CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3602	**Date: August 26, 2016**
	Change Request 9768

SUBJECT: October 2016 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 2016 OPPS update. The October 2016 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). This Recurring Update Notification applies to Chapter 4, section 50.8.

The October 2016 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming October 2016 I/OCE CR.

EFFECTIVE DATE: October 1, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 3, 2016

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

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

IV. ATTACHMENTS:

Recurring Update Notification

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 3602	Date: August 26, 2016	Change Request: 9768

SUBJECT: October 2016 Update of the Hospital Outpatient Prospective Payment System (OPPS)

EFFECTIVE DATE: October 1, 2016
**Unless otherwise specified, the effective date is the date of service.*
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I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the October 2016 OPPS update. The October 2016 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). This Recurring Update Notification applies to Chapter 4, section 50.8.

The October 2016 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming October 2016 I/OCE CR.

B. Policy:

1. New Separately Payable Procedure Code

Effective October 1, 2016 a new HCPCS code C9744 has been created. Table 1, attachment A, provides the short and long descriptors and the APC placement for this new code.

2. Smoking Cessation Codes

Effective September 30, 2016, HCPCS codes G0436 (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) and G0437 (Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes) are deleted. The services previously represented by HCPCS codes G0436 and G0437 should be billed under existing CPT codes 99406 (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) and 99407 (Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes) respectively. See table 2, attachment A.

3. Reporting for Certain Outpatient Department Services (That Are Similar to Therapy Services) ("Non-Therapy Outpatient Department Services") That Are Adjunctive to Comprehensive APC Procedures

Non-therapy outpatient department services are services such as physical therapy, occupational therapy, and speech-language pathology provided during the perioperative period (of a Comprehensive APC (C-APC) procedure) without a certified therapy plan of care. These are not therapy services as described in section 1834(k) of the Act, regardless of whether the services are delivered by therapists or other non-therapist health care workers. Therapy services are those provided by therapists under a plan of care in accordance with section 1835(a)(2)(C) and section 1835(a)(2)(D) of the Act and are paid for under section 1834(k) of the Act, subject to annual therapy caps as applicable (78 FR 74867 and 79 FR 66800). Because these services are outpatient department services and not therapy services, the requirement for functional reporting under the regulations at 42 CFR 410.59(a)(4) and 42 CFR 410.60(a)(4) does not apply.

The comprehensive APC payment policy packages payment for adjunctive items, services, and procedures into the most costly primary procedures under the OPPS at the claim level. When non-therapy outpatient

department services are included on the same claim as a C-APC procedure (status indicator (SI) = J1) (*see* 80 FR 70326) or the specific combination of services assigned to the Observation Comprehensive APC 8011 (SI = J2), these services are considered adjunctive to the primary procedure. Payment for non-therapy outpatient department services is included as a packaged part of the payment for the C-APC procedure.

Effective for claims received on or after October 1, 2016 with dates of service on or after January 1, 2015, providers may report non-therapy outpatient department services (that are similar to therapy services) that are adjunctive to a C-APC procedure (SI = J1) or the specific combination of services assigned to the Observation Comprehensive APC 8011 (SI = J2), in one of two ways:

1. Without using the therapy CPT codes and instead reporting these non-therapy services with Revenue Code 0940 (Other Therapeutic Services); or

2. Reporting non-therapy outpatient department services that are adjunctive to J1 or J2 services with the appropriate occurrence codes, CPT codes, modifiers, revenue codes and functional reporting requirements.

4. Advanced Care Planning (ACP)

Effective January 1, 2016 payment for the service described by CPT code 99497 (Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate) is conditionally packaged under the OPPS and is consequently assigned to a conditionally packaged payment status indicator of ‘‘Q1.’’ When this service is furnished with another service paid under the OPPS, payment is packaged; when it is the only service furnished, payment is made separately. CPT code 99498 (Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)) is an add-on code and therefore payment for the service described by this code is unconditionally packaged (assigned status indicator ‘‘N’’) in the OPPS in accordance with 42 CFR 419.2(b)(18).

