Program Memorandum Intermediaries

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 2503

SUBJECT: 2003 Update of the Hospital Outpatient Prospective Payment System (OPPS)

This Program Memorandum (PM) outlines changes in the OPPS for calendar year 2003. These changes were discussed in the OPPS final rule for 2003, which was published in the **Federal Register** on November 1, 2002. Unless otherwise noted, all changes discussed in this PM are effective for services furnished on or after January 1, 2003.

The PM addresses the following subjects:

I. Limitations on Beneficiary Co-payment
II. Outlier Payments
III. Outpatient billing for Dialysis
IV. Partial Hospitalization Program (PHP)
V. Billing and Payment Requirements for Observation Services
VI. Payment Policy When a Surgical Procedure on the Inpatient List Is Performed on an Emergency Basis or When a Patient Whose Status is Outpatient Dies
VII. New G Codes Under HCPCS and Status Under OPPS
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I. Limitations on Beneficiary Copayment

For calendar year 2003, the national unadjusted copayment amount for an ambulatory payment classification (APC) will be limited to 55 percent of the APC payment rate, as it was in 2002. In addition, the wage-adjusted copayment amount for a procedure or service cannot exceed the inpatient hospital deductible amount for 2003 of $840.

II. Outlier Payments

For calendar year 2003, the outlier threshold is reduced from 3.5 to 2.75 times the OPPS payments for the service, and the outlier payment percentage is reduced from 50 percent to 45 percent of the cost in excess of the outlier threshold. In 2003, outlier payments will be made if the cost of providing a service exceeds 2.75 times the OPPS payments for the service, and the amount of the outlier payment will be 45 percent of the amount by which the provider's costs exceed 2.75 times the OPPS payments.

III. Outpatient Billing For Dialysis

Generally, Medicare does not allow payment under the OPPS for routine dialysis treatments furnished to End Stage Renal Disease (ESRD) patients in the outpatient department of a hospital that does not have a certified dialysis facility. However, in certain medical situations in which the ESRD patient cannot obtain her or his regularly scheduled dialysis treatment at a certified ESRD facility, the OPPS rule for 2003 allows payment for non-routine dialysis treatments furnished to ESRD patients in the outpatient department of a hospital that does not have a certified dialysis facility. Payment is limited to unscheduled dialysis for ESRD patients in the following circumstances:

- Dialysis performed following or in connection with a vascular access procedure;
- Dialysis performed following treatment for an unrelated medical emergency; e.g., if a patient goes to the emergency room for chest pains and misses a regularly scheduled dialysis treatment that cannot be rescheduled, we allow the hospital to provide and bill Medicare for the dialysis treatment; or
- Emergency dialysis for ESRD patients who would otherwise have to be admitted as inpatients in order for the hospital to receive payment.

In these situations, non-ESRD certified hospital outpatient facilities are to bill Medicare using a new Healthcare Common Procedure Coding System (HCPCS) code, G0257 - *Unscheduled or emergency treatment for dialysis for ESRD patient in the outpatient department of a hospital that does not have a certified ESRD facility.* This new code is assigned to APC 0170, with status indicator (SI) "S".

Instruct your hospitals not to use G0257 to bill for the provision of dialysis treatment to patients with acute renal failure. At a later date, we will issue instructions governing the specific use of this code as well as develop system edits to monitor the use of this code to prevent potential fraud and abuse.

Because of current edits that are in effect related to Skilled Nursing Facility (SNF) consolidated billing, dialysis following or in connection with a vascular access procedure will not be separately payable when furnished by a hospital to beneficiaries who are in a covered Part A stay in a SNF. Separate instructions will be issued addressing the edit changes that will be made to pay for dialysis in this situation in the future.

IV. Partial Hospitalization Program (PHP)

A. Coding Partial Hospitalization Services

Addendum B of the November 1, 2002, CY 2003 OPPS final rule does not identify clearly all the HCPCS codes that are covered and may be billed for PHP patients. We plan to revise this addendum in the 2004 update so that all PHP services are identified. In addition, we are planning to update the provider and intermediary manuals. In the meantime, in order to avoid billing errors, we are providing the following list of the current revenue codes and HCPCS codes for PHPs:

Revenue Codes	Description	HCPCS Codes
250 *	Pharmacy	HCPCS code not required
43X	Occupational Therapy	G0129
904	Activity Therapy	G0176
910	Psychiatric General Services	90801, 90802, 90875, 90876, 90899
914	Individual Psychotherapy	90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829
915	Group Therapy	90849, 90853, 90857
916	Family Psychotherapy	90846, 90847, 90849
918	Psychiatric Testing	96100, 96115, 96117
942	Education/Training	G0177

* Limited to Medicare covered, i.e., not usually self-administered drugs

B. Billing of services furnished by Clinical Social Workers (CSWs)

In the August 9, 2002, OPPS proposed rule, we proposed to revise 410.43 to add clinical social worker (CSW) services that meet the requirements of section 1861(hh)(2) of the Act to the list of professional services not considered to be PHP services. Under this proposal, hospitals and community mental health centers (CMHCs) would have billed the carrier for CSW services furnished to PHP patients. However, in the November 2002 final rule, we indicated that we would not finalize this policy and would address the issue in a future rulemaking. Therefore, for CY 2003, hospitals and CMHCs will not bill the carrier for the professional services furnished by CSWs. Rather, the hospital's and CMHC's costs associated with the services of CSWs will continue to be billed to the intermediary and paid through the PHP per diem amount.

V. Billing and Payment Requirements for Observation Services

Under the OPPS, hospitals are required to bill for observation services in one of two ways: 1) as packaged services, or 2) as a separately payable APC when certain conditions are met for patients having diagnoses of chest pain, asthma, or congestive heart failure, for whom observation services are furnished.

A. Changes in Billing and Payment Requirements for Observation Services

1. Hospitals may bill for patients who are "direct admissions" to observation. A "direct admission" occurs when a physician in the community refers a patient to the hospital for observation, bypassing the clinic or emergency department (ED). Effective for services furnished on or after January 1, 2003, hospitals may bill for patients directly admitted for observation services using one of the following HCPCS codes:

a. G0263, *Direct admission of patient with diagnosis of congestive heart failure, chest pain or asthma for observation services that meet all criteria for G0244.*

b. G0264, Initial *nursing assessment of patient directly admitted to observation with diagnosis other than congestive heart failure, chest pain, or asthma or patient directly admitted to observation with diagnosis of congestive heart failure, chest pain or asthma when the observation stay does not meet all criteria for G0244.*

The determination of whether use of G0263 is appropriate will be made after reviewing all diagnoses submitted on the claim (e.g., admission, principal, and secondary diagnoses).

Code G0263 must be billed with G0244. Although code G0263 is treated as a packaged service and will not generate a payment under OPPS, the code will be recognized as taking the place of a visit or critical care code in meeting the observation criteria for patients directly admitted to observation.

Code G0264 should not be billed with G0244. G0264 is assigned to APC 0600 and is paid the same amount as a low-level clinic visit. This code provides a way to recognize and pay for the initial nursing assessment and any packaged observation services attributable to patients that are directly admitted to observation but whose observation services do not meet the criteria necessary to qualify for a separate observation payment.

2. Effective January 1, 2003, HCPCS code G0258*, Intravenous infusion(s) during separately payable observation stay, per observation stay (must be reported with G0244)*, is deleted from the OPPS. Hospitals should bill for infusion therapy provided during a separately payable observation stay (HCPCS code G0244) using Q0081, Infusion therapy other than chemotherapy. As with G0258, Q0081 may be reported for infusions started in the emergency department, clinic or observation area, so long as the infusion continues during the observation stay. An edit has been installed in the Outpatient Code Editor (OCE) to allow payment, effective for services furnished on or after April 1, 2002, for HCPCS code G0244 when billed with Q0081, subject to all other conditions for payment having been met.

