CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1487	**Date: April 8, 2008**
	Change Request 5999

Subject: April 2008 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 April 2008 OPPS update. The April 2008 Integrated 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 notification.

The April 2008 revisions to the I/OCE data files, instructions, and specifications are provided in Change Request (CR) 5969, "April 2008 Integrated Outpatient Code Editor (I/OCE) Specifications Version 9.1." The attached Recurring Update Notification applies to Chapter 4, Section 50.7. In addition, this CR incorporates changes to §260.1.1 which were included in CR 5893, Transmittal 1472, dated March 6, 2008.

New / Revised Material
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

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

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

R/N/D	Chapter / Section / Subsection / Title
R	4/Table of Contents
R	4/10.11.8/Methodology for Calculation of Hospital Overall CCR for Hospitals that Have Nursing and Paramedical Education Programs
R	4/20.5/Clarification of HCPCS Code to Revenue Code Reporting
D	4/20.5.1/Appropriate Revenue Codes to Report Medical Devices That Have Been Granted Pass-Through Status
D	4/20.5.1.1/Packaged Revenue Codes
D	4/20.5.1.2/Clarification Regarding Revenue Codes 0274 and 0290

D	4/20.5.1.3/Clarification of HCPCS Code to Revenue Code Reporting
D	4/20.5.2/HCPCS/Revenue Code Edits
R	4/20.6/Use of Modifiers
N	4/20.6.10/Use of HCPCS Modifier -FC
R	4/231.2/ When a Provider Paid Under the OPPS Purchases Blood or Blood Products from a Community Blood Bank or When a Provider Paid Under the OPPS Assesses a Charge for Blood or Blood Products Collected By Its Own Blood Bank That Reflects More Than Blood Processing and Storage
R	4/231.4/Billing for Split Unit of Blood
R	4/231.6/Billing for Frozen and Thawed Blood and Blood Products
R	4/231.7/Billing for Unused Blood
R	4/260.1/Special Partial Hospitalization Billing Requirements for Hospitals, Community Mental Health Centers, and Critical Access Hospitals
R	4/260.1.1/Bill Review for Partial Hospitalization Services Provided in Community Mental Health Centers (CMHC)

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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

IV. ATTACHMENTS:

Recurring Update Notification

Manual Instruction

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1487	Date: April 8, 2008	Change Request: 5999

SUBJECT: April 2008 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Effective Date: **April 1, 2008**

Implementation Date: April 7, 2008

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to, and billing instructions for various payment policies implemented in the April 2008 OPPS update. The April 2008 Integrated 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 notification.

The April 2008 revisions to the I/OCE data files, instructions, and specifications are provided in Change Request (CR) 5969, "April 2008 Integrated Outpatient Code Editor (I/OCE) Specifications Version 9.1." The attached Recurring Update Notification applies to Chapter 4, Section 50.7.

B. Policy:

1. Changes to Procedure to Device Edits for April 2008

Procedure to device edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code. Failure to pass these edits will result in the claim being returned to the provider. We have deleted the procedure to device edits for CPT code 36815, retroactive to their original implementation date of October 1, 2005. The complete list of updated edits can be found at www.cms.hhs.gov/HospitalOutpatientPPS/ under downloads.

2. Modification of Methodology for Calculation of Hospital Overall Cost-to-Charge Ratio (CCR) for Hospitals that Have Nursing and Paramedical Education Programs

CMS is updating §10.11.8 of the Medicare Claims Processing Manual, Pub. 100-04, Chapter 4, to further refine the methodology of the calculation of the hospital overall CCR for hospitals that have nursing and paramedical education programs. Specifically, the instructions for calculating the CCR for cost center 6200, non-distinct unit observation beds are being modified. This is a prospective change that is effective April 1, 2008. It is unnecessary to retroactively re-calculate CCRs that are affected by this instruction.

3. Billing for Drugs, Biologicals, and Radiopharmaceuticals

Hospitals are strongly encouraged to report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. It is also of great importance that hospitals billing for these products make certain that the

reported units of service of the reported HCPCS code are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used in the care of the patient.

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

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective April 1, 2008

In the CY 2008 OPPS final rule, it was stated that payments for separately payable drugs and biologicals based on average sale prices (ASPs) will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, we will incorporate changes to the payment rates in the April 2008 release of the OPPS PRICER. The updated payment rates effective April 1, 2008, will be included in the April 2008 update of the OPPS Addendum A and Addendum B, which will be posted on the CMS Web site shortly.

b. Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2008

Four drugs have been granted OPPS pass-through status effective April 1, 2008. These drugs, their descriptors and APC assignments are identified in Table 1 below.

