CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2061	**Date: October 1, 2010**
	Change Request 7117

Transmittal 2050, dated September 17, 2010 is rescinded and replaced by Transmittal 2061, dated October 1, 2010. A reference to a special payment indicator (Policy Section 6.B) that incorrectly stated a 'Y' has been corrected in the Recurring Update Notification to specify a '2' instead. All other information remains the same.

SUBJECT: October 2010 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 October 2010 OPPS update. The October 2010 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).

October 2010 revisions to I/OCE data files, instructions, and specifications are provided in CR 7111, October 2010 Integrated Outpatient Code Editor (I/OCE) Specifications Version 11.3. The attached Recurring Update Notification applies to Chapter 4, Section 10.7.1.

EFFECTIVE DATE: October 1, 2010
IMPLEMENTATION DATE: October 4, 2010

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	1/50.3.2/Policy and Billing Instructions for Condition Code 44
R	4/10.7.1/Outlier Adjustments

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

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

IV. ATTACHMENTS:

Manual Instruction

Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal:2061	Date: October 1, 2010	Change Request: 7117

Transmittal 2050, dated September 17, 2010 is rescinded and replaced by Transmittal 2061, dated October 1, 2010. A reference to a special payment indicator (Policy Section 6.B) that incorrectly stated a 'Y' has been corrected in the Recurring Update Notification to specify a '2' instead. All other information remains the same.

SUBJECT: October 2010 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Effective Date: October 1, 2010

Implementation Date: October 4, 2010

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the October 2010 OPPS update. The October 2010 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this Change Request (CR).

The October 2010 revisions to I/OCE data files, instructions, and specifications are provided in CR 7111, "October 2010 Integrated Outpatient Code Editor (I/OCE) Specifications Version 11.3."

B. Policy:

1. Procedure and Device Edits for October 2010

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. Procedures for which both a Device A and a Device B are specified require that at least one each of Device A and Device B be present on the claim (i.e., there must be some combination of a Device A with a Device B in order to pass the edit). Device B can be reported with any Device A for the same procedural HCPCS code.

Device to procedure edits require that a claim that contains one of a specified set of device codes be returned to the provider if it fails to contain an appropriate procedure code. The updated lists of both types of edits can be found under "Device, Radiolabeled Product, and Procedure Edits" at http://www.cms.gov/HospitalOutpatientPPS/.

2. New Device Pass-Through Category

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.

We are establishing one new category as of October 1, 2010. The following table provides a listing of new coding and payment information concerning the new device category for transitional pass-through payment.

Table 1 – New Device Pass-Through Codes

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Device Offset from Payment
C1749	10-01-10	H	1749	Endo, colon, retro imaging	Endoscope, retrograde imaging/illumination colonoscope device (implantable)	$0

a. Device Offset from Payment

Section 1833(t)(6)(D)(ii) of the Act requires that we deduct from pass-through payments for devices an amount that reflects the portion of the APC payment amount that we determine is associated with the cost of the device (70 FR 68627-8). We have determined that we are not able to identify a portion of the APC payment amount associated with the cost of the device, that is, Endoscope, retrograde imaging/illumination colonoscope device (implantable), in APC 143, Lower GI Endoscopy or in APC 0158, Colorectal Cancer Screening: Colonoscopy. The Device Offset from Payment represents this deduction from pass-through payments for category C1749, when it is billed with a service included in APC 143 or APC 0158. Therefore, we are establishing an offset amount for C1749 of $0 and will not make any deductions from pass-through payment for category C1749.

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 codes 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 two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used in the care of the patient. The mixing together of two or more products does not constitute a "new" drug as regulated by the Food and Drug Administration (FDA) under the New Drug Application (NDA) process. In these situations, hospitals are reminded that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, Unclassified drug or biological, is for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned.