B. Hospital Billing Requirements for Packaged Observation Services (for patients other than those with diagnoses of asthma, chest pain, or congestive heart failure)

1. Hospitals are required to report observation charges under revenue code 762. "Observation Room". HCPCS coding is not required but if reported, the appropriate HCPCS code(s) are 99217 through 99220 and 99234 through 99236.

2. In the units field, hospitals should enter the number of hours the outpatient is in observation status.

3. Hospitals should report laboratory, radiology, or other diagnostic services under revenue codes 30X, 31X, 32X, etc., as appropriate.

4. As stated in section A. above, when a physician in the community orders that an outpatient be directly admitted to observation, without going through the hospital's emergency department or clinic, the hospital should bill for the direct admission using HCPCS code G0264. Hospitals should report G0264 under revenue code 762.

5. Instruct hospitals to use G0264 to bill for an outpatient directly admitted to observation with a diagnosis of asthma, congestive heart failure or chest pain that does not qualify for G0244 because the required criteria are not fully met, e.g., the observation stay was less than eight hours, the qualifying diagnostic tests were not performed, etc.

C. Hospital Billing Requirements to Receive Separate Payment Under APC 339 for Observation Services Furnished to Patients With Diagnosis of Asthma, Chest Pain, or Congestive Heart Failure

1. To bill for separate payment under APC 339, hospitals should report HCPCS code G0244, *Observation care provided by a facility to a patient with CHF, chest pain, or asthma, minimum eight hours, maximum forty-eight hours*.

2. Admission requirements to bill for separate observation payment effective January 1, 2003:

   Hospitals must bill either an emergency department visit (APC 0610, 0611, or 0612) or a clinic visit (APC 0600, 0601,or 0602), or critical care (APC 620), or G0263, *Direct admission of patient with diagnosis of congestive heart failure, chest pain or asthma for observation services that meet all criteria for separate payment,* with each bill for separate observation payment using HCPCS G0244.

   a. To receive separate payment for G0244, hospitals must bill an Evaluation/Management (E/M) code for an emergency room, clinic visit or critical care on the day before or the day that the patient is admitted to observation.

      i. If hospitals bill for more than one period of observation on a single claim, each observation period must be paired with a separate E/M visit.

      ii. Hospitals must bill the E/M code associated with observation on the same claim as the observation service.

      iii. Hospitals must use modifier –25 with the E/M code in order to receive payment for G0244.

   b. Effective for services furnished on or after January 1, 2003, when a patient with congestive heart failure, chest pain, or asthma is a "direct admission" to observation, hospitals should bill:
      G0263, *Direct admission of patient with diagnosis of congestive heart failure, chest pain or asthma for observation services that meet all criteria for separate payment,* or
      G0264, *Initial nursing assessment of patient directly admitted to observation with diagnosis other than congestive heart failure, chest pain, or asthma or patient directly admitted to observation with diagnosis of congestive heart failure, chest pain or asthma when the observation stay does not qualify for separate payment.*
      A "direct admission" occurs when a physician in the community refers a patient to the hospital for observation, bypassing the clinic or emergency department (ED).

      i. Hospitals must use modifier –25 with G0263 in order to receive payment for G0244.

      ii. Hospitals should bill G0263 and G0264 with revenue code 762.

3. Diagnoses Required for Separate Observation Payment

   When billing for separate payment for observation services using HCPCS code G0244, hospitals must include at least one of the ICD-9-CM diagnoses listed below on the bill as the admitting, primary, or secondary diagnosis.

   a. Required Diagnoses For Chest Pain:

      411.0 Postmyocardial infarction syndrome
      411.1 Intermediate coronary syndrome
      411.81 Coronary occlusion without myocardial infarction

411.89 Other acute ischemic heart disease
413.0 Angina decubitus
413.1 Prinzmetal angina
413.9 Other and unspecified angina pectoris
786.05 Shortness of breath
786.50 Chest pain, unspecified
786.51 Precordial pain
786.52 Painful respiration
786.59 Other chest pain

b. Required Diagnoses For Asthma:

493.01 Extrinsic asthma with status asthmaticus
493.02 Extrinsic asthma with acute exacerbation
493.11 Intrinsic asthma with status asthmaticus
493.12 Intrinsic asthma with acute exacerbation
493.21 Chronic obstructive asthma with status asthmaticus
493.22 Chronic obstructive asthma with acute exacerbation
493.91 Asthma, unspecified with status asthmaticus
493.92 Asthma, unspecified with acute exacerbation

c. Required Diagnoses For Congestive Heart Failure:

391.8 Other acute rheumatic heart disease
398.91 Rheumatic heart failure (congestive)
402.01 Malignant hypertensive heart disease with congestive heart failure
402.11 Benign hypertensive heart disease with congestive heart failure
402.91 Unspecified hypertensive heart disease with congestive heart failure
404.01 Malignant hypertensive heart and renal disease with congestive heart failure
404.03 Malignant hypertensive heart and renal disease with congestive heart and renal failure
404.11 Benign hypertensive heart and renal disease with congestive heart failure
404.13 Benign hypertensive heart and renal disease with congestive heart and renal failure
404.91 Unspecified hypertensive heart and renal disease with congestive heart failure
404.93 Unspecified hypertensive heart and renal disease with congestive heart and renal failure
428.0 Congestive heart failure
428.1 Left heart failure
*428.20 Unspecified systolic heart failure
*428.21 Acute systolic heart failure
*428.22 Chronic systolic heart failure;
*428.23 Acute on chronic systolic heart failure
*428.30 Unspecified diastolic heart failure
*428.31 Acute diastolic heart failure
*428.32 Chronic diastolic heart failure
*428.33 Acute on chronic diastolic heart failure
*428.40 Unspecified combined systolic and diastolic heart failure
*428.41 Acute combined systolic and diastolic heart failure
*428.42 Chronic combined systolic and diastolic heart failure
*428.43 Acute on chronic combined systolic and diastolic heart failure
428.9 Heart failure, unspecified

***** Denotes new ICD-9 codes effective October 1, 2002**.**

4. Diagnostic Tests Required for Separate Observation Payment

In order to receive separate payment for observation services billed using HCPCS G0244, hospitals must furnish and bill for specific diagnostic services typically performed on patients requiring observation care for the three specified conditions. Hospitals must perform the specified diagnostic services within the dates of the E/M visit plus the first 24 hours of observation and must bill for the diagnostic services on the same claim as the observation services to which they are related. The required diagnostic tests are as follows:

a. For chest pain, at least two sets of cardiac enzymes (either two CPK (82550, 82552, or 82553), or two troponin (84484 or 84512)], and two sequential electrocardiograms (93005)).

b. For asthma, a breathing capacity test (94010) or pulse oximetry (94760 or 94761 or 94762).

c. For congestive heart failure, a chest x-ray (71010, 71020, or 71030) and an electrocardiogram (93005) and pulse oximetry (94760, 94761, or 94762).

Note: Pulse oximetry codes 94760, 94761, and 94762 are treated as packaged services under the OPPS. Although no separate payment is made for packaged codes, hospitals must separately report the HCPCS code and a charge for pulse oximetry in order to establish that observation services for congestive heart failure and asthma diagnoses meet the criteria for separate payment.