5. Drugs, Biologicals, and Radiopharmaceuticals

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective October 1, 2016

Payment for separately payable nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals (status indicator “K”) 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 addition, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals (status indicator “G”) 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. Updated payment rates effective October 1, 2016 and drug price restatements can be found in the October 2016 update of the OPPS Addendum A and Addendum B on the CMS Web site at http://www.cms.gov/HospitalOutpatientPPS/.

b. Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates

Some drugs and biologicals paid based on the ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the CMS Web site on the first date of the quarter at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html?redirect=/HospitalOutpatientPPS/01_overview.asp.

Providers may resubmit claims that were impacted by adjustments to previous quarter's payment files.

c. Drugs and Biologicals with OPPS Pass-Through Status Effective October 1, 2016

Four drugs and biologicals have been granted OPPS pass-through status effective October 1, 2016. These items, along with their descriptors and APC assignments, are identified in table 3, attachment A.

d. Revised Status Indicator for Biosimilar Biological Product

On April 5, 2016, a biosimilar biological product, Inflectra®, was approved by the FDA.

Due to the unavailability of pricing information, Inflectra®, described by CPT code Q5102 (Injection, Infliximab, Biosimilar, 10 mg), is assigned SI= E (Not paid under OPPS or any other Medicare payment system.) Inflectra® was previously assigned SI= K (Separately paid nonpass-through drugs and biologicals, including therapeutic radiopharmaceuticals) in the July 2016 update. This change is effective July 1, 2016.

Table 4 in attachment A lists the code and the effective date for the status indicator change.

e. Billing Guidance for the Topical Application of Mitomycin During or Following Ophthalmic Surgery

Hospital outpatient departments should only bill HCPCS code J7315 (Mitomycin, ophthalmic, 0.2 mg) or HCPCS code J7999 (Compounded drug, not otherwise classified) for the topical application of mitomycin during or following ophthalmic surgery. J7315 may be reported only if the hospital uses mitomycin with the trade name Mitosol®. Any other topical mitomycin should be reported with J7999. Hospital outpatient departments are not permitted to bill HCPCS code J9280 (Injection, mitomycin, 5 mg) for the topical application of mitomycin.

6. Changes to OPPS Pricer Logic

a. ASP Fee Amounts Moves from the OPPS Pricer to the Fiscal Intermediary Shared System (FISS)

Outpatient PPS drug pricing will now apply the ASP fee schedule amounts from the standard system and not the OPPS Pricer. OPPS covered drugs with allowed payment amounts will continue to have Status Indicators "G" and "K" applied. Drugs that are listed as packaged under OPPS will continue to be packaged with this change of payment application systems. (See CR9479, CR9501, and CR9601 for more system logic details).

b. Outpatient Coinsurance Cap Logic as ASP Payment for Drugs Moves from the OPPS Pricer to the Fiscal Intermediary Shared System (FISS)

Outpatient procedure coinsurance is capped to the inpatient deductible limit (IP Limit). The cap is calculated by adding the highest wage adjusted national coinsurance amount for the procedure line (identified by status indicators S, T, V, P, J1 or J2) plus the coinsurance for the blood products (identified by status indicator "R") and comparing to the inpatient Part A deductible. The difference is the amount of coinsurance to be applied to the ASP drug lines. The coinsurance of the ASP drug lines with the same dates of service as the procedure code are added together. The coinsurance reduction percentage is calculated by dividing the amount of coinsurance to be applied to the ASP drug lines by the total coinsurance of the ASP drug lines. The coinsurance amount for each of ASP drug lines should be reduced by the multiplication of the drug line coinsurance and the coinsurance reduction percentage. The difference between the original coinsurance and the reduced coinsurance is then added to the payment. CMS' shared system will cap the coinsurance for the drugs with status indicator G or K (except for Pass-Through drugs with a Payment Adjustment Flags (PAF) 10, or 18-20 [indicating no coinsurance applies]) that was not assigned to the IP Limit for the calendar year. (See attachment B for claim examples).

c. Pass-through Drug Offset Moves from the OPPS Pricer to the Shared System

Outpatient Pass-Through drugs with offsets will be identified by the I/OCE payer only value codes (QR, QS, and QT) when appropriate pairings are found on the claim. Offsets will continue to be wage-adjusted prior to application and will apply to the drug line(s) payment amount. Pass-Through Drugs with are eligible for an offset continue to not have coinsurance applied whether the off-set is made or not.

