CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2845	**Date: December 27, 2013**
	Change Request 8572

SUBJECT: January 2014 Update of the Hospital Outpatient Prospective Payment System (OPPS)

I. SUMMARY OF CHANGES: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the January 2014 OPPS update. Most of these policies are also outlined in CY 2014 OPPS/ASC final rule. The January 2014 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 January 2014 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming January I/OCE CR.

This Recurring Update Notification applies to Chapter 04, section 50.

EFFECTIVE DATE: January 1, 2014
IMPLEMENTATION DATE: January 6, 2014

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
N	4/10.6.3.2/Payment Adjustment for Certain Cancer Hospitals for CY 2014
R	4/200.3.3 - Billing for Stereotactic Radiosurgery (SRS) Planning and Delivery
D	4/200.3.4 - Billing for Linear Accelerator (Robotic Image-Guided and Non-Robotic Image-Guided) SRS Planning and Delivery
R	4/200.9 - Billing for “Sometimes Therapy” Services that May be Paid as Non-Therapy Services for Hospital Outpatients

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically

authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Recurring Update Notification

Pub. 100-04	Transmittal: 2845	Date: December 27, 2013	Change Request: 8572

SUBJECT: January 2014 Update of the Hospital Outpatient Prospective Payment System (OPPS)

EFFECTIVE DATE: January 1, 2014
IMPLEMENTATION DATE: January 6, 2014

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the January 2014 OPPS update. Most of these policies are also outlined in CY 2014 OPPS/ASC final rule. The January 2014 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 January 2014 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming January I/OCE CR.

B. Policy:

1. Changes to Device Edits for January 2014

The most current list of device edits can be found under "Device and Procedure Edits" at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/. Failure to pass these edits will result in the claim being returned to the provider.

2. No Cost/ Full Credit and Partial Credit Devices

Effective January 1, 2014, we will no longer recognize in the OPPS the FB or FC modifiers to identify a device that is furnished without cost or with a full or partial credit. Also effective January 1, 2014, for claims with APCs that require implantable devices and have significant device offsets (greater than 40%), the amount of the device credit will be specified in the amount portion for value code “FD” (Credit Received from the Manufacturer for a Replaced Medical Device) and will be deducted from the APC payment for the applicable procedure. The OPPS payment deduction for the applicable APCs referenced above will be limited to the total amount of the device offset when the FD value code appears on a claim. The offset amounts for the above referenced APCs are available on the CMS website.

3. New Services

New services listed in table 1, Attachment A, are assigned for payment under the OPPS, effective Jan. 1, 2014.

4. Clinic Visits

Effective January 1, 2014, CMS will recognize HCPCS code G0463 (Hospital outpatient clinic visit for assessment and management of a patient) for payment under the OPPS for outpatient hospital clinic visits. Effective January 1, 2014, CPT codes 99201-99205 and 99211-99215 will no longer be recognized for payment under the OPPS.

5. Extended Assessment and Management (EAM) Composite APC (8009)

Effective January 1, 2014 CMS will provide payment for all qualifying extended assessment and management encounters through newly created composite APC 8009 (Extended Assessment and Management (EAM) Composite). A clinic visit (G0463), a Level 4 (99284) or Level 5 Type A ED visit (99285), or Level 5 Type B ED visit (G0384) furnished by a hospital in conjunction with observation services of eight or more hours will qualify for payment through APC 8009. Effective January 1, 2014 CMS will no longer provide payment for extended assessment and management encounters through APCs 8002 (Level I Extended Assessment and Management Composite) and 8003 (Level I Extended Assessment and Management Composite), which have been deleted.

6. Billing for Stereotactic Radiosurgery (SRS) Planning and Delivery

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

As instructed in the CY 2014 OPPS/ASC final rule, CPT code 77371 is to be used only for single session cranial SRS cases performed with a Cobalt-60 device, and CPT code 77372 is to be used only for single session cranial SRS cases performed with a linac-based device. The term "cranial" means that the pathological lesion(s) that are the target of the radiation is located in the patient's cranium or head. The term "single session" means that the entire intracranial lesion(s) that comprise the patient's diagnosis are treated in their entirety during a single treatment session on a single day. CPT code 77372 is never to be used for the first fraction or any other fraction of a fractionated SRS treatment. CPT code 77372 is to be used only for single session cranial linac-based SRS treatment. Fractionated SRS treatment is any SRS delivery service requiring more than a single session of SRS treatment for a cranial lesion, up to a total of no more than five fractions, and one to five sessions (but no more than five) for non-cranial lesions. CPT code 77373 is to be used for any fraction (including the first fraction) in any series of fractionated treatments, regardless of the anatomical location of the lesion or lesions being radiated. Fractionated cranial SRS is any cranial SRS that exceeds one treatment session and fractionated non-cranial SRS is any non-cranial SRS, regardless of the number of fractions but never more than five. Therefore, CPT code 77373 is the exclusive code (and the use of no other SRS treatment delivery code is permitted) for any and all fractionated SRS treatment services delivered anywhere in the body, including, but not limited to, the cranium or head. 77372 is not to be used for the first fraction of a fractionated cranial SRS treatment series and must only be used in cranial SRS when there is a single treatment session to treat the patient's entire condition.