5. Additional billing requirements

a. In order to receive payment for G0244, hospitals must bill observation services for a minimum of 8 hours up to a maximum of 48 hours. In billing for observation services, hospitals should enter as units of service for G0244 the number of hours the patient spends in observation.

i. Hospitals should not use G0244 to bill for observation services of less than 8 hours. Observation services of less than 8 hours should be billed as packaged services using revenue code 762, as explained above.

ii. If a period of observation spans more than one calendar day, hospitals should include all of the hours for the entire period of observation on a single line and enter as the date of service for that line the date the patient is admitted to observation.

iii. Observation time begins at the clock time appearing on the nurse's observation admission note, which should coincide with the initiation of observation care or with the time of the patient's arrival in the observation unit.

iv. Observation time ends at the clock time documented in the physician's discharge orders, or, in the absence of such a documented time, the clock time when the nurse or other appropriate person signs off on the physician's discharge order. This time should coincide with the end of the patient's period of monitoring or treatment in observation.

b. The medical record must document that the beneficiary was under the care of a physician during the period of observation, as indicated by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.

c. Effective for services furnished on or after January 1, 2003, hospitals should discontinue using HCPCS code G0258 to bill for intravenous infusion(s) furnished during a separately payable observation stay that is billed using

G0244. Rather, hospitals should use HCPCS code Q0081, Infusion therapy other than chemotherapy, when billing for an infusion furnished during the observation stay. Hospitals may resubmit claims that were denied for services furnished on or after April 1, 2002 through December 31, 2002 because G0244 is billed with Q0081.

D. Requirements Affecting Separate Payment Under APC 339 for Observation Services Furnished to Patients With Diagnosis of Asthma, Chest Pain, or Congestive Heart Failure

1. If more than one non-overlapping observation is billed on a single claim, each of which meets the required conditions for payment, pay for each observation separately.

2. Allow separate payment for observation services that meet the required conditions only when billed on a 13X bill type.

3. Pay separately for any service that is separately payable under the OPPS, that is, procedures with status indicators S, X, K, G, V, or H, when billed with G0244.

4. Payment for G0244 is not allowed if a surgical procedure or any service that has a status indicator of "T" (with the exception of Q0081) occurs on the day before or the day that the patient is admitted to observation.

5. Data in the admitting diagnosis field (form locator number 76 or its electronic equivalent) will be captured for use in outpatient claims processing as of January 1, 2003. Notify hospitals that the admitting diagnosis will be taken into account in determining separate observation payment for services furnished on or after April 1, 2002, when the bill is submitted or resubmitted, or when an adjustment bill is submitted to you after January 1, 2003. See PM A-02-075, issued August 7, 2002, for further information.

6. Pay separately for multiple observation periods on a claim if the required criteria are met for each observation.

7. If there are multiple observation periods for the same diagnoses, each of the required diagnostic tests must be performed multiple times, i.e., the tests must be rerun for each period of observation. Therefore, if a claim contains 2 separate periods of observation related to chest pain, 4 EKGs and 4 cardiac enzyme tests must be performed.

8. If multiple observations are for different diagnoses, permit the re-use of tests. For example, if there are 2 periods of observation on a claim, one for chest pain and one for congestive heart failure, 2 EKGs, not 3, are needed. The EKGs that are performed to meet the diagnostic test requirements for observation related to chest pain may also be used for the observation related to congestive heart failure.

9. Do not allow separate payment for any hours a beneficiary spends in observation over 24 hours; all costs beyond 24 hours will be included in the APC payment for observation services.

10. If all criteria for G0244 are not met, the claim will be returned to the provider. The hospital should resubmit the claim reporting the observation services under revenue code 762 alone or with HCPCS codes 99217 through 99220 or 99234 through 99236.

11. Payment for G0264 is made under APC 600. Although no separate payment is made for G0263, charges billed with G0263 are packaged in determining costs associated with APC 339.

VI. Payment Policy When a Surgical Procedure on the Inpatient List Is Performed on an Emergency Basis or When a Patient Whose Status is Outpatient Dies

A. Billing and Payment Rules For Using New Modifier: –CA, Procedure payable only in the inpatient setting when performed emergently on an outpatient who dies prior to admission

1. Instruct hospitals that in order to receive payment for a service billed with modifier –CA, all of the following conditions must be met:

    a. The status of the patient is outpatient;

    b. The patient has an emergent, life-threatening condition;

    c. A procedure on the inpatient list (designated by payment status indicator C) is performed on an emergency basis to resuscitate or stabilize the patient;

    d. The patient dies without being admitted as an inpatient.

2. If all of the conditions for payment are met, instruct hospitals to submit a claim using a 13X bill type for all services that were furnished, including the inpatient procedure (e.g., a procedure designated by OPPS payment status indicator C). Hospitals should include modifier –CA on the line with the HCPCS code for the inpatient procedure.

3. Payment for all services on a claim that have the same date of service as the HCPCS code billed with modifier –CA is made under APC 977. Separate payment is not allowed for other services furnished on the same date.

4. Suspend claims submitted with modifier –CA appended to a HCPCS code that has a status indicator "C" if billed with other services furnished on the same date of service. Substitute Medicare Summary Notice (MSN) #18.20 ("Medicare does not pay for this service separately since payment for it is included in our allowance for other services you received on the same day") for the MSN that is triggered by OCE edit 49.

B. Summary of Billing and Payment Rules When a Patient Dies

1. If a patient dies in the emergency department, and the patient's status is outpatient, the hospital should bill for payment under the OPPS for the services that were furnished.

2. If the emergency department or other physician orders the patient to the operating room for a surgical procedure, and the patient dies in surgery, payment will be made based on the status of the patient.

    a. If the patient was admitted as an inpatient, the hospital should submit a claim for payment under the hospital inpatient PPS (a DRG-based payment).

    b. If the patient dies and is not admitted as an inpatient, the hospital should bill for payment under the OPPS for the services that were furnished.

    c. If the patient dies and is not admitted as an inpatient, and a procedure designated as an inpatient procedure (by OPPS status indicator C) is performed, the hospital should bill for payment under the OPPS for the services that were furnished on that date and should include modifier –CA on the line with the HCPCS code for the inpatient procedure. Payment for all services, other than the inpatient procedure designated under OPPS by a status indicator C, furnished on the same date is bundled into a single payment under APC 977.

C. Summary of Billing and Payment Rules When a Procedure Designated as an Inpatient Procedure (by OPPS status indicator C) Is Performed On a Patient Whose Status Is Outpatient

1. If a procedure designated as an inpatient procedure must be performed on a patient whose status is that of an outpatient, the hospital may:

    a. Admit the patient and submit an inpatient claim for payment under the inpatient PPS, or

    b. Admit and transfer the patient to another provider and submit a claim for a per diem DRG rate.

2. Under the OPPS, a procedure assigned status indicator C (indicating a procedure on the inpatient list) is never payable as an APC. Therefore, if a procedure designated as an inpatient procedure is billed without the –CA modifier for a patient whose status is that of an outpatient, the line on the claim for the procedure with status indicator C will receive a line item denial, and no services furnished on the same date will be paid.

3. Observation services are outpatient services and do not constitute an inpatient admission. Under the OPPS, a procedure assigned status indicator C (indicating a procedure on the inpatient list) is never payable as an APC. Therefore, if a procedure designated as an inpatient procedure is billed without the –CA modifier for a patient admitted for observation, the line on the claim for the procedure with status indicator C will receive a line item denial, and no services furnished on the same date will be paid.

4. The –CA modifier is not to be used to bill for a procedure with status indicator "C" that is performed on an elective basis or scheduled to be performed on a patient whose status is that of an outpatient.

D. Documentation Requirements

1. For a hospital to receive payment when a procedure with OPPS status indicator C is performed and 1) the patient dies without being admitted as an inpatient, or 2) the patient survives the procedure and is admitted as an inpatient and transferred following the procedure, the patient's medical record must contain all of the following information:

    a. If the patient is transferred, written orders to admit the patient to the hospital performing the procedure and transfer the patient to another hospital following the procedure.

    b. Documentation that the reported HCPCS code for the surgical procedure with OPPS payment status indicator C was actually performed.

    c. Documentation that the reported surgical procedure with status indicator C was medically necessary.

    d. If the patient is admitted as an inpatient and subsequently transferred to another facility, documentation that the transfer was medically necessary, such as the patient requiring postoperative treatment unavailable at the transferring facility.