Table 1 - Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2008

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 4/1/08
C9241	Injection, doripenem, 10 mg	9241	G
C9240	Injection, ixabepilone, 1 mg	9240	G
C9238	Injection, levetiracetam, 10 mg	9238	G
J9226	Histrelin implant (Supprelin La), 50 mg	1142	G

c. New HCPCS Codes for Drugs and Biologicals Effective April 1, 2008

Three new HCPCS codes have been created effective April 1, 2008. These new HCPCS codes, their descriptors, OPPS status indicators and APC assignments are listed in Table 2 below.

Table 2 - New HCPCS Codes for Drugs and Biologicals Effective April 1, 2008

HCPCS Code	Long Descriptor	APC	Status Indicator
Q4096	Injection, Von Willebrand factor complex, human, ristocetin cofactor (not otherwise specified), per i.u. VWF:RCO	1213	K
Q4097	Injection, immune globulin (Privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg	1214	K

Q4098	Injection, iron dextran, 50 mg	1215	K

d. Revised Long and Short HCPCS Code Descriptors for Cardiac Echocardiography Services

Cardiac Echocardiography With Contrast

In the January 2008 Update to the OPPS (CR 5912, dated January 18, 2008), we listed eight new C-codes for cardiac echocardiography with contrast services. These codes, specifically C8921 through C8928, were listed in Table 14. To ensure appropriate reporting of these services, we have revised the short and long descriptors for C8921 through C8928, which are reflected in Table 3 below, to appropriately reflect those services that either use contrast or are performed without contrast followed by with contrast. Hospitals are reminded that these codes should be reported for echocardiograms with contrast, and hospitals are advised to report the appropriate units of the HCPCS codes for the contrast agents used in the performance of the echocardiograms. The contrast HCPCS Q-codes associated with these services should be reported separately.

Table 3 - Revised Long and Short HCPCS Code Descriptors for Cardiac Echocardiography Services

HCPCS	Revised Short Descriptor	Revised Long Descriptor
C8921	TTE w or w/o fol w/cont, com	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; complete
C8922	TTE w or w/o fol w/cont, f/u	Transthoracic echocardiography with contrast, or without contrast followed by with contrast; follow-up or limited study
C8923	2D TTE w or w/o fol w/con,co	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2d) with or without m-mode recording; complete
C8924	2D TTE w or w/o fol w/con,fu	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, material real-time with image documentation (2d) with or without m-mode recording; follow-up or limited study
C8925	2D TEE w or w/o fol w/con,in	Transesophageal echocardiography (tee) with contrast, or without contrast followed by with contrast, real time with image documentation (2d) (with or without m-mode recording); including probe placement, image acquisition, interpretation and report
C8926	TEE w or w/o fol w/cont,cong	Transesophageal echocardiography (tee) with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
C8927	TEE w or w/o fol w/cont, mon	Transesophageal echocardiography (tee) with contrast, or without contrast followed by with contrast, for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis
C8928	TEE w or w/o fol w/con,stres	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2d), with or without m-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report

Cardiac Echocardiography Without Contrast

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

e. Recognition of Multiple HCPCS Codes For Drugs

Prior to January 1, 2008, the OPPS generally recognized only the lowest available administrative dose of a drug if multiple HCPCS codes existed for the drug; for the remainder of the doses, the OPPS assigned a status indicator "B" indicating that another code existed for OPPS purposes. For example, if drug X has 2 HCPCS codes, 1 for a 1 ml dose and a second for a 5 ml dose, the OPPS would assign a payable status indicator to the 1 ml dose and status indicator "B" to the 5 ml dose. Hospitals then were required to bill the appropriate number of units for the 1 ml dose in order to receive payment under the OPPS. However, beginning January 1, 2008, the OPPS has recognized each HCPCS code for a Part B drug, regardless of the units identified in the drug descriptor. Hospitals may choose to report multiple HCPCS codes for a single drug, or to continue billing the HCPCS code with the lowest dosage descriptor available.

f. Correct Reporting of Drugs and Biologicals When Used As Implantable Devices

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

g. Correct Reporting of Units for Drugs

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

4. HCPCS Code G0377

HCPCS code G0377, Administration of vaccine for Part D drug, that was in effect for 2007 is discontinued for CY 2008. The April 2008 I/OCE will implement this change effective January 1, 2008. Hospitals should no longer be reporting this service under OPPS, as this service is covered under the Part D benefit beginning in 2008.