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

We note that the APC assignment, OPPS status indicators, and payment rates for these SRS planning and delivery services can be found in Addendum B of the January 2014 OPPS Update that is posted on the CMS website.

7. Drugs, Biologicals, and Radiopharmaceuticals

a. New CY 2014 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

For CY 2014, several new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. These new codes are listed in Table 4, Attachment A.

b. Other Changes to CY 2014 HCPCS and CPT Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals

Many HCPCS and CPT codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS and CPT code descriptors that will be effective in CY 2014. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2013 and replaced with permanent HCPCS codes in CY 2014. Hospitals should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the active CY 2014 HCPCS and CPT codes.

Table 5, Attachment A, notes those drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS/CPT code, their long descriptor, or both. Each product's CY 2013 HCPCS/CPT code and long descriptor are noted in the two left hand columns and the CY 2014 HCPCS/CPT code and long descriptor are noted in the adjacent right hand columns.

c. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective January 1, 2014

For CY 2014, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2014, 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. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Effective January 1, 2014, payment rates for many drugs and biologicals have changed from the values published in the CY 2014 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2013. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2014 release of the OPPS Pricer. CMS is not publishing the updated payment rates in this Change Request implementing the January 2014 update of the OPPS. However, the updated payment rates effective January 1, 2014 can be found in the January 2014 update of the OPPS Addendum A and Addendum B on the CMS Web site at http://www.cms.gov/HospitalOutpatientPPS/.

d. Updated Payment Rate for C1204 Effective October 1, 2013 through December 31, 2013

The payment rate for C1204 was incorrect in the October 2013 OPPS Pricer. The corrected payment rate is listed in Table 6, Attachment A, and has been installed in the January 2014 OPPS Pricer, effective for services furnished on October 1, 2013, through December 31, 2013.

e. Elimination of Nuclear Medicine Procedure-to-Radiolabeled Product Edits

Beginning January 1, 2008, CMS implemented OPPS edits that require hospitals to include a HCPCS code for a radiolabeled product when a separately payable nuclear medicine procedure is present on a claim. Effective January 1, 2014, the nuclear medicine procedure-to-radiolabeled product edits are no longer required. Hospitals are still expected to adhere to the guidelines of correct coding and append the correct radiolabeled product code to the claim when applicable. However, claims will no longer be returned to providers when HCPCS codes for radiolabeled products do not appear on claims with nuclear medicine procedures.

f. Skin Substitute Procedure Edits

Effective January 1, 2014, the payment for skin substitute products that do not qualify for pass-through status will be packaged into the payment for the associated skin substitute application procedure. The skin substitute products are divided into two groups: 1) high cost skin substitute products and 2) low cost skin substitute products for packaging purposes. Table 7, Attachment A, lists the skin substitute products and their assignment as either a high cost or a low cost skin substitute product, when applicable. Beginning January 1, 2014, CMS will implement an OPPS edit that requires hospitals to report all high cost skin substitute products in combination with one of the skin application procedures described by CPT codes 15271-15278 and to report all low cost skin substitute products in combination with one of the skin

application procedures described by HCPCS code C5271-C5278. All pass-through skin substitute products are to be reported in combination with one of the skin application procedures described by CPT code 15271-15278.

g. Offset from Payment for Pass-Through Skin Substitute Products

Section 1833(t)(6)(D)(i) of the Act requires that CMS deduct from pass-through payments for drugs or biologicals an amount that reflects the portion of the APC payment amount that CMS determines is associated with the cost of the drug or biological. Effective January 1, 2014, there will be five skin substitute products receiving pass-through payment. All pass-through skin substitute products are to be reported in combination with one of the skin application procedures described by CPT code 15271-15278. These skin application procedure codes are assigned to either APC 0328 (Level III Skin Repair) or APC 0329 (Level IV Skin Repair). CMS has determined that it is able to identify a portion of the APC payment amount associated with the cost of skin substitute products in APC 0328 and APC 0329. This portion of the APC payment represents the required deduction from pass-through payments for skin substitute products when they are billed with a skin substitute application procedure code in APC 0328 or APC 0329. The offset amount for APC 0328 and APC 0329, along with the offsets for other APCs, is available under "Annual Policy Files" on the CMS OPPS Web site at http://www.cms.gov/Hospital OutpatientPPS/.