VII. New G Codes Under HCPCS and Status Under OPPS

The table below provides a summary of the new G HCPCS codes that have been issued since the October 2002 OPPS update (PM A-02-076). The table indicates the reason the new code was developed by reference to a previously issued PM, a section in this PM, or other description.

HCPCS CODE	Effective Date	Status Indicator	APC	Short Descriptor	Long Descriptor	Reason for Code
G0256	1/1/2003	T	0649	Prostate Brachy w palladium	Prostate brachytherapy using permanently implanted palladium seeds, including transperitoneal placement of needles or catheters into the prostate, cystoscopy and application of permanent interstitial radiation source	See section IX of this PM
G0257	1/1/2003	S	0170	Unsched dialysis ESRD pt hos	Unscheduled or emergency treatment for dialysis for ESRD patient in the outpatient department of a hospital that does not have a certified ESRD	See section III of this PM
G0259	1/1/2003	N		Inject for sacroiliac joint	Injection procedure for sacroiliac joint; arthrography	See section XIII of this PM
G0260	1/1/2003	T	0204	Inj for sacroiliac jt anesth	Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent and arthrography	See Section XIII of this PM
G0261	1/1/2003	T	0684	Prostate brachythera py w/iodine see	Prostate brachytherapy using permanently implanted iodine seeds, including transperitoneal placement of needles or catheters into the prostate, cystoscopy and application of permanent interstitial radiation source	See section IX of this PM
G0262	1/1/2003	S	0711	Sm intestinal image capsule	Small intestinal imaging; intraluminal, from ligament of Treitz to the ileo cecal valve, includes physician interpretation and report	Code created to describe a new diagnostic test for which there is no existing code
G0263	1/1/2003	N		Adm with CHF, CP, asthma	Direct admission of patient with diagnosis of congestive heart failure, chest pain or asthma for observation services that meet all criteria for G0244	See section V of this PM
G0264	1/1/2003	V	0600	Assmt otr CHF, CP, asthma	Initial nursing assessment of patient directly admitted to observation with diagnosis other than	See section V of this PM

HCPCS CODE	Effective Date	Status Indicator	APC	Short Descriptor	Long Descriptor	Reason for Code
					congestive heart failure, chest pain, or asthma or patient directly admitted to observation with diagnosis of congestive heart failure, chest pain or asthma when the observation stay does not meet all criteria for G0244	
G0265	1/1/2003	A		Cryopreservation Freeze +stora	Cryopreservation, freezing and storage of cells for therapeutic use, each cell line	See PM AB-02-163
G0266	1/1/2003	A		Thawing + expansion froz cell	Thawing and expansion of frozen cells for therapeutic use, each aliquot	See PM AB-02-163
G0267	1/1/2003	A		Bone Marrow or PSC harvest	Bone marrow or peripheral stem cell harvest, modification or treatment to eliminate cell type(s) (e.g. T-cells, metastatic carcinoma)	See PM AB-02-163 and Medicare Intermediary Manual (CMS Pub. 13-3) Section 3628 C.
G0268	1/1/2003	X	0340	Removal of impacted wax MD	Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing	See section VIII of this PM
G0269	1/1/2003	N		Occlusive device in vein art	Placement of occlusive device into either a venous or arterial access site, post surgical or interventional procedure (e.g., angioseal plug, vascular plug)	See Section XVI of this PM
G0270	1/1/2003	A		MNT subs tx for change dx	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes	See PM Transmittal numbers : A-02-115 and AB-02-151 Must be billed to Medicare carrier (not intermediary) prior to April 1, 2003
G0271	1/1/2003	A		Group MNT 2 or more 30 mins	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral	See PM Transmittal numbers : A-02-115

HCPCS CODE	Effective Date	Status Indicator	APC	Short Descriptor	Long Descriptor	Reason for Code
					in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease) group (2 or more individuals), each 30 minutes	and AB-02-151 Must be billed to Medicare carrier (not intermediary) prior to April 1, 2003
G0272	1/1/2003	X	0272	Naso/oro gastric tube pl MD	Naso/oro gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)	Code created because there is no existing code for this service
G0273	1/1/2003	S	0718	Pretx planning, non-Hodgkins	Radiopharmaceutical biodistribution, single or multiple scans on one or more days, pre-treatment planning for radiopharmaceutical therapy of non-Hodgkin's lymphoma, includes administration of radiopharmaceutical (e.g., radiolabeled antibodies)	See section XVII of this PM.
G0274	1/1/2003	S	0725	Radiopham tx, non-Hodgkins	Radiopharmaceutical therapy, non-Hodgkin's lymphoma, includes administration of radiopharmaceutical (.e.g. radiolabeled antibodies)	Code created because there is no existing code for this service
G0275	1/1/2003	N		Renal angio, cardiac cath	Renal angiography (unilateral or bilateral) performed at the time of cardiac catheterization, includes catheter placement in the renal artery, injection of dye, flush aortogram and radiologic supervision and interpretation and production of images (List separately in addition to primary procedure)	See section XVIII of this PM
G0278	1/1/2003	N		Iliac art angio,cardiac cath	Iliac artery angiography performed at the same time of cardiac catheterization, includes	See section XVIII of this PM

HCPCS CODE	Effective Date	Status Indicator	APC	Short Descriptor	Long Descriptor	Reason for Code
					catheter placement in the iliac artery, injection of dye, radiologic supervision and interpretation and production of images (List separately in addition to primary procedure)	
G0279	1/1/2003	A		Excorp shock tx, elbow epi	Extracorporeal shock wave therapy; involving elbow epicondylitis	New code paid under the Therapy Fee Schedule
G0280	1/1/2003	A		Excorp shock tx other than	Extracorporeal shock wave therapy; involving other than elbow epicondylitis or plantar fascitis	New code paid under the Therapy Fee Schedule
G0288	1/1/2003	T	0975	Recon, CTA for surg plan	Reconstruction, computed tomographic angiography of aorta for surgical planning for vascular surgery	Code replaces C9708
G0289	1/1/2003	N		Arthro, loose body + chondro	Arthroscopy, knee, surgical, for removal of loose body, foreign body, debridement/shaving of articular cartilage (chrondroplasty) at the time of other surgical knee arthroscopy in a different compartment of the same knee	See section XIX of this PM
G0290	1/1/2003	E		Drug-eluting stents, single	Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel	See Section XIV of this PM
G0291	1/1/2003	E		Drug-eluting stents,each add	Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel	See Section XIV of this PM
G0292	1/1/2003	S	0708	Adm exp drugs,clinical trial	Administration of experimental drug(s) only in a Medicare qualifying clinical trial (includes administration for	See Section XV of this PM

HCPCS CODE	Effective Date	Status Indicator	APC	Short Descriptor	Long Descriptor	Reason for Code
					chemotherapy and other types of therapy via infusion and/or other than infusion), per day	
G0293	1/1/2003	S	0710	Non-cov proc, clinical trial	Noncovered surgical procedure(s) using conscious sedation, regional, general or spinal anesthesia in a Medicare qualifying clinical trial, per day	See Section XV of this PM
G0294	1/1/2003	S	0707	Non-cov surg proc,clin trial	Noncovered surgical procedure(s) using either no anesthesia or local anesthesia only, in a Medicare qualifying clinical trial, per day	See Section XV of this PM
G0295	1/1/2003	E		Electro-magnetic therapy one	Electromagnetic stimulation, to one or more areas	Service not covered under Medicare

VIII. Billing Instructions for the G code for Ear Wax Removal

Hospitals performing ear wax removal on a beneficiary on the same day as audiologic function testing (CPT codes 92553 through 92598, except for non-covered codes 92559 and 92560) should use G0268 to report ear wax removal. Reporting of G0268 indicates that a physician removed the earwax at a separate encounter from the audiologic function testing. If 69210 is reported, payment for the earwax removal will be denied.