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

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective October 1, 2010

For CY 2010, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 4 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2010, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. We note that for the third quarter of CY 2010, payment for drugs and biologicals with pass-through status is not made at the Part B Drug Competitive Acquisition Program (CAP) rate, as the CAP program was suspended beginning January 1, 2009. Should the Part B Drug CAP program be reinstituted sometime during CY 2010, we would again use the Part B drug CAP rate for pass-through drugs and biologicals if they are a part of the Part B drug CAP program, as required by the statute.

In the CY 2010 OPPS/ASC final rule with comment period, we stated that payments for drugs and biologicals based on 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 October 2010 release of the OPPS Pricer. The updated payment rates, effective October 1, 2010 will be included in the October 2010 update of the OPPS Addendum A and Addendum B, which will be posted on the CMS Web site.

b. Drugs and Biologicals with OPPS Pass-Through Status Effective October 1, 2010

Five drugs and biologicals have been granted OPPS pass-through status effective October 1, 2010. These items, along with their descriptors and APC assignments, are identified in Table 2 below.

Table 2 – Drugs and Biologicals with OPPS Pass-Through Status Effective October 1, 2010

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 10/1/10
C9269*	Injection, C-1 esterase inhibitor (human), Berinert, 10 units	9269	G
C9270*	Injection, immune globulin (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg	9270	G
C9271*	Injection, velaglucerase alfa, 100 units	9271	G
C9272*	Injection, denosumab, 1 mg	9272	G
C9273*	Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF in 250 mL of Lactated Ringer's, including leukapheresis and all other preparatory procedures, per infusion	9273	G

NOTE: The HCPCS codes identified with an "*" indicate that these are new codes effective October 1, 2010.

c. Supplemental Information on HCPCS code C9273

CMS has opened a national coverage determination analysis (NCD) for HCPCS code C9273, Provenge (Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF in 250 mL of Lactated Ringer's, including leukapheresis and all other preparatory procedures, per infusion). A final decision on coverage is forthcoming in 2011. As with other drugs and biologicals, at this time, local contractors will retain the discretion to make individual claim determinations for Provenge based on the medical necessity of the service(s) being provided.

Additionally, we clarify that the language given in the long descriptor of Provenge that states "all other preparatory procedures" refers to the transportation process of collecting immune cells from a patient during a non-therapeutic leukapheresis procedure,subsequently sending the immune cells to the

manufacturing facility, and then transporting the immune cells back to the site of service to be administered to the patient.

d. Updated Payment Rate for HCPCS Code 90476 Effective April 1, 2010 through June 30, 2010

The payment rate for one HCPCS code was incorrect in the April 2010 OPPS Pricer. The corrected payment rate is listed in Table 3 below and has been installed in the October 2010 OPPS Pricer, effective for services furnished on April 1, 2010, through implementation of the July 2010 update.

Table 3 – Updated Payment Rate for HCPCS Code 90476 Effective April 1, 2010 through June 30, 2010

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
90476	K	1254	Adenovirus vaccine, type 4	$72.17	$14.43

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

The payment rates for several HCPCS codes were incorrect in the July 2010 OPPS Pricer. The corrected payment rates are listed in Table 4 below and have been installed in the October 2010 OPPS Pricer, effective for services furnished on July 1, 2010, through implementation of the October 2010 update.

Table 4 – Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2010 through September 30, 2010

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J9264	K	1712	Paclitaxel protein bound	$9.22	$1.84
C9268	G	9268	Capsaicin patch	$25.55	$5.01

f. Adjustment to Status Indicator for CPT Code 90670 Effective April 1, 2010

CPT code 90670 (Pneumococcal vacc, 13 val im) was erroneously assigned status indicator "K" effective April 1, 2010 in the July 2010 update issued in CR 6996. Therefore, retroactively effective April 1, 2010, the status indicator for CPT code 90670 will change from status indicator "K" (paid under OPPS; separate APC payment) to status indicator "L" (Not paid under OPPS. Paid at reasonable cost; not subject to deductible or coinsurance). Beginning April 1, 2010, CPT code 90670 will be paid at reasonable cost.