8. Billing for "Sometimes Therapy" Services that May be Paid as Non-Therapy Services for Hospital Outpatients

Effective January 1, 2014, CMS is updating one of the services on the manual list of "sometimes therapy" services with a newly assigned HCPCS code. HCPCS code 0183T (Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day) is being replaced with HCPCS code 97610 (Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day). The code descriptor is not changed. The limited set of sometimes therapy services listed in the manual are paid under the OPPS when they are not furnished as therapy, meaning are not furnished under a certified therapy plan of care. When a hospital furnishes these services to a hospital outpatient as non-therapy, the hospital may submit a claim for facility payment for the services to the OPPS.

9. 2014 Hospital Outpatient Clinical Diagnostic Laboratory Test Payment and Billing

Since the inception of the OPPS, OPPS hospitals were paid separately for clinical diagnostic laboratory tests or services (laboratory tests) provided in the hospital outpatient setting at Clinical Laboratory Fee Schedule (CLFS) rates. Beginning in CY 2014, payment for most laboratory tests (except for molecular pathology tests) will be packaged under the OPPS. The general rule for OPPS hospitals is that laboratory tests should be reported on a 13X bill type. There are limited circumstances described below in which hospitals can separately bill for laboratory tests, and for these specific situations we are expanding the use of the 14x bill type to allow separate billing and payment at CLFS rates for hospital outpatient laboratory tests.

Laboratory tests may be (or must be for a non-patient specimen) billed on a 14X claim in the following circumstances:

(1) non-patient laboratory specimen tests; non-patient continues to be defined as a beneficiary that is neither an inpatient nor an outpatient of a hospital, but that has a specimen that is submitted for analysis to a hospital and the beneficiary is not physically present at the hospital;

(2) beginning in 2014, when the hospital only provides laboratory tests to the patient (directly or under arrangement) and the patient does not also receive other hospital outpatient services during that same encounter; and

(3) beginning in 2014, when the hospital provides a laboratory test (directly or under arrangement) during the same encounter as other hospital outpatient services that is clinically unrelated to the other hospital

outpatient services, and the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services provided in the hospital outpatient setting. In this case the lab test would be billed on a 14X claim and the other hospital outpatient services would be billed on a 13X claim.

It will be the hospital's responsibility to determine when laboratory tests may be separately billed on the 14X claim under these limited exceptions. In addition, laboratory tests for molecular pathology tests described by CPT codes in the ranges of 81200 through 81383, 81400 through 81408, and 81479 are not packaged in the OPPS and should be billed on a 13X type of bill.

10. CY 2014 OPPS Payment Adjustment for Certain Cancer Hospitals

Consistent with Section 3138 of the Affordable Care Act, we adopted a policy beginning in CY 2012 to provide additional payments to each of the 11 cancer hospitals so that each cancer hospital's final payment to cost ratio (PCR) for services provided in a given calendar year is equal to the weighted average PCR (which we refer to as the "target PCR") for other hospitals paid under the OPPS. The target PCR is set in advance of the calendar year and is calculated using the most recent submitted or settled cost report data that are available at the time of final rulemaking for the calendar year. We are updating Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, by adding section 10.6.3.2, to reflect that the target PCR for CY 2014, for purposes of the cancer hospital payment adjustment, is 0.89 for outpatient services furnished on or after January 1, 2014 through December 31, 2014.

11. Changes to OPPS Pricer Logic

a. Rural sole community hospitals and essential access community hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in CY 2014. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with section 1833(t)(13)(B) of the Act, as added by section 411 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

b. New OPPS payment rates and copayment amounts will be effective January 1, 2014. All copayment amounts will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the CY 2014 inpatient deductible.

c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2014. This threshold of 1.75 is multiplied by the total line-item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount. The payment formula is (cost-(APC payment x 1.75))/2.

d. The fixed-dollar threshold increase in CY 2014 relative to CY 2013. The estimated cost of a service must be greater than the APC payment amount plus $2,900 in order to qualify for outlier payments.

e. For outliers for Community Mental Health Centers (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2014. This threshold of 3.4 is multiplied by the total line-item APC payment for APC 0173 to determine eligibility for outlier payments. This multiple amount is also used to determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment formula is (cost-(APC 0173 payment x 3.4))/2.

f. Effective October 1, 2013, and continuing for CY 2014, 1 device is eligible for pass-through payment in the OPPS Pricer logic. Category C1841 (Retinal prosthesis, includes all internal and external components), has an offset amount of $0, because CMS is not able to identify portions of the APC payment amounts associated with the cost of the device in APC 0672, Level III, Posterior segment eye procedures. For outlier purposes, when C1841 is billed with CPT code 0100T, assigned to APC 0672, it will be eligible for outlier calculation and payment.

g. Effective January 1, 2014, the OPPS Pricer will apply a reduced update ratio of 0.980 to the payment and copayment for hospitals that fail to meet their hospital outpatient quality data reporting requirements or that fail to meet CMS validation edits. The reduced payment amount will be used to calculate outlier payments.