IX. Billing for Prostate Brachytherapy

The two new G codes for prostate brachytherapy, G0256 and G0261, include payment for transperineal placement of needles and/or catheters into the prostate, cystourethroscopy, radioelement application, and implanted brachytherapy sources. Therefore, hospitals should not report CPT codes 55859 and 77776-77778 in addition to either of the G code. Additionally, hospitals should not separately report any HCPCS for brachytherapy sources in addition to one of the G codes. Lastly, hospitals should report only one G code for this service. As with other procedure codes, post operative recovery and/or observation, is packaged into payment for the procedure. Other services provided during the performance of prostate brachytherapy (e.g. intraoperative ultrasound, laboratory testing, diagnostic services) are separately payable and should be separately reported. The G codes should be reported with only one unit of service.

Hospitals should not use these G codes to report prostate brachytherapy that does not utilize implantable sources (e. g. remote afterloading high intensity brachytherapy, CPT codes 77781-77784). Remote afterloading high intensity brachytherapy is reported with the use of appropriate CPT codes.

X. Billing for Stereotactic Breast Biopsy

Stereotactic breast biopsy should be reported using the appropriate CPT code (e.g., 19103). Radiological or ultrasound guidance for the biopsy should be reported separately using the appropriate CPT code.

XI. Billing for Radiologic or Ultrasound Guidance

Hospitals should separately report radiological or ultrasound guidance, using the appropriate CPT code in addition to the HCPCS code for the procedure with which it is used.

XII. Billing for Active Wound Care Procedures

CPT code 97601 is a physical therapy service and is paid under the Medicare Physician Fee Schedule. Payment for CPT code 97602 is recognized under the OPPS as a packaged service, i.e., the service is not separately paid under OPPS; however, the cost of the service is packaged into whatever other service is provided on that date. It is common for 97602 to be performed at the time of another physical therapy service in which case payment for 97602 is packaged into payment for the other physical therapy service. If a service coded under 97602 is performed at the time of a clinic or emergency visit, the E/M service must be documented in accordance with the hospital's documentation guidelines for clinic and emergency visits. If the only service provided to a beneficiary is 97602, the hospital may bill outpatient visit code 99211. Payment for 97602 will be packaged into the payment for 99211. If a hospital provides and bills for 97601 or 97602 and a clinic or emergency department visit, the clinic or emergency visit must be separately identifiable and documented in accordance with the hospital's guidelines for documenting clinic and emergency visits.

XIII. Sacroiliac Joint Injections

CPT code 27096, *Injection procedure for sacroiliac joint, arthrography and/or anesthetic steroid*, describes two distinct procedures, one used with diagnostic procedures and the other therapeutic. The code is properly packaged when used for diagnostic injections, but should be separately payable when used to report a therapeutic injection. Therefore, in order to facilitate appropriate reporting and payment for the procedures described by CPT code 27096, we have created two new codes: G0259, *Injection procedure for sacroiliac joint, arthrography*, and G0260, *Injection procedure for sacroiliac joint, provision of anesthetic and/or steroid*. G0259 is a packaged service and G0260 is assigned to APC 0204.

XIV. Drug Eluting Stents

Effective for services furnished on or after April 1, 2003, contingent upon their prior approval by the Food and Drug Administration (FDA), we are implementing payment under APC 656, Transcatheter Placement of Drug-Eluting Coronary Stents, for two temporary HCPCS codes that describe drug-eluting stents:

G0290 Transcatheter placement of a drug-eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel.

G0291 Transcatheter placement of a drug-eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel.

Payment for HCPCS codes G0290 and G0291 under APC 0656 will not be implemented before April 1, 2003.

- **If the FDA approves the drug-eluting stents before January 1, 2003**, advise your hospitals that they should hold claims containing these HCPCS codes for services furnished on or after January 1, 2003 through March 31, 2003 until after April 1, 2003. If a hospital furnishes additional services that would be reported on the same claim as the codes for the insertion of drug-eluting stents (G0290 and G0291), they may wish to remove those codes from the claim in order to receive payment for the remaining services. In this instance, the hospital would have to submit an adjustment bill after April 1 that includes the new HCPCS code(s) for insertion of the drug-eluting stents.

- **If the FDA approves the drug-eluting stents after December 31, 2002 but before April 1, 2003** and a hospital, subsequent to their approval by the FDA, uses drug-eluting stents for services furnished in an outpatient setting prior to April 1, 2003, payment for placement of the stents will be made under APC 0104.

- **If the FDA does not grant approval of drug-eluting stents by April 1, 2003**, we will announce by Program Memorandum a new effective date for APC 0656 and for HCPCS codes G0290 and G0291.

XV. Outpatient Services Under Clinical Trials

There are three new G codes for use in reporting services furnished in hospital outpatient departments under national clinical trials:

G0292 *Administration(s) of experimental drug(s) only in a Medicare qualifying clinical trial (includes administration for chemotherapy and other types of therapy via infusion and/or other than infusion), per day.*

G0293 *Noncovered surgical procedure(s) using conscious sedation, regional, general or spinal anesthesia in a Medicare qualifying clinical trial, per day*.

G0294 *Noncovered surgical procedure(s) using either no anesthesia or local anesthesia only, in a Medicare qualifying clinical trial, per day.*

On September 19, 2000, Medicare issued a national coverage decision stating that Medicare will pay for the routine costs of clinical trials. This policy is published as section 30-1 of Medicare's Coverage Issues Manual (CMS-Pub.6). Because the experimental intervention is not covered, but items and services required solely because of the intervention are covered, we needed to identify ways to properly code for and pay for the routine costs when delivered in a hospital outpatient department.

We believe that to pay accurately for the covered services associated with the administration of drugs as part of a clinical trial, we need to create a new code to allow for correct billing and payment for routine costs, as defined by the national coverage determination. Therefore, the code G0292, *"Administration(s) of experimental drug(s) only in a Medicare qualifying clinical trial (includes administration for chemotherapy and other types of therapy via infusion and/or other than infusion), per day,"* should be billed when only experimental drugs are administered as part of a Medicare qualifying clinical trial. When an experimental drug is being administered in conjunction with payable drugs or on the same day as payable drugs, G0292 should not be used. Instead, the appropriate drug administration code should be billed.

There are also procedures that may be performed in the hospital outpatient department as part of a qualifying clinical trial. Because the intervention is not covered under Medicare's clinical trial policy, we need a mechanism to pay the hospital for its covered fixed costs associated with providing the service under the clinical trial. We have created two codes to allow for correct billing of procedures performed as the focus of qualifying clinical trials, G0293 and G0294. G0293 is defined as *"Noncovered surgical procedure(s) using conscious sedation, regional, general or spinal anesthesia in a Medicare qualifying clinical trial, per day,"* and G0294 is defined as *"Noncovered surgical procedure(s) using either no anesthesia or local anesthesia only, in a Medicare qualifying clinical trial, per day."*

ICD-9 diagnosis code V70.7 must be reported on the claim as a diagnosis other than the primary diagnosis in order for hospitals to bill for G0292, G0293 and G0294. All three of these codes are for OPPS use only. Other provider types may not bill these codes.

XVI. Placement of Occlusive Device

We created a new code, G0269 - *Placement of occlusive device into either a venous or arterial access site, post surgical or interventional procedure (e.g., angioseal plug, vascular plug)*. The code was developed to ensure proper reporting of this service. It has come to our attention that this service was being inappropriately reported with codes for such procedures as "blood vessel repair" and "repair of arterial pseudoaneurysm." This service is a packaged service under OPPS.

