

# CMS Manual System

## Pub 100-04 Medicare Claims Processing

Transmittal 976

Department of Health &  
Human Services (DHHS)

Centers for Medicare &  
Medicaid Services (CMS)

Date: JUNE 9, 2006

Change Request 5027

### SUBJECT: Billing of Temporary 'C' HCPCS Codes by Non-Outpatient Prospective Payment System (Non-OPPS) Providers

**I. SUMMARY OF CHANGES:** This Change Request (CR) allows the billing of temporary 'C' HCPCS codes or an appropriate CPT code by non-OPPS providers on Types of Bill (TOBs) 12X, 13X, or 85X. Section 20.7 is being added to Chapter 4 of Pub. 100-04, the Medicare Claims Processing Manual to document this change. Please note that a revision to Section 250.1 in Chapter 4 of Pub. 100-04 is included with this CR. The information on low osmolar contrast material (LOCM) has been deleted. It was replaced with Section 250.8.1 in Chapter 4 (in CR 4234), which was released on January 3, 2006. There are no policy changes attached to the change in this manual section.

#### NEW/REVISED MATERIAL

**EFFECTIVE DATE: October 1, 2006**

**IMPLEMENTATION DATE: October 2, 2006**

*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
N	4/20/20.7/Billing of 'C' HCPCS Codes by Non-OPPS Providers
R	4/250/250.1/Standard Method - Cost Based Facility Services, with Billing of Carrier for Professional Services

### **III. FUNDING:**

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

### **IV. ATTACHMENTS:**

Business Requirements

Manual Instruction

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

# Attachment - Business Requirements

Pub. 100-04	Transmittal: 976	Date: June 9, 2006	Change Request 5027
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**SUBJECT: Billing of Temporary ‘C’ HCPCS Codes by Non-Outpatient Prospective Payment System (Non-OPPS) Providers**

## I. GENERAL INFORMATION

**A. Background:** Temporary ‘C’ HCPCS codes were established to permit implementation of Section 201 of the Balanced Budget Refinement Act (BBRA) of 1999. The C-codes only identified items that may qualify for “pass through” payment under the Outpatient Prospective Payment System (OPPS) or items or services for which an appropriate HCPCS code does not exist for the purposes of implementing the OPPS. CMS realizes that these C-codes have evolved and now also target services that are uniquely hospital services that may be provided by an OPPS provider, or other providers or providers paid under other payment systems. Non-OPPS providers have requested that they be allowed the option to bill using the C-codes or an appropriate Current Procedure Terminology (CPT) code.

**B. Policy:** Effective 10/01/2006, the following non-OPPS providers may elect to bill using the C-codes or an appropriate CPT code on Types of Bill (TOBs) 12X, 13X, or 85X:

- Critical Access Hospitals (CAHs);
- Indian Health Service Hospitals (IHS);
- Hospitals located in American Samoa, Guam, Saipan or the Virgin Islands; and
- Maryland waiver hospitals.

The OPPS providers shall continue to receive pass through payment on items or services that qualify for pass through payment. Non-OPPS providers will be paid under their normal payment methodologies and are not eligible for pass through payments. Although, non-OPPS providers may elect to bill using the C-codes, the payment methodology for OPPS and non-OPPS providers is not changing.

The CMS HCPCS Coding Book currently contains the following note for processing note 0093:

“C-codes are unique temporary pricing codes established by CMS for the Prospective Payment System. The C-codes are only valid for Medicare on claims for hospital outpatient department services and procedures. Any implementation of Section 201B of the BBRA 1999 and the hospital outpatient other use for Medicare is not valid.”

Effective 10/01/2006, processing note 0093 shall be updated as follows: “C-codes are unique temporary pricing codes that were initially established by CMS for the Hospital Outpatient Prospective Payment System (OPPS). The C-codes are used on Medicare OPPS claims but may also be recognized on claims from other providers or by other payment systems.”

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

code. Providers are encouraged to access the CMS Web site to view the quarterly HCPCS Code updates. The URL to view the quarterly updates is <http://www.cms.hhs.gov/HCPCSReleaseCodeSets/>.

The billing of C-codes by Method I and Method II Critical Access Hospitals (CAHs) is limited to the billing for facility (technical) services. The C-codes shall not be billed by Method II CAHs for professional services with revenue codes (RCs) 96X, 97X, or 98X.

**NOTE:** This Change Request (CR) does not change existing requirements when non-OPPS provider claims require the use of a CPT or HCPCS code. It simply gives non-OPPS providers the option of billing under a C-code or an appropriate CPT code.

**Please note** that a revision to Pub. 100-04, the Medicare Claims Processing Manual is included with this CR. The information on low osmolar contrast material (LOCM) has been deleted from Chapter 4, §250.1. It was replaced with §250.8.1 in Chapter 4 (in CR 4234), which was released on January 3, 2006. There are no policy changes attached to the change in this manual section.