5. Use of HCPCS Modifiers

We updated the Medicare Claims Processing Manual, Pub 100-04, Chapter 4, §20.6 to reflect the addition of HCPCS modifiers –FB and –FC effective January 1, 2007, and January 1, 2008, respectively. We added §20.6.10, which includes the definition of the modifier -FC ("Partial credit received for replaced device"). OPPS hospitals must report the -FC modifier for cases in which the hospital receives a partial credit of 50 percent or more of the cost of a new replacement device under warranty, recall, or field action. The hospital must append the -FC modifier to the procedure code (not the device code) that reports the services provided to replace the device.

6. Clarification of HCPCS Code to Revenue Code Reporting

We updated the Medicare Claims Processing Manual, Pub. 100-04, Chapter 4, §20.5 to reflect that, generally, CMS does not instruct hospitals on the assignment of HCPCS codes to revenue codes for services provided under OPPS since hospitals' assignments of costs vary. Where explicit instructions are not provided, providers should report their charges under the revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report. Previous language providing guidance on HCPCS code and revenue code billing was deleted.

7. Clarification of Manual Instructions Regarding Billing and Payment for Blood and Blood Products Under the OPPS

We updated the Medicare Claims Processing Manual, Pub 100-04, Chapter 4, §§231.2-231.7 to provide important clarifications regarding billing for blood and blood products. In §231.2, we specify the requirement that the same line item date of service, the same number of units, the same HCPCS code, and HCPCS modifier BL must be reported on **both** lines, applies to all OPPS providers that transfuse blood. We also clarify that, in order to ensure correct application of the Medicare blood deductible, providers should report charges for whole units of packed red cells using Revenue Code 381 (Packed red cells), and should report charges for whole units of whole blood using Revenue Code 382 (Whole blood). Revenue Codes 381 and 382 should be used only to report charges for packed red cells and whole blood, respectively. The blood coding requirements discussed in §231.2 do not apply to blood and blood products carrying only a processing and storage fee; when billing only for blood processing and storage, OPPS providers should follow the coding requirements outlined in §231.1. Revenue Code 380 is not a valid revenue code for Medicare billing.

In §231.4, we clarify that providers should bill split units of packed red cells and whole blood using Revenue Code 389 (Other blood), and should not use Revenue Codes 381 (Packed red cells) or 382 (Whole blood). Providers should bill split units of other blood products using the applicable revenue codes for the blood product type, such as 383 (Plasma) or 384 (Platelets), rather than 389. Reporting revenue codes according to these specifications will ensure the Medicare beneficiary's blood deductible is applied correctly. In §231.6 we provide a chart of blood and blood products indicating whether providers should bill separately for freezing and thawing using the available CPT codes.

In §231.7, we specify that where blood or a blood product is split or irradiated specifically with the intent of transfusion to a beneficiary but is not then used, the hospital may bill for the services of splitting or irradiating the unit of blood, but may not bill for the HCPCS code for the blood product that was not transfused. The date of service must be the date on which the decision not to use the blood was made and indicated in the patient's medical record. Where the unit of blood is split or irradiated and

stored without specific intention to administer it to a Medicare beneficiary at the time of splitting or irradiation and is not subsequently transfused, there is no service to be reported.

8. Outpatient Partial Hospitalization Program Services

We are updating the Medicare Claims Processing Manual, Pub. 100-04, Chapter 4, §§260.1 and 260.1.1 to reflect our current policies for Outpatient Partial Hospitalization Program Services.

9. Coverage Determinations

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

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5999.1	Medicare contractors shall install the April 2008 OPPS Pricer.	X		X		X	X				COBC
5999.2	Medicare contractors shall update the overall CCR to include the costs for cost center 6200 from worksheet D-1 Part IV for all hospitals, excluding the costs for nursing and paramedical education programs, at the next scheduled CCR update. See the attached Medicare Claims Processing Manual, Pub. 100-04, Chapter 4 for the manual change to §10.11.8.	X		X		X					COBC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5999.3	A provider education article related to this instruction will be available at	X		X		X					COBC

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

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

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
CR 5969	April 2008 Integrated Outpatient Code Editor (I/OCE) Specifications Version 9.1

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

V. CONTACTS

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

Post-Implementation Contact(s): Regional Office

VI. FUNDING

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

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

Section B: *For Medicare Administrative Contractors (MACs)*:

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

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

Table of Contents

(Rev.1487, 04-08-08)

10.11.8 - Methodology for Calculation of Hospital Overall CCR for Hospitals that Have Nursing and Paramedical Education Programs

(Rev.1487, Issued: 04-08-08, Effective: 04-01-08, Implementation: 04-07-08)

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

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

Step 1 -- Determining costs for each department: From Worksheet B, Part 1 – Column 27, deduct the nursing and paramedical education costs found on the applicable line in Columns 21, and 24 of Worksheet B, Part I to calculate a cost for each cost center. Exception: The costs for 6200 are not calculated on this worksheet. For cost center 6200, non-distinct unit observation beds, use the cost reported on Worksheet D-1, Part IV, line 85, *and deduct the nursing and paramedical education costs found on Worksheet D-1, Part IV, line 89 and subscripts, column 5.* See Step 3 below.

