Program Memorandum Intermediaries

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal A-01-50 **Date: APRIL 12, 2001**

CHANGE REQUEST 1585

SUBJECT: Further Guidance Regarding Billing Under the Outpatient Prospective Payment System (OPPS)

The purpose of this Program Memorandum (PM) is to provide further guidance related to specific areas of billing under OPPS and to incorporate several Questions and Answers previously posted on the Internet.

Proper Billing for Blood Products and Blood Storage and Processing

When a hospital purchases blood or blood products from a community blood bank, or runs its own blood bank and assesses a charge for the blood or blood product, they report blood and blood products in Revenue Code Series 38X "Blood" along with the appropriate blood HCFA Common Procedure Coding System (HCPCS) code. The amount billed should reflect the hospital's charge.

When a hospital does not pay for the blood or blood product, it often incurs an administrative cost from a community blood bank for the bank's processing, storage and related expenses. In this situation, the hospital bills the charge associated with these blood bank storage and processing costs in Revenue Code 390 "Blood Storage/Processing" and reports the HCPCS code assigned to the blood or blood product and the number of units transfused. Payment is based on the Ambulatory Payment Classification (APC) to which the HCPCS code is assigned, times the number of units transfused.

If a hospital purchases blood, or blood products, or runs its own blood bank, it is not appropriate to bill both the blood or blood product in Revenue Code series 38X and an additional blood bank storage and processing charge in Revenue Code 390.

A transfusion APC will be paid to the hospital for transfusing blood once per day, regardless of the number of units transfused. Hospitals should bill for transfusion services using Revenue Code 391 "Blood Administration" and HCPCS code 36430 through 36460. The hospital may also bill the laboratory Revenue Codes (30X or 31X) along with the HCPCS codes for blood typing and cross matching and other laboratory services related to the patient who receives the blood.

Proper Billing of Outpatient Surgical Procedures

When multiple surgical procedures are performed at the same session, it is not necessary to bill separate charges for each procedure. It is acceptable to bill a single charge under the revenue code that describes where the procedure was performed (e.g., operating room, treatment room, etc.) on the same line as one of the surgical procedure CPT/HCPCS codes and bill the other procedures using the appropriate CPT/HCPCS code and the same revenue code, but with "0" charges in the charge field.

In the past, some hospitals billed a single emergency room (ER) visit charge which included charges for any surgical procedures that were performed in the ER at the time of the ER visit. Under the OPPS, HCFA requires your hospitals to bill a separate charge for ER visits and surgical procedures effective with claims with dates of service on or after July 1, 2001. If a surgical procedure is performed in the ER, the charge for the procedure must be billed with the emergency room revenue code. If an ER visit occurs on the same day, a charge should be billed for the ER visit and a separate

charge should be billed for the surgical procedure(s) performed. As described above, a single charge may be billed for all surgical procedures if more than one is performed in the ER during the same session.

The following is an example of how a claim should be completed under these new reporting requirements:

7/5/2001	450	99283 25	$150
7/5/2001	450	12011	$300
7/5/2001	450	12035	
7/5/2001	250		$70
7/5/2001	270		$85

The charge for both surgical procedures in this example is reflected in the $300 charge shown on the line with procedure code 12011.

NOTE: This instruction was previously posted on the Internet as a question and answer with an effective date of January 1, 2001. Since many hospitals did not change their reporting requirements based on the question and answer, this PM reflects a new prospective date of July 1, 2001.

Inpatient Part B Services

Inpatient Part B services which are paid under OPPS include diagnostic X-ray tests, and other diagnostic tests (excluding clinical diagnostic laboratory tests); X-ray, radium, and radioactive isotope therapy, including materials and services of technicians; surgical dressings applied during an encounter at the hospital and splints, casts, and other devices used for reduction of fractures and dislocations (splints and casts, etc., include dental splints); implantable prosthetic devices; pneumococcal vaccine and its administration, hepatitis B vaccine and its administration; and certain preventive screening services (pelvic exams, screening sigmoidoscopies, screening colonoscopies, bone mass measurements, prostate screening.)

NOTE: Payment for some of these services is packaged into the payment rate of other separately payable services.

Inpatient Part B services paid under other payment methods include:

Clinical diagnostic laboratory tests, prosthetic devices other than implantable ones and other than dental which replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices; leg, arm, back and neck braces, trusses, and artificial legs, arms, and eyes, including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition; take home surgical dressings, outpatient physical therapy, outpatient occupational therapy, and outpatient speech pathology services; ambulance services; screening pap smears, screening fecal occult blood tests, and screening mammography.

Appropriate Revenue Codes to Report Medical Devices That Have Been Granted Pass-Through Status

Hospitals must report all pass-through devices using HCPCS codes that begin with a "C" under any of the following revenue codes 272, 274, 275, 276, 278, 279, 280, 289, 290 or 624 to bill implantable or medical devices of brachytherapy and cryoablation that have been granted pass-through status. These devices should not be reported utilizing any other revenue code series or sub-categories.

For services furnished on or after April 1, 2001, devices that qualify for transitional pass-through payments are those that fit in one of the established active device categories. The initial categories are listed in PM A-01-41 issued on March 22, 2001. To qualify for pass-through payments, a device must meet the definition of a device and all of the requirements compiled in 42 CFR 419.43 and other requirements set forth in Transmittal A-01-41. In particular, one aspect of that definition states that devices are "single use," come in contact with human tissue, and are surgically implanted or inserted.

HCPCS Clarification

The following revenue codes when billed without HCPCS are covered services. However, no separate payment is made under OPPS. The charge for these services is included in the transitional outpatient payment (TOP) and outlier calculations. The applicable revenue codes are: 250, 251, 252, 254, 255, 257, 258, 259, 260, 262, 263, 264, 269, 270, 271, 272, 274, 275, 276, 278, 279, 280, 289, 290, 370, 371, 372, 379, 390, 399, 560, 569, 621, 622, 624, 630, 631, 632, 633, 637, 700, 709, 710, 719, 720, 721, 762, 810, 819, and 942.

Any other revenue codes that are billable on a hospital outpatient claim must contain a HCPCS code in order to assure payment under OPPS. Intermediaries should return to provider (RTP), claims which contain revenue codes that require HCPCS when no HCPCS is shown on the line.

Removal of HCPCS/Revenue Code Edits

Standard System Maintainers must remove any edits currently in place that match revenue codes to HCPCS for services payable under OPPS with the exception of editing for revenue codes required to be billed with pass-through medical devices as described above.

The *effective date* for this PM is as follows :

- **For surgical procedures, claims with dates of service on or after July 1, 2001;**
- **For blood procedures, claims with dates of service on or after August 1, 2000; and**
- **For removal of edits that match revenue codes to HCPCS and the edit requirement of pass-through medical devices, January 1, 2002.**

The *implementation date* for this PM is August 2000 for blood, July 1, 2001, for surgical procedures, and January 1, 2002 for remaining items.

These instructions should be implemented within your current operating budget.

This PM may be discarded after January 1, 2003.

If you have any questions, please contact your regional office.