g. Payment for Vaccine CPT Code 90662

CPT code 90662 (Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use) has been assigned status indicator "E". However, 90662 received approval from the FDA on December 23, 2009. Therefore, effective

December 23, 2009, CPT code 90662 is assigned status indicator "L" (Not paid under OPPS. Paid at reasonable cost; not subject to deductible or coinsurance). CPT code 90662 will be paid at reasonable cost.

h. Correct Reporting of Biologicals When Used As Implantable Devices

When billing for biologicals where the HCPCS code describes a product that is solely surgically implanted or inserted, whether the HCPCS code is identified as having pass-through status or not, hospitals are to report the appropriate HCPCS code for the product. Units should be reported in multiples of the units included in the HCPCS descriptor. Providers and hospitals should not bill the units based on the way the implantable biological is packaged, stored, or stocked. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the implantable biological. Therefore, before submitting Medicare claims for biologicals that are used as implantable devices, it is extremely important to review the complete long descriptors for the applicable HCPCS codes. In circumstances where the implanted biological has pass-through status, either as a biological or a device, a separate payment for the biological or device is made. In circumstances where the implanted biological does not have pass-through status, the OPPS payment for the biological is packaged into the payment for the associated procedure.

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

i. Correct Reporting of Units for Drugs

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

As discussed in the Medicare Claims Processing Manual, Pub.100-04, Chapter 17, Section 40, CMS encourages hospitals to use drugs efficiently and in a clinically appropriate manner. However, CMS also recognizes that hospitals may discard some drug and biological product when administering from a single use vial or package. In that circumstance, Medicare pays for the amount of drug or biological discarded *as well as* the *dose* administered, up to the amount of the drug or biological as indicated on the

vial or package label. Multi-use vials are not subject to payment for discarded amounts of drug or biological.

j. Reporting of Outpatient Diagnostic Nuclear Medicine Procedures

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

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

When a radiolabeled product is administered in one hospital and the nuclear medicine scan is subsequently performed at another hospital, hospitals should comply with the OPPS policy that requires that radiolabeled products be reported and billed with nuclear medicine scans. In these specific cases, the hospital that bills for the nuclear medicine procedure would receive payment for both the nuclear medicine procedure and the radiolabeled product since a hospital cannot bill and be paid for a radiolabeled product solely submitted on a claim. In order for the hospital that administers the radiolabeled product to be paid, hospitals may enter into an arrangement (under Section 1861 (w)(1) of the Act, and as discussed in 42 CFR 410.28(a)(1) and defined in 42 CFR 409.3) where the hospital that administers the nuclear medicine scan pays the appropriate amount for the radiolabeled product to the hospital that administers the radiolabeled product. We consider the radiolabeled product and the nuclear medicine scan to be part of one procedure and we would expect both services to be performed together.

4. Coding and Payment for Magnetic Resonance Angiography (MRA)

Effective for claims with dates of service on and after June 3, 2010, CMS permits local Medicare contractors to cover (or not cover) all indications of MRA that are not specifically nationally covered or nationally non-covered. CMS has created the six Level II HCPCS codes in Table 5 below to allow OPPS providers to bill for certain MRA services that were previously non-covered but may now be covered at local Medicare contractor discretion. The six Level II HCPCS codes must be used in place of existing CPT codes for the previously non-covered MRA procedures due to a statutory requirement that the OPPS provide payment for imaging services provided with contrast and without contrast through separate payment groups. Specifically, HCPCS codes C8931, C8932, and C8933 replace CPT code 72159 (Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)), while HCPCS codes C8934, C8935, and C8936 replace CPT code 73225 (Magnetic resonance angiography, upper extremity, with or without contrast material(s)). CMS has changed the assignment of CPT codes 72159 and 73225 from status indicator “E” to status indicator “B” to indicate that these codes are not recognized by OPPS when submitted on an outpatient hospital Part B bill type 12x or 13x.