7. Coverage Determinations

As a reminder, 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	
9768.1	Medicare contractors shall install the October 2016 OPPS Pricer.	X		X		X				BCRC
9768.2	Medicare contactors shall manually add the following codes to their systems: • HCPCS code C9744, listed in table 1, attachment A, effective October 1, 2016; • HCPCS codes C9139-C9483, listed in table 3, attachment A, effective October 1, 2016; • HCPCS codes G0490, G9679-G9686, listed in the upcoming October 2016 I/OCE CR, effective October 1, 2016; **Note:** These HCPCS codes will be included with the October 2016 I/OCE update. Status and payment indicators for these HCPCS codes will be listed in the October 2016 update of the OPPS Addendum A and Addendum B on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html	X		X						BCRC
9768.3	Medicare contactors shall add the termination date of	X		X						BCRC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	September 30, 2016, to the following HCPCS codes in their systems: • HCPCS codes G0436-G0437 listed in table 2, attachment A; **Note:** These deletions will be reflected in the October 2016 I/OCE update and in the October 2016 Update of the OPPS Addendum A and Addendum B on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html									
9768.4	Medicare contractors shall allow HCPCS codes 99497 and 99498 to be reported on Critical Access Hospital (CAH) claims for 85X type of bills (TOBs) with revenue codes 096x, 097x and 098x, on Outpatient Prospective Payment System (OPPS) for TOB 13X with revenue codes 051x, on Rural Health Clinic (RHC) claims for TOBs 71X with revenue code 052x, and Federally Qualified Health Clinic (FQHC) claims for TOBs 77X with revenue code 052X for dates of service on or after January 1, 2016.	X		X						BCRC
9768.5	Medicare contractors shall adjust, as appropriate, claims brought to their attention with any retroactive changes that were received prior to implementation of October 2016 OPPS Pricer.	X		X						BCRC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9768.6	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	X		X		

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the 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.					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

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

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

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 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.

ATTACHMENTS: 2

Attachment A − Tables for the Policy Section

Table 1 – New Separately Payable Procedure Code Effective October 1, 2016

HCPCS	Short Descriptor	Long Descriptor	OPPS SI	OPPS APC	Effective Date
C9744	Abd us w/contrast	Ultrasound, abdominal, with contrast	S	5571	10/01/2016

Table 2 – Deleted Smoking Cessation HCPCS Codes and the Existing Replacement CPT Codes

Deleted HCPCS Code	Long Description	Add Date	Termination Date	Existing Replacement CPT Code
G0436	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	01/01/2008	09/30/2016	99406
G0437	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	01/01/2008	09/30/2016	99407

Table 3 – Drugs and Biologicals with OPPS Pass-Through Status Effective October 1, 2016

HCPCS Code	Long Descriptor	SI	APC
C9139	Injection, Factor IX, albumin fusion protein (recombinant), Idelvion, 1 i.u.	G	9171
C9481	Injection, reslizumab, 1 mg	G	9481
C9482	Injection, sotalol hydrochloride, 1 mg	G	9482
C9483	Injection, atezolizumab, 10 mg	G	9483

Table 4 – Drugs and Biologicals with Revised Status Indicators

HCPCS Code	Long Descriptor	OPPS SI	Effective Date
Q5102	Injection, Infliximab, Biosimilar, 10 mg	E	07/01/2016

Attachment B – Claim Examples

Example 1 of inpatient deductible capped amount:

Drug Line A has a fee of $2,000.00, a payment of $1,600.00, and coinsurance of $400.00.
Drug Line B has a fee of $1,000.00, a payment of $800.00, and coinsurance of $200.00.
Drug Line C has a fee of $500.00, a payment of $400.00 and coinsurance of $100.00.
Drug Line D has a fee of $500.00, a payment of $400.00 and coinsurance of $100.00.