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

Step 3 – Determining the CCRs for each department without nursing and paramedical education costs: For each line, divide the costs from Step1 by the charges from Step 2 to acquire CCRs for each line, without inclusion of nursing and paramedical education costs. Exception: For cost center 6200, non-distinct unit observation beds, use the cost reported on Worksheet D-1, Part IV, line 85*, and deduct the nursing and paramedical education costs found on Worksheet D-1, Part IV, line 89 and subscripts, column 5.* .

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

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

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

20.5 - *Clarification* of HCPCS Code *to* Revenue Code *Reporting*

(Rev.1487, Issued: 04-08-08, Effective: 04-01-08, Implementation: 04-07-08)

Generally, CMS does not instruct hospitals on the assignment of HCPCS codes to revenue codes for services provided under OPPS since hospitals' assignment of cost vary. Where explicit instructions are not provided, *providers should* report their charges under the revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report.

20.6 - Use of Modifiers

(Rev.1487, Issued: 04-08-08, Effective: 04-01-08, Implementation: 04-07-08)

The Integrated Outpatient Code Editor (I/OCE) accepts all valid CPT and HCPCS modifiers on OPPS claims. Definitions *for the following modifiers* may be found in the CPT *and* HCPCS *guides:*

Level I (CPT) Modifiers

-25, -27, -50, -52, -58, -59, -73, -74, -76, -77, -78, -79, -91

Level II (HCPCS) Modifiers

-CA, -E1, -E2, -E3, -E4, -FA, -FB, -FC, -F1, -F2, -F3, -F4, -F5, -F6, -F7, -F8, -F9, -GA, -GG, -GH, -GY, -GZ, -LC, -LD, -LT, -QL, -QM, -RC, -RT, -TA, -T1, -T2, -T3, -T4, -T5, -T6, -T7, -T8, -T9

As indicated in §20.6.2, modifier -50, while it may be used with diagnostic and radiology procedures as well as with surgical procedures, should be used to report bilateral procedures that are performed at the same operative session as a single line item. Modifiers RT and LT are not used when modifier -50 applies. A bilateral procedure is reported on one line using modifier -50. Modifier -50 applies to any bilateral procedure performed on both sides at the same session.

NOTE: Use of modifiers applies to services/procedures performed on the same calendar day.

Other valid modifiers that are used under other payment methods are still valid and should continue to be reported, e.g., those that are used to report outpatient rehabilitation and ambulance services. Modifiers may be applied to surgical, radiology, and other diagnostic procedures. Providers must use any applicable modifier where appropriate.

Providers do not use a modifier if the narrative definition of a code indicates multiple occurrences.

EXAMPLES:

The code definition indicates two to four lesions. The code indicates multiple extremities.

Providers do not use a modifier if the narrative definition of a code indicates that the procedure applies to different body parts.

EXAMPLES:

Code 11600 (Excision malignant lesion, trunks, arms, or legs; lesion diameter 0.5 cm. or less)

Code 11640 (Excision malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 0.5 cm. or less)

Modifiers -GN, -GO, and -GP must be used to identify the therapist performing speech language therapy, occupational therapy, and physical therapy respectively.

Modifier -50 (bilateral) applies to diagnostic, radiological, and surgical procedures.

Modifier -52 applies to radiological procedures.

Modifiers -73, and -74 apply only to certain diagnostic and surgical procedures that require anesthesia.

Following are some general guidelines for using modifiers. They are in the form of questions to be considered. If the answer to any of the following questions is yes, it is appropriate to use the applicable modifier.

1. Will the modifier add more information regarding the anatomic site of the procedure?

EXAMPLE: Cataract surgery on the right or left eye.

2. Will the modifier help to eliminate the appearance of duplicate billing?

EXAMPLES: Use modifier 77 to report the same procedure performed more than once on the same date of service but at different encounters.

Use modifier 25 to report significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.

Use modifier 58 to report staged or related procedure or service by the same physician during the postoperative period.

Use modifier 78 to report a return to the operating room for a related procedure during the postoperative period.

Use modifier 79 to report an unrelated procedure or service by the same physician during the postoperative period.