h. Effective January 1, 2014, there will be one diagnostic radiopharmaceutical receiving pass-through payment in the OPPS Pricer logic. For APCs containing nuclear medicine procedures, Pricer will reduce the amount of the pass-through diagnostic radiopharmaceutical payment by the wage-adjusted offset for the APC with the highest offset amount when the radiopharmaceutical with pass-through appears on a claim with a nuclear procedure. The offset will cease to apply when the diagnostic radiopharmaceutical expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals are the "policy-packaged" portions of the CY 2014 APC payments for nuclear medicine procedures and may be found on the CMS Web site.

i. Effective January 1, 2014, there will be five skin substitute products receiving pass-through payment in the OPPS Pricer logic. For skin substitute application procedure codes that are assigned to APC 0328 (Level III Skin Repair) or APC 0329 (Level IV Skin Repair), Pricer will reduce the payment amount for the pass-through skin substitute product by the wage-adjusted offset for the APC when the pass-through skin substitute product appears on a claim with a skin substitute application procedure that maps to APC 0328 or APC 0329. The offset amounts for skin substitute products are the "policy-packaged" portions of the CY 2014 payments for APC 0328 and APC 0329.

j. Pricer will update the payment rates for drugs, biologicals, therapeutic radiopharmaceuticals, and diagnostic radiopharmaceuticals with pass-through status when those payment rates are based on ASP on a quarterly basis.

k. Effective January 1, 2014, CMS is adopting the FY 2014 IPPS post-reclassification wage index values with application of out-commuting adjustment authorized by Section 505 of the MMA to non-IPPS hospitals discussed below.

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

12. Update the Outpatient Provider Specific File (OPSF)

For January 1, 2014, contractors shall maintain the accuracy of the provider records in the Outpatient Provider Specific File (OPSF) as changes occur in data element values.

Update the OPSF for New Core-Based Statistical Area (CBSA) and Wage Indices for Non-IPPS Hospitals Eligible for the Out-Commuting Adjustment Authorized by Section 505 of the MMA

This includes updating the CBSA in the provider records, as well as updating the "special wage index" value for those providers who qualify for the Section 505 adjustment as annotated in Table 8, Attachment A. As always, the OPPS applies the IPPS fiscal year 2014 post-reclassification wage index values to all hospitals and community mental health centers participating in the OPPS for the 2014 calendar year.

Contractors shall do the following to update the OPSF (effective January 1, 2014):

1. Update the CBSA value for each provider in Table 8, Attachment A;

2. For non-IPPS providers who qualify for the 505 adjustment in CY 2014 (Table 8, Attachment A);

a. Create a new provider record, effective January 1, 2014 and

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

c. Enter the final wage index value (given for the provider in Table 8, Attachment A.) in the Special Wage Index field in the OPSF.

3. For non-IPPS providers who received a special wage index in CY 2013, but no longer receive it in CY 2014;

a. Create a new provider record, effective January 1, 2014 and

b. Enter a blank in the Special Payment Indicator field; and

c. Enter zeroes in the special wage index field.

NOTE: Although the Section 505 adjustment is static for each qualifying county for 3 years, the special wage index will need to be updated (using the final wage index in Table 8, Attachment A) because the post-reclassification CBSA wage index has changed.

NOTE: Payment for Distinct Part Units (DPUs) located in an acute care hospital is based on the wage index for the labor market area where the hospital is located, even if the hospital has a reclassified wage index. If the DPU falls in a CBSA eligible to receive the section 505 out-commuting adjustment, the DPU's final wage index should consist of the geographic wage index plus the appropriate out-commuting adjustment.

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

Cancer and children's hospitals are permanently held harmless under section 1833(t)(7)(D)(ii) of the Social Security Act and continue to receive hold harmless TOPs permanently. For CY 2014, cancer hospitals will continue to receive an additional payment adjustment.

b.) Updating the OPSF for the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) Requirements

Effective for OPPS services furnished on or after January 1, 2009, Subsection (d) hospitals that have failed to submit timely hospital outpatient quality data as required in Section 1833(t)(17)(A) of the Act will receive payment under the OPPS that reflects a 2 percentage point deduction from the annual OPPS update for failure to meet the HOP QDRP requirements. This reduction will not apply to hospitals not required to submit quality data or hospitals that are not paid under the OPPS.