XVII. Radiopharmaceutical Biodistribution of Zevalin

We created a new code, G0273 - *Radiopharmaceutical biodistribution, single or multiple scans on one or more days, pre-treatment planning for radiopharmaceutical therapy of non-Hodgkin's lymphoma, includes administration of radiopharmaceutical (e.g., radiolabeled antibodies)* to describe radionuclide scanning to determine the biodistribution of Zevalin. The procedure encompasses administration of Indium labeled Zevalin and whole body radionuclide scanning 2 - 24 hours and 48 - 72 hours after administration of Zevalin. Rarely, a third scan is necessary. The purpose of the scanning is to ensure that the biodistribution of Zevalin is normal, thus decreasing the risk of toxic effects from administration of a therapeutic dose of Zevalin. The published criteria for determining appropriate biodistribution involve making a qualitative comparison of isotope uptake in several organ systems between the two scans. Therefore, these scans cannot be read in isolation and this code should be reported only once no matter how many scans are performed.

This code includes the administration of the radiopharmaceutical and performance of all scans. Also note that the infusion of rituxumab prior to the administration of Zevalin is separately payable.

When billing G0273 and G0274 for Zevalin, the payment amount includes payment for both the procedure and the radiopharmaceutical. For diagnostic administration of Zevalin, G0273, CPT codes for diagnostic administration of radiopharmaceuticals (78990 and 78999) and diagnostic scanning should not be reported (78800 -78803). For therapeutic administration of Zevalin G0274, CPT codes for therapeutic administration of radiopharmaceuticals (79900), radiopharmaceutical therapy (79100, 79400), and infusion or instillation of radioelement solution (77750) should not be reported.

XVIII. Renal and Iliac Angiography Performed with Cardiac Angiography

We created the following add-on codes to assure proper reporting of and payment for renal and iliac angiography performed at the time of cardiac angiography:

G0275 - R*enal angiography (unilateral or bilateral) performed at the time of cardiac catheterization, includes catheter placement in the renal artery, injection of dye, flush aortogram and radiologic supervision and interpretation and production of images (List separately in addition to primary procedure)* and

G0278 - *Iliac artery angiography performed at the same time of cardiac catheterization, includes catheter placement in the iliac artery, injection of dye, radiologic supervision and interpretation and production of images (List separately in addition to primary procedure)*

These procedures are performed frequently on Medicare patients and are currently reported using codes that describe placement of a catheter in the renal and/or iliac artery(s) (CPT codes 36245 and 36246) and radiological supervision and interpretation of renal and/or iliac angiography (CPT codes 75710, 75716, 75722, and 75724). CPT codes 36245, 36246 75710, 75716, 75722, and 75724 should not be used to report these procedures. The new codes, G0275 and G0278 are packaged services under OPPS.

XIX. Arthroscopic Procedures of the Knee

We created the following code to permit appropriate reporting of arthroscopic procedures performed in different compartments of the same knee during the same operative session:

G0289 - *Arthroscopy, knee, surgical, for removal of loose body, foreign body, debridement/shaving of articular cartilage (chrondroplasty) at the time of other surgical knee arthroscopy in a different compartment of the same knee.*

This is an add-on code and should be added to the knee arthroscopy code for the major procedure being performed. This code is only to be reported once per extra compartment, even if chondroplasty, loose body removal, and foreign body removal are all performed. The code may be reported twice (or with a unit of two) if the physician performs these procedures in two compartments in addition to the compartment where the main procedure was performed.

This code should be reported only when the physician spends at least 15 minutes in the additional compartment performing the procedure. It should not be reported if the reason for performing the procedure is due to a problem caused by the arthroscopic procedure itself. We note that this code is to be used when a procedure is performed in the lateral, medial, or patellar compartments in addition to the main procedure. We will not allow billing of CPT codes 29874, *Arthroscopy, knee, surgical; for removal of loose body or foreign body (e.g., osteochrondritis dissecans fragmentation, chondral fragmentation)* and 29877, *Arthroscopy, knee,surgical; debridement/shaving of articular cartilage (chrondroplasty)* with other arthroscopic procedures on the same knee. The new code is a packaged service under OPPS. CPT code 29874 should not be used to report the services described by the new code G0289.

XX. Billing for Radiation Therapy (CPT Codes 77401 through 77416)

CPT codes 77401 through 77416 are to be reported only once per date of service. Furthermore, only one of these codes may be reported per date of service per patient. CPT Codes 77402 through 77406 describe treatment delivery for a single treatment area. CPT Codes 77407 through 77411 describe treatment delivery to two treatment areas. CPT Codes 77412 through 77416 describe treatment delivery to three or more treatment areas. In the cases of CPT Codes 77407 through 77416 the radiation delivered to each treatment area is added and the sum determines which code to report. For example, if three treatment areas are each treated with 11 MeV, then the proper code to bill is 77416 for "20 MeV or greater". It is incorrect to report 77414 (for "11-19 MeV") three times.

XXI. Hospital OPPS Modifiers

As indicated in Section 442.9 of the Medicare Hospital Manual and Section 3627.11 of the Medicare Intermediary Manual, the Centers for Medicare & Medicaid Services (CMS) requires the reporting of CPT and HCPCS Level II modifiers for accuracy in reimbursement, coding consistency, editing, and capturing payment data for constructing Medicare outpatient groups for the OPPS.

Effective January 1, 2003, a new Level II modifier has been added to the list of reportable modifiers under the OPPS.

-CA Procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission

See section VI of this PM for an explanation of how this modifier is to be used.

Below is a listing of all the modifiers that are reported under the OPPS as of January 1, 2003:

Level I (CPT)	Level II (HCPCS)
-25 -59 -78	-CA -FA -F5 -GA - LC -RC -T3 -T8
-27 -73 -79	-E1 -F1 -F6 -GG - LD -RT -T4 -T9
-50 -74 -91	-E2 -F2 -F7 -GH - LT -TA -T5
-52 -76	-E3 -F3 -F8 -GY -QM -T1 -T6
-58 -77	-E4 -F4 -F9 -GZ -QN -T2 -T7

XXII. Pass-Through Devices

A. New Pass-Through Device Category Codes

As of January 1, 2003, C-codes C1884, C2614, and C2632 will be reportable under the OPPS. The C-codes and APCs will be in the January 2003 OCE and OPPS PRICER. Intermediaries must add C1884 to the HCPCS file in their internal claims processing systems.

HCPCS	SI	APC	Short Descriptor	Long Descriptor
C1884	H	1884	Embolization protect sys	Embolization Protective System
C2614	H	2614	Probe, perc lumb disc	Probe, percutaneous lumbar discectomy
C2632	H	2632	Brachytx sol, I-125, per mCi	Brachytherapy solution, iodine –125, per mCi

B. Comprehensive List of Device Category Codes in Effect as of January 1, 2003

Below is a complete listing of the device categories that are reportable under the hospital OPPS as of January 1, 2003. If a device is described by one of the existing device categories but is packaged as a component of a system, only the device that meets the pass-through criteria would be eligible for pass-through payment under the appropriate category.

Note that 95 device categories will expire after December 31, 2002, and are no longer reportable. See section XXII.D below for a list and discussion of the billing for these device codes.

	HCPCS Codes	Category Long Descriptor	Effective Date
1	C1765*	Adhesion barrier	7/1/01
2	C1783	Ocular implant, aqueous drainage assist device	7/1/02
3	C1884	Embolization Protective System	1/1/03
4	C1888	Catheter, ablation, non-cardiac, endovascular (implantable)	7/1/02
5	C1900	Lead, left ventricular coronary venous system	7/1/02
6	C2614	Probe, percutaneous lumbar discectomy	1/1/03
7	C2618	Probe, cryoablation	4/1/01
8	C2632	Brachytherapy solution, iodine –125, per mCi	1/1/03

* Additional information regarding this category can be found in Transmittal A-02-050.