3. Would a modifier help to eliminate the appearance of unbundling?

EXAMPLE: CPT codes *90765 (Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour)* and 36000 (Introduction of needle or intra catheter, vein): If procedure 36000 was performed for a reason other than as part of the IV infusion, modifier -59 would be appropriate.

20.6.10 - Use of HCPCS Modifier -FC

(Rev.1487, Issued: 04-08-08, Effective: 04-01-08, Implementation: 04-07-08)

*Effective January 1, 2008, the definition of modifier -FC is "**Partial credit received for replaced device.**" See the Medicare Claims Processing Manual, Pub 100-04, Chapter 4, §61.3 for instructions regarding charges for items billed with the -FC modifier.*

OPPS hospitals must report the - FC modifier for cases in which the hospital receives a partial credit of 50 percent or more of the cost of a new replacement device under warranty, recall, or field action. The hospital must append the -FC modifier to the procedure code (not the device code) that reports the services provided to replace the device.

231.2 - When a Provider Paid Under the OPPS Purchases Blood or Blood Products from a Community Blood Bank or When a Provider Paid Under the OPPS Assesses a Charge for Blood or Blood Products Collected By Its Own Blood Bank That Reflects More Than Blood Processing and Storage

(Rev.1487, Issued: 04-08-08, Effective: 04-01-08, Implementation: 04-07-08)

If an OPPS provider pays for the actual blood or blood product itself, in addition to paying for processing and storage costs when blood or blood products are supplied by either a community blood bank or the OPPS provider's own blood bank, the OPPS provider must separate the charge for the unit(s) of blood or blood product(s) from the charge for processing and storage services. The OPPS provider reports charges for the blood or blood product itself using Revenue Code series 038X *(excluding 0380, which is not a valid revenue code for Medicare billing)* with the LIDOS, the number of units transfused, and the appropriate blood product HCPCS code and HCPCS modifier BL. The OPPS provider reports charges for processing and storage services on a separate line using Revenue Code 0390 or 0399 with the LIDOS, the number of units transfused, and the appropriate blood product HCPCS code and HCPCS modifier BL. *The same LIDOS, the same number of units, the same HCPCS code, and HCPCS modifier BL must be reported on **both** lines. This requirement applies to all OPPS providers that transfuse blood.*

Effective for services furnished on or after July 1, 2005, the I/OCE will return to providers any claim that reports a charge for blood or blood products using Revenue Code 038X without a separate line for processing and storage services using Revenue

Code 0390 or 0399. Moreover, in order to process to payment, both lines must report the same line item date of service, the same number of units, and the same HCPCS code accompanied by modifier BL. Payment for blood and blood products is based on the Ambulatory Payment Classification (APC) Group to which its HCPCS code is assigned, multiplied by the number of units transfused.

Units of whole blood or packed red cells for which only processing and storage charges are reported are not subject to the blood deductible. The Medicare blood deductible is applicable only if the OPPS provider purchases whole blood or packed red cells from a community blood blank or if the OPPS provider assesses a charge that reflects more than blood processing and storage for whole blood or packed red cells collected by its owns blood bank. If the beneficiary has not already fulfilled the annual blood deductible or replaced the blood, OPPS payment will be made for processing and storage costs only. The beneficiary is liable for the blood portion of the payment as the blood deductible. *In order to ensure correct application of the Medicare blood deductible, providers should report charges for whole units of packed red cells using Revenue Code 381 (Packed red cells), and should report charges for whole units of whole blood using Revenue Code 382 (Whole blood). Revenue Codes 381 and 382 should be used only to report charges for packed red cells and whole blood, respectively.*

Please note that the blood coding requirements discussed in this section do not apply to blood and blood products carrying only a processing and storage fee; when billing only for blood processing and storage, OPPS providers should follow the coding requirements outlined in §231.1.

EXAMPLE: An OPPS provider purchases 2 units of leukocyte-reduced red blood cells from a community blood bank and incurs a charge for the red cells themselves, and a charge for the blood bank's processing and storage of the red blood cell unit. The OPPS provider further incurs costs related to additional processing and storage of the red blood cell units after the OPPS provider has received the 2 units. A Medicare beneficiary is transfused the two units of leukocyte-reduced red blood cells.

The OPPS provider should report the charges for 2 units of P9016 by separately billing the red blood cell charges and the total processing and storage charges incurred. The charges for the red blood cell units are to be reported on one line with the date the blood was transfused, Revenue Code series 038X *(excluding 380)*, 2 units, HCPCS code P9016, and modifier BL. The total charges for processing and storage are to be reported on the same claim, on a separate line, showing the date the blood was transfused, Revenue Code 390 or 399, 2 units, HCPCS code P9016, and modifier BL. Note that HCPCS modifier BL is reported on both lines.