Under the hospital OPPS, these new HCPCS codes are assigned status indicator "Q3" to indicate that these services will be paid with one composite APC payment each time a hospital bills for second and subsequent imaging procedures in the same imaging family on a single date of service. The standard (non-composite) APC will be assigned when there are no other imaging procedures in the same imaging family present on the claim for the same date of service. The I/OCE logic will determine the assignment of the composite APCs for payment.

Further information on billing and coverage for MRA will be available to contractors in CR XXXX, issued xxxxxxx, 2010.

Table 5 – MRA Codes

HCPCS Code	Long Descriptor	Composite APC	Standard (Non-Composite) APC
C8931	Magnetic resonance angiography with contrast, spinal canal and contents	8008	0284
C8932	Magnetic resonance angiography without contrast, spinal canal and contents	8007 or 8008	0336
C8933	Magnetic resonance angiography without contrast followed by with contrast, spinal canal and contents	8008	0337
C8934	Magnetic resonance angiography with contrast, upper extremity	8008	0284
C8935	Magnetic resonance angiography without contrast, upper extremity	8007 or 8008	0336
C8936	Magnetic resonance angiography without contrast followed by with contrast, upper extremity	8008	0337

5. Clarification on Billing for Observation Services on Condition Code 44 Claims

In this instruction, we are updating the Medicare Claims Processing Manual, Pub. 100-04, Chapter 1, Section 50.3 to clarify billing for observation services on Condition Code 44 claims.

6. Updating the OPSF for New CBSA and Wage Indices for Hospitals Receiving Section 508 Reclassification

This serves as a reminder that per our instructions published in Transmittal 726, CR 7029, issued July 15, 2010, contractors shall update the OPSF specifically for providers for which reclassifications under section 508 have been extended through September 30, 2010, that will no longer be reclassified under Section 508 for the last quarter of CY 2010 (10/1-12/31). Contractors shall do the following when creating a new provider record, effective October 1, 2010:

a) If the provider has an MGCRB reclassification and is not reclassified to CBSA 35644 for the last quarter of CY 2010,
   i. Enter a 'Y' in the special payment indicator field in the OPSF
   ii. Enter the reclassification CBSA (given for the provider in column 3 of table 6) in the wage index CBSA field

b) If the provider has an MGCRB reclassification to CBSA 35644 for the last quarter of CY 2010,
   i. Enter a '2' in the special payment indicator field in the OPSF
   ii. Enter the final wage index value (given for the provider in column 4 of Table 6) in the Special Wage Index field in the OPSF (until the wage index for CBSA 35644 is corrected in the OPPS Pricer).

c) If the provider does not have an MGCRB reclassification and is not eligible for the out commuting adjustment,

   i. Enter a blank in the Special Payment Indicator field; and
   ii. Enter zeroes in the special wage index field.
   iii. Verify that the geographic CBSA in the OPSF corresponds to the CBSA shown in column 2 of table 6

d) If the provider does not have an MGCRB reclassification and is eligible for the out commuting adjustment,

   i. Enter a value of "1" in the Special Payment Indicator field; and

   ii. Enter the final wage index value (given for the provider in column 4 of Table 6) in the Special Wage Index field in the OPSF.

Table 6 – October 1, 2010 to December 31, 2010 Wage Index for Section 508 Hospitals that Receive Payment Under the OPPS

Provider	Geographic CBSA	MGCRB Reclassification CBSA	Special Wage Index	Section 505 Out-Commuting Adjustment	Section 508 Provider
010150	01	NA	0.7516	YES	YES
020008	02	11260	NA		YES
050549	37100	NA	1.2216		YES
060075	06	24300	NA		YES
070001	35300	35004	NA		YES
070005	35300	35004	NA		YES
070010	14860	**35644**	1.2695		YES
070016	35300	35004	NA		YES
070017	35300	35004	NA		YES
070019	35300	35004	NA		YES
070022	35300	35004	NA		YES
070028	14860	**35644**	1.2695		YES
070031	35300	35004	NA		YES
070039	35300	35004	NA		YES
150034	23844	16974	NA		YES
160040	47940	NA	0.8564		YES
160064	16	24	NA		YES
160067	47940	NA	0.8564		YES
160110	47940	NA	0.8564		YES