For January 1, 2014, contractors shall maintain the accuracy of the provider records in the OPSF by updating the Hospital Quality Indicator field. CMS will release a Technical Direction Letter that lists Subsection (d) hospitals that are subject to and fail to meet the HOP QDRP requirements. Once this list is released, FIs/MACs will update the OPSF by removing the '1', (that is, ensure that the Hospital Quality Indicator field is blank) for all hospitals identified on the list and will ensure that the OPSF Hospital Quality Indicator field contains '1' for all hospitals that are not on the list. CMS notes that if these hospitals are later determined to have met the HOP QDRP requirements, FIs/MACs shall update the OPSF. For greater detail regarding updating the OPSF for the HOP QDRP requirements, see Transmittal 368, CR 6072, issued on August 15, 2008.

c.) Updating the OPSF for the Outpatient Cost to Charge Ratio (CCR)

As stated in Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, Section 50.1, contractors must maintain the accuracy of the data and update the OPSF as changes occur in data element values, including changes to provider cost–to-charge ratios. The file of OPPS hospital upper limit CCRs and the file of Statewide CCRs are located on the CMS Web site at www.cms.gov/HospitalOutpatientPPS/ under "*Annual Policy Files*."

d.) Updating the OPSF for Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals Under §412.103

An urban hospital that reclassifies as a rural hospital under §412.103 is considered rural. The FIs and A/B MACs shall enter the rural CBSA (2-digit State code) in the Wage Index Location CBSA field in the OPSF rather than the urban CBSA corresponding to their actual location to ensure correct payment under the OPPS**.** Please reference Table 9 C of the FY 2014 IPPS Final rule**.**

13. 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. Medicare Administrative Contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8572.1	Medicare contractors shall install the January 2014 OPPS Pricer.	X				X				COBC
8572.2	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1. Have dates of service that fall on or after October 1, 2013, but prior to January 1, 2014; 2. Contain HCPCS code C1204; and 3. Were originally processed prior to the installation of the January 2014 OPPS Pricer.	X								COBC
8572.3	As specified in chapter 4, section 50.1, Medicare contractors shall maintain the accuracy of the data and update the OPSF file as changes occur in data element values. For CY 2013, this includes all changes to the OPSF identified in Section 12 of this Change Request.	X								COBC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8572.4	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X				

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: None

V. CONTACTS

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

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

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

Attachments (2)

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

Table of Contents

(Rev.2845, Issued: 12-27-13)

10.6.3.2 - Payment Adjustment for Certain Cancer Hospitals for CY 2014
(Rev.2845, Issued: 12-27-13, Effective: 01-01-14, Implementation: 01-06-14)

The target PCR that should be used in the calculation of the interim monthly payments associated with the cancer hospital adjustment, as described above in section 10.6.3, and at final cost report settlement is 0.89 for hospital outpatient services furnished on or after January 1, 2014 through December 31, 2014.

200.3.3 - Billing for Stereotactic Radiosurgery (SRS) Planning and Delivery
(Rev.2845, Issued: 12-27-13, Effective: 01-01-14, Implementation: 01-06-14)

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

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

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

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

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

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

200.9 - Billing for "Sometimes Therapy" Services that May be Paid as Non-Therapy Services for Hospital Outpatients

(Rev.2845, Issued: 12-27-13, Effective: 01-01-14, Implementation: 01-06-14)

Section 1834(k) of the Act, as added by Section 4541 of the BBA, allows payment at 80 percent of the lesser of the actual charge for the services or the applicable fee schedule amount for all outpatient therapy services; that is, physical therapy services, speech-language pathology services, and occupational therapy services. As provided under Section 1834(k)(5) of the Act, a therapy code list was created based on a uniform coding system (that is, the HCPCS) to identify and track these outpatient therapy services paid under the Medicare Physician Fee Schedule (MPFS).

The list of therapy codes, along with their respective designation, can be found on the CMS Website, specifically at http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage. Two of the designations that are used for therapy services are: "always therapy" and "sometimes therapy." An "always therapy" service must be performed by a qualified therapist under a certified therapy plan of care, and a "sometimes therapy" service may be performed by an individual outside of a certified therapy plan of care.

Under the OPPS, separate payment is provided for certain services designated as "sometimes therapy" services if these services are furnished to hospital outpatients as a non-therapy service, that is, without a certified therapy plan of care. Specifically, to be paid under the OPPS for a non-therapy service, hospitals SHOULD NOT append the therapy modifier GP (physical therapy), GO (occupational therapy), or GN (speech language pathology), or report a therapy revenue code 042x, 043x, or 044x in association with the "sometimes therapy" codes listed in the table below.

To receive payment under the MPFS, when "sometimes therapy" services are performed by a qualified therapist under a certified therapy plan of care, providers should append the appropriate therapy modifier GP, GO, or GN, and report the charges under an appropriate therapy revenue code, specifically 042x, 043x, or 044x. This instruction does not apply to claims for "sometimes therapy" codes furnished as therapy services in the hospital outpatient department and paid under the OPPS.

Effective January 1, 2010, CPT code 92520 (Laryngeal function studies (i.e., aerodynamic testing and acoustic testing)), is newly designated as a "sometimes therapy" service under the MPFS. CPT code 92520 is not a new code, however, its "sometimes therapy" designation is new and effective January 1, 2010. Under the OPPS, hospitals will receive separate payment when they bill CPT code 92520 as a non-therapy service.