C. Explanation of Terms/Definitions for Specific Category Codes

Adhesion barrier (C1765) - A bioresorbable substance placed on and around the neural structures, which inhibits cell migration (fibroblasts) and minimizes scar tissue formation. It is principally used in spine surgeries, such as laminectomies and diskectomies.

Catheter, ablation, non-cardiac, endovascular (C1888) – a radiofrequency catheter designed to occlude or obliterate blood vessels (e.g., veins).

Embolization protective system (C1884) – A system designed and marketed for use to trap, pulverize, and remove atheromatous or thrombotic debris from the vascular system during an angioplasty, atherectomy, or stenting procedure.

Left ventricular coronary venous system lead (C1900) - Designed for left heart placement in a cardiac vein via the coronary sinus and is intended to treat the symptoms associated with heart failure.

D. Billing for Devices for Which C-codes Have Expired

As noted above, 95 pass-through device categories will expire effective January 1, 2003. We provide this list below. The list of device categories with expiration dates of December 31, 2002, was announced in Section IV of Transmittal A-02-050 dated June 17, 2002.

	HCPCS Codes	Category Long Descriptor

		HCPCS Codes	Category Long Descriptor
1		C1883	Adaptor/extension, pacing lead or neurostimulator lead (implantable)
2		C1713	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)
3		C1715	Brachytherapy needle
4	*	C1716	Brachytherapy seed, Gold 198
5		C1717	Brachytherapy seed, High Dose Rate Iridium 192
6	*	C1718	Brachytherapy seed, Iodine 125
7	*	C1719	Brachytherapy seed, Non-High Dose Rate Iridium 192
8	*	C1720	Brachytherapy seed, Palladium 103
9	*	C2616	Brachytherapy seed, Yttrium-90
10		C1721	Cardioverter-defibrillator, dual chamber (implantable)
11		C1882	Cardioverter-defibrillator, other than single or dual chamber (implantable)
12		C1722	Cardioverter-defibrillator, single chamber (implantable)
13		C1726	Catheter, balloon dilatation, non-vascular
14		C1727	Catheter, balloon tissue dissector, non-vascular (insertable)
15		C1728	Catheter, brachytherapy seed administration
16		C1729	Catheter, drainage
17		C1730	Catheter, electrophysiology, diagnostic, other than 3D mapping (19 or fewer electrodes)
18		C1731	Catheter, electrophysiology, diagnostic, other than 3D mapping (20 or more electrodes)
19		C1732	Catheter, electrophysiology, diagnostic/ablation, 3D or vector mapping
20		C1733	Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, other than cool-tip
21		C2630	Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, cool-tip
22		C1887	Catheter, guiding (may include infusion/perfusion capability)
23		C1750	Catheter, hemodialysis/peritoneal, long-term
24		C1752	Catheter, hemodialysis/peritoneal, short-term
25		C1751	Catheter, infusion, inserted peripherally, centrally or midline (other than hemodialysis)
26		C1759	Catheter, intracardiac echocardiography
27		C1754	Catheter, intradiscal
28		C1755	Catheter, intraspinal
29		C1753	Catheter, intravascular ultrasound
30		C2628	Catheter, occlusion
31		C1756	Catheter, pacing, transesophageal
32		C2627	Catheter, suprapubic/cystoscopic
33		C1757	Catheter, thrombectomy/embolectomy
34		C1885	Catheter, transluminal angioplasty, laser
35		C1725	Catheter, transluminal angioplasty, non-laser (may include guidance, infusion/perfusion capability)
36		C1714	Catheter, transluminal atherectomy, directional
37		C1724	Catheter, transluminal atherectomy, rotational
38		C1758	Catheter, ureteral
39		C1760	Closure device, vascular (implantable/insertable)

	HCPCS Codes	Category Long Descriptor
40 **	L8614	Cochlear implant system
41	C1762	Connective tissue, human (includes fascia lata)
42	C1763	Connective tissue, non-human (includes synthetic)
43	C1881	Dialysis access system (implantable)
44	C1764	Event recorder, cardiac (implantable)
45	C1767	Generator, neurostimulator (implantable)
46	C1768	Graft, vascular
47	C1769	Guide wire
48	C1770	Imaging coil, magnetic resonance (insertable)
49	C1891	Infusion pump, non-programmable, permanent (implantable)
50	C2626	Infusion pump, non-programmable, temporary (implantable)
51	C1772	Infusion pump, programmable (implantable)
52	C1893	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, other than peel-away
53	C1766	Introducer/sheath, guiding, intracardiac electrophysiological, steerable, other than peel-away
54	C1892	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, peel-away
55	C1894	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, non-laser
56	C2629	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, laser
57	C1776	Joint device (implantable)
58	C1895	Lead, cardioverter-defibrillator, endocardial dual coil (implantable)
59	C1777	Lead, cardioverter-defibrillator, endocardial single coil (implantable)
60	C1896	Lead, cardioverter-defibrillator, other than endocardial single or dual coil (implantable)
61	C1778	Lead, neurostimulator (implantable)
62	C1897	Lead, neurostimulator test kit (implantable)
63	C1898	Lead, pacemaker, other than transvenous VDD single pass
64	C1779	Lead, pacemaker, transvenous VDD single pass
65	C1899	Lead, pacemaker/cardioverter-defibrillator combination (implantable)
66	C1780	Lens, intraocular (new technology)
67	C1878	Material for vocal cord medialization, synthetic (implantable)
68	C1781	Mesh (implantable)
69	C1782	Morcellator
70	C1784	Ocular device, intraoperative, detached retina
71	C2619	Pacemaker, dual chamber, non rate-responsive (implantable)
72	C1785	Pacemaker, dual chamber, rate-responsive (implantable)
73	C2621	Pacemaker, other than single or dual chamber (implantable)
74	C2620	Pacemaker, single chamber, non rate-responsive (implantable)
75	C1786	Pacemaker, single chamber, rate-responsive (implantable)
76	C1787	Patient programmer, neurostimulator
77	C1788	Port, indwelling (implantable)
78	C1789	Prosthesis, breast (implantable)
79	C1813	Prosthesis, penile, inflatable
80	C2622	Prosthesis, penile, non-inflatable

	HCPCS Codes	Category Long Descriptor
81	C1815	Prosthesis, urinary sphincter (implantable)
82	C1816	Receiver and/or transmitter, neurostimulator (implantable)
83	C1771	Repair device, urinary, incontinence, with sling graft
84	C2631	Repair device, urinary, incontinence, without sling graft
85	C1773	Retrieval device, insertable
86	C2615	Sealant, pulmonary, liquid (implantable)
87	C1817	Septal defect implant system, intracardiac
88	C1874	Stent, coated/covered, with delivery system
89	C1875	Stent, coated/covered, without delivery system
90	C2625	Stent, non-coronary, temporary, with delivery system
91	C2617	Stent, non-coronary, temporary, without delivery system
92	C1876	Stent, non-coated/non-covered, with delivery system
93	C1877	Stent, non-coated/non-covered, without delivery system
94	C1879	Tissue marker (implantable)
95	C1880	Vena cava filter

***** The pass-through device category expires after December 31, 2002, however, beginning January 1, 2003 the HCPCS code is assigned to an APC for payment as a non pass-through brachytherapy seeds.
****** Although the pass-through device category for the cochlear implant system expires after December 31, 2002, the code L8614 may continue to be reported. See discussion below.

