MD Waiver hospitals). Part B deductible and coinsurance do not apply.

Inpatient without Part A – Payment to a hospital for laboratory tests payable on the Clinical Diagnostic Laboratory Fee Schedule, is the lesser of the actual charge, fee schedule amount, or the NLA. Part B deductible and coinsurance do not apply. Laboratory tests not payable on the Clinical Diagnostic Laboratory Fee Schedule will be based on OPPS (for hospitals subject to OPPS) and current methodology for hospitals not subject to OPPS. For hospitals subject to the OPPS, beginning January 1, 2014 Part B inpatient laboratory tests are packaged as ancillary services and do not receive separate payment unless the service with which the labs would otherwise be packaged is not a payable Part B inpatient service (see Chapter 6, Section 10 of the Medicare Benefit Policy Manual, Pub. 100-02). Payment to a SNF inpatient without Part A coverage is made under the laboratory fee schedule.

Inpatient or SNF patient with Part A - Payment to a hospital for laboratory tests furnished to an inpatient, whose stay is covered under Part A, is included in the PPS rate for PPS facilities or is made on a reasonable cost basis for non-PPS hospitals and is made at 101 percent of reasonable cost for CAHs. Payments for lab services for beneficiaries in a Part A stay in a SNF, other than a swing bed in a CAH are included in the SNF PPS rate. For such services provided in a swing bed of a CAH, payment is made at 101 percent of reasonable cost.

Sole community hospital – Sole community hospitals are subject to the OPPS, therefore OPPS packaging rules apply. When the OPPS exception for separate payment of outpatient laboratory tests under the CLFS appl*ies*, a sole community hospital with a qualified hospital laboratory identified on the hospital's certification in the

Provider Specific File is paid the least of the actual charge, the 62 percent fee schedule amount, or the 62 percent NLA. The Part B deductible and coinsurance do not apply.

Waived Hospitals - Payment for outpatient (bill type13X), to a hospital which has been granted a waiver of Medicare payment principles for outpatient services is subject to Part B deductible and coinsurance unless otherwise waived as part of an approved waiver. Specifically, laboratory fee schedules do not apply to laboratory tests furnished by hospitals in States or areas that have been granted waivers of Medicare reimbursement principles for outpatient services. The State of Maryland has been granted such a waiver. Payment for non-patient laboratory specimens (bill type14X) is based on the fee schedule. Laboratory tests not payable on the Clinical Diagnostic Laboratory Fee Schedule will be paid based on current methodology.

Critical Access Hospital - When the CAH bills a 14X bill type as a non-patient laboratory specimen, it is paid on the laboratory fee schedule. If the beneficiary is an outpatient of the CAH, the CAH bills using an 85x bill type and is paid based on 101 percent of reasonable cost.

Beneficiaries are not liable for any coinsurance, deductible, co-payment, or other cost sharing amount with respect to CAH clinical laboratory services.

Section 148 of the Medicare Improvements for Patients and Providers Act (MIPPA)

Effective for services furnished on or after July 1, 2009, the beneficiary is no longer required to be physically present in a CAH at the time the specimen is collected in order for the CAH to be paid based on 101 percent of reasonable cost. However, the beneficiary must be an outpatient of the CAH, as defined at 42 CFR §410.2 and be receiving services directly from the CAH. In order for the beneficiary to be receiving services directly from the CAH if he/she is not present in the CAH when the specimen is collected, the beneficiary must either be receiving outpatient services in the CAH on the same day the specimen is collected, or the specimen must be collected by an employee of the CAH or of a facility provider-based to the CAH.

Dialysis facility - Effective for items and services furnished on or after January 1, 2011 Section 153b of the Medicare Improvements for Patients and Providers Act (MIPPA) requires that all ESRD-related laboratory tests be reported by the ESRD facility whether provided directly or under arrangements with an independent laboratory. When laboratory services are billed by a laboratory other than the ESRD facility and the laboratory service furnished is designated as a laboratory test that is included in the ESRD PPS (i.e., ESRD-related), the claim will be rejected or denied. The list of items and services subject to consolidated billing located at http://www.cms.gov/ESRDPayment/50_Consolidated_Billing.asp#TopOfPage includes the list of ESRD-related laboratory tests that are routinely performed for the treatment of ESRD. In the event that an ESRD-related laboratory service was furnished to an ESRD beneficiary for reasons other than for the treatment of ESRD, the supplier may submit a claim for separate payment using modifier “AY”. See Pub.100-04, Chapter 8 for more information regarding Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims.

Rural Health Clinic (RHC)/Federally Qualified Health Center (FQHC) - Payment to a RHC/FQHC for laboratory tests performed for a patient of that clinic/center is not included in the all-inclusive rate and may be billed separately by either the base provider for a provider-based RHC/FQHC, or by the physician for an independent or free-standing RHC/FQHC. Payment for the laboratory service is not subject to Part B deductible and coinsurance. If the RHC/FQHC is provider-based, payment for lab tests is to the base provider (i.e., hospital). If the RHC/FQHC is independent or freestanding, payment for lab tests is made to the practitioner (physician) via the clinical lab fee schedule. (See Sections 30.1.1 and 40.5 for details on RHC/FQHC billing.)

Enrolled in Managed Care - Payment to a participating health maintenance organization (HMO) or health care prepayment plan (HCPP) for laboratory tests provided to a Medicare beneficiary who is an enrolled member is included in the monthly capitation amount.

Non-enrolled Managed Care - Payment to a participating HMO or HCPP for laboratory tests performed for a patient who is not a member is the lesser of the actual charge, or the fee schedule, or the NLA. The Part B deductible and coinsurance do not apply.

Hospice - Payment to a hospice for laboratory tests performed by the hospice is included in the hospice rate.