The list of HCPCS codes designated as "sometimes therapy" services that may be paid as non-therapy services when furnished to hospital outpatients *following* January 1, 2010, is displayed in the table below.

Services Designated as "Sometimes Therapy" that May be Paid as Non-Therapy Services for Hospital Outpatients

HCPCS Code	Long Descriptor
92520	Laryngeal function studies (i.e., aerodynamic testing and acoustic testing)
97597	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters
97598	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area greater than 20 square centimeters
97602	Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (e.g., wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session
97605	Negative pressure wound therapy (e.g., vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters
97606	Negative pressure wound therapy (e.g., vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters
97610	Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day
G0456	Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters
G0457	Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters

Attachment A. − Tables for the Policy Section

Table 1 – New Services Payable under OPPS Effective January 1, 2014

HCPCS	Effective date	SI	APC	Short Descriptor	Long descriptor	Payment	Minimum Unadjusted Copayment
C9737	1/01/2014	T	0174	Lap esoph augmentation	Laparoscopy, surgical, esophageal sphincter augmentation with device (eg, magnetic band)	See Addendum B of CY 2014 final rule	See Addendum B of CY 2014 final rule

Table 2 – CPT Codes that are Reportable for SRS Delivery Services Effective January 1, 2014

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

Table 3 – CPT Codes that are Reportable for SRS Planning Services Effective January 1, 2014

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

Table 4 -– New CY 2014 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2014 HCPCS Code	CY 2014 Long Descriptor	CY 2014 SI	CY 2014 APC
A9575	Injection, Gadoterate Meglumine, 0.1 mL	N	
A9586	Florbetapir f18, diagnostic, per study dose, up to 10 millicuries	N	
A9599	Radiopharmaceutical, Diagnostic, For Beta-amyloid Positron Emission Tomography (PET) Imaging, Per Study Dose	N	
C9133	Factor ix (antihemophilic factor, recombinant), Rixubis, per i.u.	G	1467

C9441	Injection, ferric carboxymaltose, 1 mg	G	9441
C9497	Lozapine, inhalation powder, 10 mg	G	9497
J0401	Injection, Aripiprazole, Extended Release, 1 mg	K	1468
J1446	Injection, TBO-Filgrastim, 5 micrograms	E	
J1602	Injection, golimumab, 1 mg, for intravenous use	K	1474
J7508	Tacrolimus, Extended Release, Oral, 0.1 mg	G	1465
J9371	Injection, Vincristine Sulfate Liposome, 1 mg	G	1466
Q4137	Amnioexcel or Biodexcel, Per Square Centimeter	N	
Q4138	BioDfence DryFlex, Per Square Centimeter	N	
Q4139	AmnioMatrix or BioDMatrix, injectable, 1 cc	N	
Q4140	Biodfence, Per Square Centimeter	N	
Q4141	Alloskin AC, Per Square Centimeter	N	
Q4142	XCM Biologic Tissue Matrix, Per Square Centimeter	N	
Q4143	Repriza, Per Square Centimeter	N	
Q4145	Epifix, Injectable, 1mg	N	
Q4146	Tensix, Per Square Centimeter	N	
Q4147	Architect Extracellular Matrix, Per Square Centimeter	N	
Q4148	Neox 1k, Per Square Centimeter	N	
Q4149	Excellagen, 0.1 cc	N	

Table 5 -– Other CY 2014 HCPCS and CPT Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2013 HCPCS /CPT code	CY 2013 Long Descriptor	CY 2014 HCPCS /CPT Code	CY 2014 Long Descriptor
C1204	Technetium Tc 99m tilmanocept, diagnostic, up to 0.5 millicuries	A9520	Technetium Tc 99m tilmanocept, diagnostic, up to 0.5 millicuries
J0152	Injection, adenosine for diagnostic use, 30 mg (not to be used to report any adenosine phosphate compounds)	J0151	Injection, Adenosine For Diagnostic Use, 1 mg (not to be used to report any Adenosine Phosphate Compounds, Instead use A9270)
J0718	Injection, certolizumab pegol, 1 mg	J0717	Injection, certolizumab pegol , 1 mg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)
J1440	Injection, filgrastim (g-csf), 300 mcg	J1442	Injection, Filgrastim (G-CSF), 1 microgram
J1441	Injection, filgrastim (g-csf), 480 mcg	J1442	Injection, Filgrastim (G-CSF), 1 microgram
C9130	Injection, immune globulin (Bivigam), 500 mg	J1556	Injection, immune globulin (Bivigam), 500 mg
C9294	Injection, taliglucerase alfa, 10 units	J3060	Injection, taliglucerase alfa, 10 units
Q2051*	Injection, Zoledronic Acid, Not Otherwise Specified, 1 mg	J3489	Injection, Zoledronic Acid, 1mg
C9298	Injection, ocriplasmin, 0.125 mg	J7316	Injection, Ocriplasmin, 0.125mg
C9295	Injection, carfilzomib, 1 mg	J9047	Injection, carfilzomib, 1 mg
C9297	Injection, omacetaxine mepesuccinate, 0.1 mg	J9262	Injection, omacetaxine mepesuccinate, 0.01 mg
C9292	Injection, pertuzumab, 10 mg	J9306	Injection, pertuzumab, 1 mg