Highest wage adjusted national coinsurance amount for a procedure line is $888.00.

The Inpatient Part A deductible is $1,288.00 for 2016

$1,288.00 - $888.00 = $400.00 remaining coinsurance to be applied toward inpatient deductible cap.

Drug Lines A-D coinsurance is $800.00.

$400.00 cap remaining / $800.00 drug line(s) coinsurance = 50% reduction to coinsurance due to inpatient deductible cap

Apply 50% reduction of the coinsurance amounts for each line and add the remaining 50% back into the payment amount.

Drug Line A has a final payment of $1,800.00, and coinsurance of $200.00.
Drug Line B has a final payment of $900.00, and coinsurance of $100.00.
Drug Line C has a final payment of $450.00, and coinsurance of $50.00.
Drug Line D has a final payment of $450.00, and coinsurance of $50.00.

Example 2 of inpatient deductible capped amount:

Drug Line A has a fee of $2,000.00, a payment of $1,600.00, and coinsurance of $400.00.
Drug Line B has a fee of $1,000.00, a payment of $800.00, and coinsurance of $200.00.
Drug Line C has a fee of $500.00, a payment of $400.00 and coinsurance of $100.00.
Drug Line D has a fee of $500.00, a payment of $400.00 and coinsurance of $100.00.

Highest wage adjusted national coinsurance amount for a procedure line is $1,588.00.

The Inpatient Part A deductible is $1,288.00 for 2016

$1,588.00 is greater than $1,288.00. The OPPS Pricer will cap the coinsurance amount to be applied on the highest wage adjusted national coinsurance procedure line prior to application of the cap on the drug lines.

Drug Lines A-D coinsurance is $800.00.

$0 cap remaining / $800.00 = 100% reduction to coinsurance due to inpatient deductible cap

Drug Line A has a final payment of $2,000.00, and no coinsurance.
Drug Line B has a final payment of $1,000.00, and no coinsurance.
Drug Line C has a final payment of $500.00, and no coinsurance.
Drug Line D has a final payment of $500.00, and no coinsurance.

Example 3 of inpatient deductible capped amount with procedure, blood, and drug lines:

Drug Line A has a fee of $2,000.00, a payment of $1,600.00, and coinsurance of $400.00.
Drug Line B has a fee of $1,000.00, a payment of $800.00, and coinsurance of $200.00.
Drug Line C has a fee of $500.00, a payment of $400.00 and coinsurance of $100.00.
Drug Line D has a fee of $500.00, a payment of $400.00 and coinsurance of $100.00.

Highest wage adjusted national coinsurance amount for a procedure line is $800.00.

Coinsurance on blood line is 88.00.

The Inpatient Part A deductible is $1,288.00 for 2016

$1,288.00 - $888.00 = $400.00 remaining coinsurance to be applied toward inpatient deductible cap.

Drug Lines A-D coinsurance is $800.00.

$400.00 cap remaining / $800.00 drug line(s) coinsurance = 50% reduction to coinsurance due to inpatient deductible cap

Apply 50% reduction of the coinsurance amounts for each line and add the remaining 50% back into the payment amount.

Drug Line A has a final payment of $1,800.00, and coinsurance of $200.00.
Drug Line B has a final payment of $900.00, and coinsurance of $100.00.
Drug Line C has a final payment of $450.00, and coinsurance of $50.00.
Drug Line D has a final payment of $450.00, and coinsurance of $50.00.