## II. BUSINESS REQUIREMENTS

*“Shall” denotes a mandatory requirement*

*“Should” denotes an optional requirement*

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
F I S S	M C S					V M S	C W F			
5027.1	FISS shall accept temporary C-codes on TOBs 12X, 13X, and 85X submitted by non-OPPS providers effective 10/01/2006.					X				OCE
5027.2	FISS shall return to provider (RTP) claims containing a temporary C-code when billed on TOB 85X with RCs 96X, 97X, or 98X.					X				OCE

## III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)							
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers			
F I S S	M C S					V M S	C W F		

						F I S S	M C S	V M S	C W F	
5027.3	<p>A provider education article related to this instruction will be available at <a href="http://www.cms.hhs.gov/MLNMattersArticles">www.cms.hhs.gov/MLNMattersArticles</a> shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.</p> <p>Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic.</p> <p>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.</p>	X								

**IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS**

**A. Other Instructions: N/A**

X-Ref Requirement #	Instructions

**B. Design Considerations: N/A**

X-Ref Requirement #	Recommendation for Medicare System Requirements

**C. Interfaces: N/A**

**D. Contractor Financial Reporting /Workload Impact: N/A**

**E. Dependencies: N/A**

**F. Testing Considerations: N/A**

## V. SCHEDULE, CONTACTS, AND FUNDING

<p><b>Effective Date*:</b> October 1, 2006</p> <p><b>Implementation Date:</b> October 2, 2006</p> <p><b>Pre-Implementation Contact(s):</b> Susan Guerin at 410-786-6138 or <a href="mailto:susan.guerin@cms.hhs.gov">susan.guerin@cms.hhs.gov</a> (CAH and IHS billing), Valeri Ritter at 410-786-8652 or <a href="mailto:valeri.ritter@cms.hhs.gov">valeri.ritter@cms.hhs.gov</a> (Maryland waiver hospital billing).</p> <p><b>Post-Implementation Contact(s):</b> Appropriate Regional Office</p>	<p><b>No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.</b></p>
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# **Medicare Claims Processing Manual**

## **Chapter 4 - Part B Hospital**

### **(Including Inpatient Hospital Part B and OPPS)**

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*(Rev.976, 06-09-06)*

*20.7 – Billing of ‘C’ HCPCS Codes by Non-OPPS Providers*

## **20.7 – Billing of ‘C’ HCPCS Codes by Non-OPPS Providers**

**(Rev.976, Issued: 06-09-06, Effective: 10-01-06, Implementation: 10-02-06)**

*Prior to October 1, 2006, the “C” series of HCPCS codes were used exclusively by hospitals subject to OPPS to identify items that may have qualified for transitional pass through payment under OPPS or items or services for which an appropriate HCPCS code did not exist for the purposes of implementing the OPPS. The C-codes could not be used to bill services payable under other payment systems. CMS realized that these C-codes evolved and also target services that are uniquely hospital services that may be provided by an OPPS provider, other providers, or be paid under other payment systems.*

*Effective October 1, 2006, the following non-OPPS providers may elect to bill using the C-codes or an appropriate CPT code on Types of Bill (TOBs) 12X, 13X, or 85X:*

- *Critical Access Hospitals (CAHs);*
- *Indian Health Service Hospitals (IHS);*
- *Hospitals located in American Samoa, Guam, Saipan or the Virgin Islands; and*
- *Maryland waiver hospitals.*

*The OPPS providers shall continue to receive pass-through payment on items or services that qualify for pass through payment. Non-OPPS providers are not eligible for pass through payments.*

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

*Providers are encouraged to access the CMS Web site to view the quarterly HCPCS Code updates. The URL to view the quarterly updates is <http://www.cms.hhs.gov/HCPCSReleaseCodeSets/>.*

*The billing of C-codes by Method I and Method II Critical Access Hospitals (CAHs) is limited to the billing for facility (technical) services. The C-codes shall not be billed by Method II CAHs for professional services with revenue codes 96X, 97X, or 98X.*

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

*(Rev.976, Issued: 06-09-06, Effective: 10-01-06, Implementation: 10-02-06)*

Effective for cost reporting periods beginning on or after January 1, 2004, payment for outpatient CAH services under this method will be made for the lesser of: 1) 80 percent of 101 percent of the reasonable cost of the CAH in furnishing those services, or 2) 101 percent of the reasonable cost of the CAH in furnishing those services, less applicable Part B deductible and coinsurance amounts.

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

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

Bill type 85X is used for all outpatient services including services approved as ASC services. Non-patient laboratory specimens (those not meeting the criteria for reasonable cost payment in §250.6) will be billed on a 14X type of bill.

(See Section 260.6 – Clinical Diagnostic Laboratory Tests Furnished by CAHs.)