CY 2013 HCPCS /CPT code	CY 2013 Long Descriptor	CY 2014 HCPCS /CPT Code	CY 2014 Long Descriptor
C9131	Injection, ado-trastuzumab emtansine, 1 mg	J9354	Injection, ado-trastuzumab emtansine, 1 mg
C9296	Injection, ziv-aflibercept, 1 mg	J9400	Injection, Ziv-Aflibercept, 1 mg
Q0171	Chlorpromazine hydrochloride, 10 mg, oral, fda approved prescription	Q0161	Chlorpromazine hydrochloride, 5 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen
Q0172	Chlorpromazine hydrochloride, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotheapy treatment, not to exceed a 48-hour dosage regimen	Q0161	Chlorpromazine hydrochloride, 5 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen
Q2027	Injection, Sculptra, 0.1 ml	Q2028	Injection, Sculptra, 0.5 mg
Q3025	Injection, interferon beta-1a, 11 mcg for intramuscular use	Q3027	Injection, Interferon Beta-1a, 1 mcg For Intramuscular Use

Table 6 – Updated payment Rates for Certain HCPCS Codes
Effective October 1, 2013 through December 31, 2013

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
A9520	G	1463	Tc 99m tilmanocept	$223.15	$0.00

Table 7 – Skin Substitute Product Assignment to High Cost/Low Cost Status for CY 2014

CY 2014 HCPCS Code	CY 2014 Short Descriptor	CY 2014 SI	Low/High Cost Skin Substitute
C9358	SurgiMend, fetal	N	Low
C9360	SurgiMend, neonatal	N	Low
C9363	Integra Meshed Bil Wound Mat	N	Low
Q4100	Skin substitute, NOS	N	Low
Q4101	Apligraf	N	High
Q4102	Oasis wound matrix	N	Low
Q4103	Oasis burn matrix	N	Low
Q4104	Integra BMWD	N	Low
Q4105	Integra DRT	N	Low
Q4106	Dermagraft	N	High
Q4107	Graftjacket	N	High
Q4108	Integra matrix	N	Low
Q4110	Primatrix	N	High
Q4111	Gammagraft	N	Low

CY 2014 HCPCS Code	CY 2014 Short Descriptor	CY 2014 SI	Low/High Cost Skin Substitute
Q4115	Alloskin	N	Low
Q4116	Alloderm	N	High
Q4117	Hyalomatrix	N	Low
Q4119	Matristem wound matrix	N	Low
Q4120	Matristem burn matrix	N	Low
Q4121	Theraskin	N	Low
Q4122	Dermacell	G	n/a
Q4123	Alloskin	N	Low
Q4124	Oasis tri-layer wound matrix	N	Low
Q4125	Arthroflex	N	High
Q4126	Memoderm/derma/tranz/integup	N	High
Q4127	Talymed	G	n/a
Q4128	Flexhd/Allopatchhd/matrixhd	N	Low
Q4129	Unite biomatrix	N	Low
Q4131	Epifix	G	n/a
Q4132	Grafix core	G	n/a
Q4133	Grafix prime	G	n/a
Q4134	hMatrix	N	High
Q4135	Mediskin	N	Low
Q4136	EZderm	N	Low
Q4137	Amnioexcel or biodexcel, 1cm	N	Low
Q4138	BioDfence DryFlex, 1cm	N	Low
Q4140	Biodfence 1cm	N	Low
Q4141	Alloskin ac, 1 cm	N	Low
Q4142	Xcm biologic tiss matrix 1cm	N	Low
Q4143	Repriza, 1cm	N	Low
Q4146	Tensix, 1cm	N	Low
Q4147	Architect ecm, 1cm	N	Low
Q4148	Neox 1k, 1cm	N	Low

Table 8 – Wage Index by CBSA for Non-IPPS Hospitals that are Eligible for the Section 505 Out-Commuting Adjustment

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2014
012011	11500	YES	0.7337
013027	01	YES	0.7243
013032	23460	YES	0.7902
014006	23460	YES	0.7902
014016	01	YES	0.7304
014017	01	YES	0.7243
042007	38220	YES	0.8201
042011	04	YES	0.7597
052034	36084	YES	1.6462