<u>Example 4 of inpatient deductible capped amount equals procedure, blood, and drug line coinsurance:</u>

Drug Line A has a fee of $200.00, a payment of $160.00, and coinsurance of $40.00.
Drug Line B has a fee of $100.00, a payment of $80.00, and coinsurance of $20.00.
Drug Line C has a fee of $50.00, a payment of $40.00 and coinsurance of $10.00.
Drug Line D has a fee of $50.00, a payment of $40.00 and coinsurance of $10.00.

Highest wage adjusted national coinsurance amount for a procedure line is $1,120.00.

Coinsurance on blood line is 88.00.

The Inpatient Part A deductible is $1,288.00 for 2016

$1,288.00 - $1208.00 = $80.00 remaining coinsurance to be applied toward inpatient deductible cap.

Drug Lines A-D coinsurance is $80.00.

$80.00 cap remaining - $80.00 drug line(s) coinsurance = reduction to coinsurance due to inpatient deductible cap does not apply

Drug Line A has a fee of $200.00, a payment of $160.00, and coinsurance of $40.00.
Drug Line B has a fee of $100.00, a payment of $80.00, and coinsurance of $20.00.
Drug Line C has a fee of $50.00, a payment of $40.00 and coinsurance of $10.00.
Drug Line D has a fee of $50.00, a payment of $40.00 and coinsurance of $10.00.

<u>Example 5 of procedure and blood coinsurance equal inpatient deductible cap:</u>

Drug Line A has a fee of $2,000.00, a payment of $1,600.00, and coinsurance of $400.00.
Drug Line B has a fee of $1,000.00, a payment of $800.00, and coinsurance of $200.00.
Drug Line C has a fee of $500.00, a payment of $400.00 and coinsurance of $100.00.
Drug Line D has a fee of $500.00, a payment of $400.00 and coinsurance of $100.00.

Highest wage adjusted national coinsurance amount for a procedure line is $1200.00.

Coinsurance on blood line is 88.00.

The Inpatient Part A deductible is $1,288.00 for 2016

$1,288.00 - $1,288.00 = $0.00 remaining coinsurance to be applied toward inpatient deductible cap.

Drug Lines A-D coinsurance is $800.00.

$0.00 cap remaining / $800.00 drug line(s) coinsurance = 100% reduction to coinsurance due to inpatient deductible cap.

Apply 100% reduction of the coinsurance amounts for each line and add the remaining 100% back into the payment amount.

Drug Line A has a final payment of $2,000.00, and coinsurance of $0.00.
Drug Line B has a final payment of $1,000.00, and coinsurance of $0.00.
Drug Line C has a final payment of $500.00, and coinsurance of $0.00.
Drug Line D has a final payment of $500.00, and coinsurance of $0.00.

<u>Example 6 of part B deductible applies to drug charges prior to inpatient deductible capped amount:</u>

Drug Line A has a fee of $2,166.00, a deductible of $166.00, a payment of $1,600.00, and coinsurance of $400.00.
Drug Line B has a fee of $1,000.00, a payment of $800.00, and coinsurance of $200.00.
Drug Line C has a fee of $500.00, a payment of $400.00 and coinsurance of $100.00.
Drug Line D has a fee of $500.00, a payment of $400.00 and coinsurance of $100.00.

Highest wage adjusted national coinsurance amount for a procedure line is $888.00.

The Inpatient Part A deductible is $1,288.00 for 2016

$1,288.00 - $888.00 = $400.00 remaining coinsurance to be applied toward inpatient deductible cap.

Drug Lines A-D coinsurance is $800.00.

$400.00 cap remaining / $800.00 drug line(s) coinsurance = 50% reduction to coinsurance due to inpatient deductible cap

Apply 50% reduction of the coinsurance amounts for each line and add the remaining 50% back into the payment amount.

Drug Line A has a deductible of $166.00, a final payment of $1,800.00, and coinsurance of $200.00.
Drug Line B has a final payment of $900.00, and coinsurance of $100.00.
Drug Line C has a final payment of $450.00, and coinsurance of $50.00.
Drug Line D has a final payment of $450.00, and coinsurance of $50.00.