231.4 - Billing for Split Unit of Blood

(Rev.1487, Issued: 04-08-08, Effective: 04-01-08, Implementation: 04-07-08)

HCPCS code P9011 was created to identify situations where one unit of blood or a blood product is split and some portion of the unit is transfused to one patient and the other portions are transfused to other patients or to the same patient at other times. When a patient receives a transfusion of a split unit of blood or blood product, OPPS providers

should bill P9011 for the blood product transfused, as well as CPT 86985 (Splitting, blood products) for each splitting procedure performed to prepare the blood product for a specific patient.

Providers should bill split units of packed red cells and whole blood using Revenue Code 389 (Other blood), and should not use Revenue Codes 381 (Packed red cells) or 382 (Whole blood). Providers should bill split units of other blood products using the applicable revenue codes for the blood product type, such as 383 (Plasma) or 384 (Platelets), rather than 389. Reporting revenue codes according to these specifications will ensure the Medicare beneficiary's blood deductible is applied correctly.

EXAMPLE: OPPS provider splits off a 100cc aliquot from a 250 cc unit of leukocyte-reduced red blood cells for a transfusion to Patient X. The hospital then splits off an 80cc aliquot of the remaining unit for a transfusion to Patient Y. At a later time, the remaining 70cc from the unit is transfused to Patient Z.

In billing for the services for Patient X and Patient Y, the OPPS provider should report the charges by billing P9011 and 86985 in addition to the CPT code for the transfusion service, because a specific splitting service was required to prepare a split unit for transfusion to each of those patients. However, the OPPS provider should report only P9011 and the CPT code for the transfusion service for Patient Z because no additional splitting was necessary to prepare the split unit for transfusion to Patient Z. *The OPPS provider should bill Revenue Code 0389 for each split unit of the leukocyte-reduced red blood cells that was transfused.*

231.6 - Billing for Frozen and Thawed Blood and Blood Products

(Rev.1487, Issued: 04-08-08, Effective: 04-01-08, Implementation: 04-07-08)

In situations where a beneficiary receives a transfusion of frozen blood or a blood product which has been frozen and thawed for the patient prior to the transfusion, an OPPS provider may bill the specific HCPCS code which describes the frozen and thawed product, if a specific code exists, in addition to the CPT code for the transfusion.. If a specific HCPCS code for the frozen and thawed blood or blood product does not exist, then the OPPS provider should bill the appropriate HCPCS code for the blood product, along with CPT codes for freezing and/or thawing services that are not reflected in the blood product HCPCS code.

EXAMPLE: If an OPPS provider transfuses the product described by P9057 (red blood cells, frozen/deglycerolized/washed, leukocytes reduced, irradiated, each unit), it would not be appropriate to bill additional CPT codes for freezing and/or thawing since charges for freezing and thawing should be included in the charge for P9057.

If a blood product has been frozen and/or thawed in preparation for a transfusion, but the patient does not receive the transfusion of the blood product, the OPPS provider may bill the patient for the CPT code that describes the freezing and/or thawing services specifically provided for the patient. Similar to billing for autologous blood collection when blood is not transfused, the OPPS provider should bill the freezing and/or thawing services on the date when the OPPS provider is certain the blood product will not be

transfused (e.g., date of a procedure or date of outpatient discharge), rather than on the date of the freezing and/or thawing services.

The following chart of blood and blood products indicates whether providers should bill separately for freezing and thawing using the available CPT codes.