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2014
052035	42044	YES	1.2508
052039	42044	YES	1.2508
052053	42044	YES	1.2508
053034	42044	YES	1.2508
053301	36084	YES	1.6462
053304	42044	YES	1.2508
053306	42044	YES	1.2508
053308	42044	YES	1.2508
054074	46700	YES	1.5906
054110	36084	YES	1.6462
054122	34900	YES	1.5215
054135	42044	YES	1.2508
054141	46700	YES	1.5906
054146	36084	YES	1.6462
062017	22660	YES	0.9598
064007	14500	YES	0.9696
074003	25540	YES	1.3133
074007	25540	YES	1.3133
102028	10	YES	0.8445
114018	11	YES	0.7734
132001	17660	YES	0.9447
153040	15	YES	0.8553
154014	15	YES	0.8545
154035	15	YES	0.8479
154047	15	YES	0.8553
154058	15	YES	0.8553
183028	21060	YES	0.7978
184012	21060	YES	0.7978
192022	19	YES	0.7719
192026	19	YES	0.7904
192034	19	YES	0.7783
192036	19	YES	0.7888
192040	19	YES	0.7888
192050	19	YES	0.7822
193036	19	YES	0.7783
193044	19	YES	0.7888
193047	19	YES	0.7784
193049	19	YES	0.7784
193055	19	YES	0.7732
193058	19	YES	0.7733
193063	19	YES	0.7888
193067	19	YES	0.7735
193068	19	YES	0.7888
193069	19	YES	0.7733
193073	19	YES	0.7783
193079	19	YES	0.7888

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2014
193081	19	YES	0.7822
193088	19	YES	0.7822
193091	19	YES	0.7729
194047	19	YES	0.7904
194075	19	YES	0.7735
194077	19	YES	0.7719
194081	19	YES	0.7705
194082	19	YES	0.7735
194083	19	YES	0.7733
194085	19	YES	0.7822
194087	19	YES	0.7719
194091	19	YES	0.7888
194092	19	YES	0.7703
194095	19	YES	0.7783
194097	19	YES	0.7822
212002	25180	YES	0.9337
214003	25180	YES	0.9337
232019	19804	YES	0.9289
232025	35660	YES	0.8601
232027	19804	YES	0.9289
232028	12980	YES	0.9708
232031	19804	YES	0.9289
232032	19804	YES	0.9289
232035	12980	YES	0.9708
232036	27100	YES	0.9235
232038	19804	YES	0.9289
233025	12980	YES	0.9708
233027	19804	YES	0.9289
233300	19804	YES	0.9289
234028	19804	YES	0.9289
234034	19804	YES	0.9289
234035	19804	YES	0.9289
234038	19804	YES	0.9289
234040	19804	YES	0.9289
252011	25	YES	0.7965
264005	26	YES	0.8137
303026	40484	YES	1.1962
304001	40484	YES	1.1962
312018	20764	YES	1.1377
312020	35084	YES	1.1387
312024	35084	YES	1.1478
313025	35084	YES	1.1478
313300	20764	YES	1.1377
314010	35084	YES	1.1478
314011	20764	YES	1.1377
314016	35084	YES	1.1387

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2014
314020	35084	YES	1.1478
334017	39100	YES	1.1921
334049	10580	YES	0.8611
334061	39100	YES	1.1921
342019	34	YES	0.8279
344001	39580	YES	0.9192
344011	39580	YES	0.9192
344014	39580	YES	0.9192
362016	15940	YES	0.8498
362032	15940	YES	0.8498
364031	15940	YES	0.8498
364040	44220	YES	0.8583
364042	36	YES	0.8439
364043	36	YES	0.8468
364047	36	YES	0.8468
372017	37	YES	0.7755
372019	37	YES	0.8029
373032	37	YES	0.7755
392031	27780	YES	0.8687
392034	10900	YES	0.9377
393026	39740	YES	0.9331
393037	49620	YES	0.9415
393050	10900	YES	1.1374
394014	39740	YES	0.9331
394020	30140	YES	0.8794
394052	39740	YES	0.9331
422004	43900	YES	0.8658
423029	11340	YES	0.8885
424011	11340	YES	0.8885
424013	42	YES	0.8307
444008	44	YES	0.7777
444019	17300	YES	0.8074
452018	23104	YES	0.9473
452019	23104	YES	0.9473
452028	23104	YES	0.9473
452088	23104	YES	0.9473
452099	23104	YES	0.9473
452110	23104	YES	0.9473
453040	23104	YES	0.9473
453041	23104	YES	0.9473
453042	23104	YES	0.9473
453089	45	YES	0.8044
453094	23104	YES	0.9473
453300	23104	YES	0.9473
454009	45	YES	0.8108
454012	23104	YES	0.9473

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2014
454101	45	YES	0.8111
454113	23104	YES	0.9473
462005	39340	YES	0.9296
464014	39340	YES	0.9296
522005	39540	YES	0.9216
523302	36780	YES	0.9285
524002	36780	YES	0.9285
673035	23104	YES	0.9473
673044	23104	YES	0.9473
673048	23104	YES	0.9473