Provider	Geographic CBSA	MGCRB Reclassification CBSA	Special Wage Index	Section 505 Out-Commuting Adjustment	Section 508 Provider
190218	19	43340	NA		YES
220046	38340	NA	1.0735		YES
230003	26100	34740	NA		YES
230004	34740	NA	0.9830		YES
230013	47644	22420	NA		YES
230019	47644	22420	NA		YES
230020	19804	11460	NA		YES
230024	19804	11460	NA		YES
230029	47644	22420	NA		YES
230036	23	13020	NA		YES
230038	24340	34740	NA		YES
230053	19804	11460	NA		YES
230059	24340	34740	NA		YES
230066	34740	NA	0.9830		YES
230071	47644	22420	NA		YES
230072	26100	34740	NA		YES
230089	19804	11460	NA		YES
230097	23	24340	NA		YES
230104	19804	11460	NA		YES
230106	24340	34740	NA		YES
230130	47644	22420	NA		YES
230135	19804	11460	NA		YES
230146	19804	11460	NA		YES
230151	47644	22420	NA		YES
230165	19804	11460	NA		YES
230174	26100	34740	NA		YES
230176	19804	11460	NA		YES
230207	47644	22420	NA		YES
230236	24340	34740	NA		YES
230254	47644	22420	NA		YES
230269	47644	22420	NA		YES
230270	19804	11460	NA		YES
230273	19804	11460	NA		YES
230277	47644	22420	NA		YES
250002	25	NA	0.7717		YES
250078	25620	25060	NA		YES
250122	25	NA	0.7717		YES
270002	27	NA	0.8296		YES
270012	24500	NA	0.8364		YES

Provider	Geographic CBSA	MGCRB Reclassification CBSA	Special Wage Index	Section 505 Out-Commuting Adjustment	Section 508 Provider
270032	27	NA	0.8296		YES
270057	27	NA	0.8296		YES
310021	45940	NA	1.1341		YES
310028	35084	NA	1.1341		YES
310050	35084	**35644**	1.2769		YES
310051	35084	NA	1.1341		YES
310060	10900	NA	1.1341		YES
310115	10900	NA	1.1341		YES
310120	35084	NA	1.1341		YES
330049	39100	14860	NA		YES
330106	35004	**35644**	1.2930		YES
330126	39100	**35644**	1.2930		YES
330135	39100	NA	1.1908	YES	YES
330205	39100	NA	1.1908	YES	YES
330264	39100	NA	1.1908	YES	YES
340002	11700	NA	0.9082		YES
350002	13900	NA	0.7968		YES
350006	35	NA	0.7968		YES
350015	13900	NA	0.7968		YES
350019	24220	NA	0.8055		YES
380090	38	21660	NA		YES
390001	42540	NA	0.8363		YES
390003	39	NA	0.8363		YES
390045	48700	NA	0.8363		YES
390072	39	NA	0.8363		YES
390095	42540	NA	0.8363		YES
390119	42540	NA	0.8363		YES
390137	42540	NA	0.8363		YES
390169	42540	NA	0.8363		YES
390192	42540	NA	0.8363		YES
390237	42540	NA	0.8363		YES
390270	42540	NA	0.8363		YES
430005	43	NA	0.8360		YES
430008	43	NA	0.8895	YES	YES
430013	43	43620	NA		YES
430015	43	NA	0.8360		YES
430048	43	NA	0.8489	YES	YES
430060	43	NA	0.8360		YES
470003	15540	NA	1.0456		YES