HCPCS/CPT	***Short Descriptor***	*Billing of Freezing/Thawing*
P9010	*Whole blood for transfusion*	*Freezing and thawing are separately billable*
P9011	*Blood split unit*	*Freezing and thawing are separately billable*
P9012	*Cryoprecipitate each unit*	***Freezing and thawing codes not separately billable***
P9016	*RBC leukocytes reduced*	*Alternative P-code for frozen/thawed product available*
P9017	*Plasma 1 donor frz w/in 8 hr*	***Freezing and thawing codes not separately billable***
P9019	*Platelets, each unit*	*Freezing and thawing are separately billable*
P9020	*Plaelet rich plasma unit*	*Freezing and thawing are separately billable*
P9021	*Red blood cells unit*	*Alternative P-code for frozen/thawed product available*
P9022	*Washed red blood cells unit*	*Freezing and thawing are separately billable*
P9023	*Frozen plasma, pooled, sd*	***Freezing and thawing codes not separately billable***
P9031	*Platelets leukocytes reduced*	*Freezing and thawing are separately billable*
P9032	*Platelets, irradiated*	*Freezing and thawing are separately billable*
P9033	*Platelets leukoreduced irrad*	*Freezing and thawing are separately billable*
P9034	*Platelets, pheresis*	*Freezing and thawing are separately billable*
P9035	*Platelet pheres leukoreduced*	*Freezing and thawing are separately billable*
P9036	*Platelet pheresis irradiated*	*Freezing and thawing are separately billable*
P9037	*Plate pheres leukoredu irrad*	*Freezing and thawing are separately billable*
P9038	*RBC irradiated*	*Freezing and thawing are separately billable*
P9039	*RBC deglycerolized*	***Freezing and thawing codes not separately billable***
P9040	*RBC leukoreduced irradiated*	*Alternative P-code for frozen/thawed product available*
P9043	*Plasma protein fract,5%,50ml*	*Concept not applicable*
P9044	*Cryoprecipitate reduced plasma*	***Freezing and thawing codes not separately billable***
P9048	*Plasmaprotein fract,5%,250ml*	*Concept not applicable*
P9050	*Granulocytes, pheresis unit*	*Concept not applicable*
P9051	*Blood, l/r, cmv-neg*	*Freezing and thawing are separately billable*
P9052	*Platelets, hla-m, l/r, unit*	*Freezing and thawing are separately billable*
P9053	*Plt, pher, l/r cmv-neg, irr*	*Freezing and thawing are separately billable*
P9054	*Blood, l/r, froz/degly/wash*	***Freezing and thawing codes not separately billable***
P9055	*Plt, aph/pher, l/r, cmv-neg*	*Freezing and thawing are separately billable*
P9056	*Blood, l/r, irradiated*	*Freezing and thawing are separately billable*
P9057	*RBC, frz/deg/wsh, l/r, irrad*	***Freezing and thawing codes not separately billable***

P9058	*RBC, l/r, cmv-neg, irrad*	*Freezing and thawing are separately billable*
P9059	*Plasma, frz between 8-24hour*	***Freezing and thawing codes not separately billable***
P9060	*Fr frz plasma donor retested*	***Freezing and thawing codes not separately billable***

231.7 - Billing for Unused Blood

(Rev.1487, Issued: 04-08-08, Effective: 04-01-08, Implementation: 04-07-08)

When blood or blood products which the OPPS provider has collected in its own blood bank or received from a community blood bank are not used, processing and storage costs incurred by the community blood bank and the OPPS provider cannot be charged to the beneficiary. However, certain patient-specific blood preparation costs incurred by the OPPS provider (e.g., blood typing and cross-matching) can be charged to the beneficiary under Revenue Code Series 30X or 31X. Patient-specific preparation charges should be billed on the dates the services were provided.

Processing and storage costs for unused blood products should be reported as costs under cost centers for blood on the OPPS provider's Medicare Cost Report. These are costs that are not considered patient-specific blood preparation services. Costs for unused blood products which have been purchased also should be reported as costs under cost centers for blood on the Medicare Cost Report.

Where blood or a blood product is split or irradiated specifically with the intent of transfusion to a beneficiary but is not then used, the hospital may bill for the services of splitting or irradiating the unit of blood, but may not bill for the HCPCS code for the blood product that was not transfused. The date of service must be the date on which the decision not to use the blood was made and indicated in the patient's medical record. Where the unit of blood is split or irradiated and stored without specific intention to administer it to a Medicare beneficiary at the time of splitting or irradiation and is not subsequently transfused, there is no service to be reported.

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

(Rev.1487, Issued: 04-08-08, Effective: 04-01-08, Implementation: 04-07-08)

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

A. Billing Requirement

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

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

Hospitals and CAHs report condition code 41 in FLs 24-30 (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 HCPCS code for this benefit.

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

All hospitals are required to report condition code 41 in FLs 24-30 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

Revenue Code	Description	HCPCS Code
043X	Occupational Therapy	*G0129
0900	Behavioral Health Treatment/Services	90801, 90802, 90899
0904	Activity Therapy (Partial Hospitalization)	**G0176
0910	Psychiatric General Services (Dates of Service prior to October 16, 2003)	90801, 90802, 90899
0914	Individual Psychotherapy	90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829 *90845, 90865, or 90880*
0915	Group Therapy	90849, 90853, or 90857
0916	Family Psychotherapy	90846, 90847, or 90849
0918	Psychiatric Testing	*96101, 96102, 96103, 96116, 96118, 96119, or 96120*
0942	Education Training	***G0177

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

*The definition of code G0129 is as follows:

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

**The definition of code G0176 is as follows:

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

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

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

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

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

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

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

B. Professional Services

The professional services listed below when provided in all hospital outpatient departments are separately covered and paid as the professional services of physicians and other practitioners. These professional services are unbundled and these practitioners (other than physician assistants (PA) bill the Medicare Part B carrier directly for the professional services furnished to hospital outpatient partial hospitalization patients. The hospital can also serve as a billing agent for these professionals by billing the Part B carrier on their behalf under their billing number for their professional services. The professional services of a PA can be billed to the carrier only by the PAs employer. The 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 you for such nonphysician practitioner services as partial hospitalization services. Make payment for the services to the hospital.