Provider	Geographic CBSA	MGCRB Reclassification CBSA	Special Wage Index	Section 505 Out-Commuting Adjustment	Section 508 Provider
490001	49	NA	0.8101		YES
530015	53	NA	0.9390		YES

7. Coverage Determinations

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

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7117.1	Medicare contractors shall install the October 2010 OPPS Pricer.	X		X		X	X				COBC
7117.2	Medicare contactors shall manually add the following HCPCS codes to their systems: • All HCPCS listed in tables 1,2, and 5, and • HCPCS Q5010 (listed in CR7111) **NOTE**: These HCPCS codes will be included with the October 2010 IOCE update. They are currently not on the 2010 HCPCS file; however, they will be listed on the CMS Web site at http://www.cms.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp#TopOfPage. Status and payment indicators for these HCPCS codes will be listed in the October 2010 update of the OPPS Addendum A and Addendum B on the CMS Web site.	X		X		X	X			X	COBC
7117.3	Medicare contractors shall adjust as appropriate claims	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	
	brought to their attention that: 1) Have dates of service that fall on or after April 1, 2010, but prior to July 1, 2010; 2) Contain HCPCS code listed in Table 3; and 3) Were originally processed prior to the installation of the October 2010 OPPS Pricer.										
7117.4	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service that fall on or after July 1, 2010, but prior to October 1, 2010; 2) Contain HCPCS codes listed in Table 4; and 3) Were originally processed prior to the installation of the October 2010 OPPS Pricer.	X		X		X					COBC
7117.5	Medicare contractors shall update the OPSF according to the specific coding instructions provided in Policy Section I.B.6 above. **NOTE**: The instructions provided in Policy Section I.B.6 above, supersede prior OPSF instructions for the listed providers in JSM/TDL-0249, JSM/TDL-0325 and CR 7029. For example, if a contractor previously coded a provider with a "special wage index" for the last quarter of CY 2010 (based on prior CMS instruction), the contractor shall revise the OPSF to code a "reclassification" for the provider as specified in Policy Section I.B.6.	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	
7117.6	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of	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	
	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:
	None

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

Please refer to CR 7111 "October 2010 Integrated Outpatient Code Editor (I/OCE) Specifications Version 11.3" for supporting information.

V. CONTACTS

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

Post-Implementation Contact(s): Regional Office

VI. FUNDING

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

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

Section B: For Medicare Administrative Contractors (MACs), include the following statement:

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 1 - General Billing Requirements

50.3.2 - Policy and Billing Instructions for Condition Code 44

(Rev.2061, Issued: 10-01-10, Effective: 10-01-10, Implementation: 10-04-10)

In cases where a hospital utilization review committee determines that an inpatient admission does not meet the hospital's inpatient criteria, the hospital may change the beneficiary's status from inpatient to outpatient and submit an outpatient claim (bill type 13x or 85x) for medically necessary Medicare Part B services that were furnished to the beneficiary, provided all of the following conditions are met:

1. The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital;

2. The hospital has not submitted a claim to Medicare for the inpatient admission;

3. A physician concurs with the utilization review committee's decision; and

4. The physician's concurrence with the utilization review committee's decision is documented in the patient's medical record.

When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be billed as an outpatient episode of care on a 13x bill type and outpatient services that were ordered and furnished should be billed as appropriate.

Refer to Pub. 100-04, Medicare Claims Processing Manual; Chapter 30, Financial Liability Protections; Section 20, Limitation On Liability (LOL) Under §1879 Where Medicare Claims Are Disallowed, for information regarding financial liability protections.