PA services can only be billed by the actual employer of the PA. The employer of a PA may be such entities or individuals such as a physician, medical group, professional corporation, hospital, SNF, or nursing facility. For example, if a physician is the employer of the PA and the PA renders services in the hospital, the physician and not the hospital would be responsible for billing the carrier on Form CMS-1500 for the services of the PA.

C. Outpatient Mental Health Treatment Limitation

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

D. Reporting of Service Units

Hospitals report 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.

You must RTP claims that contain more than one unit for HCPCS codes G0129 per day.

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

E. Line Item Date of Service Reporting

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

F. Payment

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

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.

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

(Rev.1487, Issued: 04-08-08, Effective: 04-01-08, Implementation: 04-07-08)

A. General

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

B. Special Requirements

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

C. Billing Requirements

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

The acceptable revenue codes are as follows:

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

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

Revenue Codes	Description	HCPCS Code
043X	Occupational Therapy (Partial Hospitalization)	*G0129
0900	Behavioral Health Treatments/Services	90801, 90802, 90899
0904	Activity Therapy (Partial Hospitalization)	**G0176
0910	Psychiatric General Services (Dates of Service prior to October 16, 2003)	90801, 90802, 90899

Revenue Codes	Description	HCPCS Code
0914	Individual Psychotherapy	90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829*, 90845, 90865, or 90880*
0915	Group Psychotherapy	90849, 90853, or 90857
0916	Family Psychotherapy	90846, 90847, or 90849
0918	Psychiatric Testing	*96101, 96102, 96103, 96116, 96118, 96119, or 96120*
0942	Education Training	***G0177

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

*The definition of code G0129 is as follows:

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

**The definition of code G0176 is as follows:

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

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

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

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

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

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

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

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

The professional services listed below are separately covered and are paid as the professional services of physicians and other practitioners. These professional services are unbundled and these practitioners (other than physician assistants (PAs)) bill the Medicare Part B carrier directly for the professional services furnished to CMHC partial hospitalization patients. The CMHC can also serve as a billing agent for these professionals by billing the Part B carrier on their behalf for their professional services. The professional services of a PA can be billed to the carrier only by the PAs employer.

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

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

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

The PA services can be billed only by the actual employer of the PA. The employer of a PA may be such entities or individuals as a physician, medical group, professional corporation, hospital, SNF, or nursing facility. For example, if a physician is the employer of the PA and the PA renders services in the CMHC, the physician and not the CMHC would be responsible for billing the carrier on Form CMS-1500 for the services of the PA.

D. Outpatient Mental Health Treatment Limitation

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

E. Reporting of Service Units

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

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

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

The FI returns to the provider claims that contain more than one unit for HCPCS code G0129 or that does not contain service units for a given HCPCS code.

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

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

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 the HIPAA 837, FIs report as follows:

Record Type	Revenue Code	HCPCS	Dates of Service	Units	Total Charges
61	0915	90849	19980505	1	$80
61	0915	90849	19980529	2	$160

For the hardcopy Form CMS-1450, FIs report as follows:

Revenue Code	*HCPCS*	*Dates of Service*	*Units*	*Total Charges*
0915	90849	050598	1	$80
0915	90849	052998	2	$160

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

The FIs return to provider claims that span two or more dates if a line item date of service is not entered for each HCPCS code reported or if the line item dates of service reported are outside of the statement covers period. Line item date of service reporting is effective for claims with dates of service on or after June 05, 2000.

G. Payment

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

Payment principles applicable to partial hospitalization services furnished in CMHCs are contained in §2400 of the Medicare Provider Reimbursement Manual. FIs are to furnish each CMHC with one copy of that manual.

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

NOTE: Occupational therapy services provided to partial hospitalization patients are not subject to the prospective payment system for outpatient rehabilitation services, and therefore the financial limitation required under §4541 of the Balanced Budget Act (BBA) does not apply.

H. Medical Review

The FIs follow medical review guidelines in the Medicare Program Integrity Manual.

I. Coordination With CWF

See Chapter 27. 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.