When the hospital submits a 13x or 85x bill for services furnished to a beneficiary whose status was changed from inpatient to outpatient, the hospital is required to report Condition Code 44 on the outpatient claim in one of Form Locators 24-30, or in the ANSI X12N 837 I in Loop 2300, HI segment, with qualifier BG, on the outpatient claim. Additional information may be found in Chapter 25 of this manual, (Completing and Processing the Form CMS-1450 Data Set). Condition Code 44 is used by CMS and QIOs to track and monitor these occurrences. The reporting of Condition Code 44 on a claim does not affect the amount of hospital outpatient payment that would otherwise be made for a hospital outpatient claim that did not require the reporting Condition Code 44.

One of the requirements for the use of Condition Code 44 is physician concurrence with the determination that an inpatient admission does not meet the hospital's admission criteria and that

the patient should have been registered as an outpatient. This prerequisite for use of Condition Code 44 is consistent with the requirements in the CoP in 42 C.F.R. §482.30 (d) of the regulations. This paragraph provides that the practitioner or practitioners responsible for the care of the patient must be consulted and allowed to present their views before the UR committee or QIO makes its determination that an admission is not medically necessary. It may also be appropriate to include the practitioner who admitted the patient if this is a different person than the practitioner responsible for the care of the patient.

If the conditions for use of Condition Code 44 are not met, the hospital may submit a 12x bill type for covered "Part B Only" services that were furnished to the inpatient. Medicare may still make payment for certain Part B services furnished to an inpatient of a hospital when payment cannot be made under Part A because an inpatient admission is determined not to be medically necessary. Information about "Part B Only" services is located in Pub. 100-02, Medicare Benefit Policy Manual, chapter 6, section 10. Examples of such services include, but are not limited to, diagnostic x-ray tests, diagnostic laboratory tests, surgical dressings and splints, prosthetic devices, and certain other services. The Medicare Benefit Policy Manual includes a complete list of the payable "Part B Only" services.

Entries in the medical record cannot be expunged or deleted and must be retained in their original form. Therefore, all orders and all entries related to the inpatient admission must be retained in the record in their original form. If a patient's status changes in accordance with the requirements for use of Condition Code 44, the change must be fully documented in the medical record, complete with orders and notes that indicate why the change was made, the care that was furnished to the beneficiary, and the participants in making the decision to change the patient's status.

When Condition Code 44 is appropriately used, the hospital reports on the outpatient bill the services that were ordered and provided to the patient for the entire patient encounter. However, in accordance with the general Medicare requirements for services furnished to beneficiaries and billed to Medicare, even in Condition Code 44 situations, hospitals may not report observation services using HCPCS code G0378 (Hospital observation service, per hour) for observation services furnished during a hospital encounter prior to a physician's order for observation services. Medicare does not permit retroactive orders or the inference of physician orders. Like all hospital outpatient services, observation services must be ordered by a physician. The clock time begins at the time that observation services are initiated in accordance with a physician's order.

While hospitals may not report observation services under HCPCS code G0378 for the time period during the hospital encounter prior to a physician's order for observation services, in Condition Code 44 situations, as for all other hospital outpatient encounters, hospitals may include charges on the outpatient claim for the costs of all hospital resources utilized in the care of the patient during the entire encounter. For example, a beneficiary is admitted as an inpatient and receives 12 hours of monitoring and nursing care, at which point the hospital changes the status of the beneficiary from inpatient to outpatient and the physician orders observation services, with all criteria for billing under Condition Code 44 being met. On the outpatient claim on an uncoded line with revenue code 0762, the hospital could bill for the 12 hours of

monitoring and nursing care that were provided prior to the change in status and the physician order for observation services, in addition to billing HCPCS code G0378 for the observation services that followed the change in status and physician order for observation services. For other rules related to billing and payment of observation services, see Chapter 4, §290 of this manual, and Chapter 6, §20.6 of the Medicare Benefit Policy Manual, Pub. 100-02.

Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

10.7.1 - Outlier Adjustments

(Rev. 2061, Issued: 10-01-10, Effective: 10-01-10, Implementation: 10-04-10)

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.

Future updates will be issued in a Recurring Update Notification.