The device categories expire after December 31, 2002. With the exception of C1716, C1718, C1719, C1720 and C2616, the respective "C" HCPCS codes for the device categories cannot be reported after December 31, 2002. The expiring "C" codes will not have a 90-day grace period. Any claims that contain these codes will be returned to hospitals. The Outpatient Code Editor will return the claim to the hospital so that the hospital may remove the expired pass-through device HCPCS code. Hospitals should be instructed to resubmit the charge for the device with either no HCPCS code or, at the hospital's option, with a current HCPCS code, if one exists for the device. Hospitals are not required to bill using a HCPCS code, but they may do so. Hospitals must use one of the following revenue codes when billing for devices that are not pass-through devices: 272, 275, 276, 278, 279, 280, 289, or 624. Note that revenue codes 274 and 290, which are acceptable codes for reporting pass-through devices, always require HCPCS codes. If the non-pass-through device is an implantable orthotic or prosthetic device or implantable durable medical equipment, report the device under a revenue code other than 274 or 290, for example 278 – *other implants.*

The code for cochlear implant system, L8614, is a permanent HCPCS code that will not expire. Although the cochlear implant system device category will expire for pass-through payment purposes, the code may continue to be reported after December 31, 2002. Beginning January 1, 2003 charges reported with L8614 will be considered as charges attributable to a packaged device under OPPS.

Instruct your hospitals that only one unit may be reported under code C2616, *Brachytherapy seed, Yttrium-90*. Standard systems maintainers should edit to ensure that claims containing more than one unit for this code are returned to the hospital.

Instruct your hospitals that although a device may no longer be eligible for pass-through payment and may no longer have a reportable HCPCS code, it is essential that they continue to include a charge on the claim for any device they furnish, either as part of the charge for the procedure or as a separate charge billed under a device revenue code. This is equally important for devices that have never been eligible for pass-through payments. Hospitals are required to bill for packaged devices to ensure that the cost of the device is taken into account in determining the hospital's transitional corridor and outlier payments and that all device costs are included in the data we use in updating APC payments for the procedure in the future.

Hospitals have the option of whether or not to bill using HCPCS codes for packaged devices. However, hospitals must be made aware that for purposes of future APC rate-setting for procedures

that use devices, we will include in calculating the median cost of a procedure the cost of all devices that appear on claims whether billed using a HCPCS code or billed with only a revenue code.

E. General Coding, Billing Instructions and Explanations For Pass-Through Devices

C1900 - Left ventricular coronary venous system lead: This code should be reported with CPT Codes 33224 and 33225. The APC assignments for these two CPT codes do not include payment for the pass-through device.

Devices Implanted, Removed, and Implanted Again, Not Associated With Failure (Applies to Transitional Pass-through Devices Only): In instances where the physician is required to implant another device because the first device fractured, the hospitals may bill for both devices – the device that resulted in fracture and the one that was implanted into the patient. We realize that there may be instances where an implant is tried but later removed due to the device's inability to achieve the necessary surgical result or due to inappropriate size selection of the device by the physician (e.g., physician implants an anchor to bone and the anchor breaks because the bone is too hard or must be replaced with a larger anchor to achieve desirable result). In such instances, Medicare will provide separate reimbursement for both devices. This situation does not extend to devices that result in failure or are found to be defective. For failed or defective devices, hospitals are advised to contact the vendor/manufacturer. NOTE: This applies to transitional pass-through devices only and not to devices packaged into an APC.

Kits: Manufacturers frequently package a number of individual items used in a particular procedure in a kit. Generally, to avoid complicating the category list unnecessarily and to avoid the possibility of double coding, we have not established codes for such kits. However, hospitals are free to purchase and use such kits. If the kits contain individual items that separately qualify for transitional pass-through payments, these items may be separately billed using applicable codes. Hospitals may not bill for transitional pass-through payments for supplies that may be contained in kits.

Multiple units: Hospitals must bill for multiple units of items that qualify for transitional pass-through payments when such items are used with a single procedure by entering the number of units used on the bill.

Reprocessed devices: Hospitals may bill for transitional pass-through payments only for those devices that are "single use." Reprocessed devices may be considered "single use" if they are reprocessed in compliance with enforcement guidance of the Food and Drug Administration (FDA) relating to the reprocessing of devices applicable at the time the service is delivered. The FDA is phasing in new enforcement guidance relating to reprocessing during 2001 and 2002. For further information, see FDA's guidance document entitled "Enforcement Priorities for Single-Use Devices Reprocessed by Third Parties and Hospitals," published August 14, 2000, and subsequent FDA guidance or regulatory documents.

F. Example of how a transitional pass-through payment would be calculated for a pass-through device furnished on or after January 1, 2003 :

Our formula for calculating device pass-through payments has changed from last year's calculation. There is no pro rata adjustment to this year's pass-through calculations. The APCs that have device offset amounts for 2003 and the offset amounts are published in Table 11 of the 2003 OPPS final rule. The offset adjustment is applied only when a pass-through device is billed with one of the APCs listed in Table 11 if the 2003 OPPS final rule published on November 1, 2002.

Device: (C1884 – Embolization Protective System)
Device cost = Hospital charge converted to cost = $ 1200.00

Associated procedure: CPT 92982 (APC0083)
Payment rate = $2,710.57
Coinsurance amount = $ 542.11

Total offset amount to be applied for each APC that contains device costs = $802.06

Note: the total offset amount is wage-index adjusted and multiple procedure discount factor adjusted before it is subtracted from the device cost. This example assumes a wage index of 1.0000

Device cost adjusted by total offset amount:
$1200.00 -802.06 = $397.94

Medicare program payment (before wage index adjustment) for APC 0083:
$2710.57-542.11 = $2168.46

Medicare program payment for pass-through device C1884
$397.94

Beneficiary coinsurance liability for APC 0083:
$542.11.

Total amount received by provider for APC 0083 and pass-through device C1884:
$2168.46 Medicare program payment for CPT code 92982 when used with device code C1884
542.11 Beneficiary coinsurance amount for CPT code 92982
397.94 Transitional pass-through payment for device
$3108.51 Total amount received by the provider

XXIII. Changes to Pass-Through Drugs, Biologicals and Radiopharmaceuticals

A. HCPCS Replacements Codes for Retiring Pass-Through Drugs

The HCPCS codes listed in the left column are being retired effective December 31, 2002; however, because of the grace period hospitals have for reporting the new 2003 HCPCS codes, these codes are in effect for hospital outpatient billing for drugs furnished through March 31, 2003. Beginning April 1, 2003, these codes are no longer reportable under the hospital OPPS. These codes have been replaced with new HCPCS codes indicated in the column titled "New HCPCS Code" effective April 1, 2003, and will be reportable under the hospital OPPS.

The latest payment rates associated with each APC number listed below may be found in the OPPS PRICER file available on our Web site, as well as in Addendum A and B of the OPPS final rule.

OLD HCPCS	APC	Short Descriptor	New HCPCS	APC	Short Descriptor
C1012	1012	Platelet Conc, L/R, Irrad	P9033	0954	Platelets leukoreduced irrad
C1013	1013	Platelet Conc, L/R, Unit	P9031	1013	Platelets leukocytes reduced
C1014	1014	Platelet, Aph/Pher, L/R, unit	P9035	9501	Platelet pheres leukoreduced
C1058	1058	TC 99M oxidronate, per vial	Q3009	*	Technetium tc99m oxidronate
C1064	1064	I-131 cap each add mCi	A9517	*	I-131 sodium iodide capsule
C1065	1065	I-131 sol each add mCi	A9518	1348	I-131 sodium iodide solution
C1066	1066	IN 111 satumomab pendetide	A4642	*	Satumomab pendetide per dose
C1087	1087	I-123 per 100 uCi	A9516	*	I-123 sodium iodide capsule
C1094	1094	TC 99M albumin aggr, 1.0 mCI	A9519	*	Technetium tc99m macroag albu

OLD HCPCS	APC	Short Descriptor	New HCPCS	APC	Short Descriptor
C1096	1096	TC 99M Exametazime, per dose	A9521	1096	Technetium tc99m exametazin
C1097	1097	TC 99 Mebrofenin, per vial	A9513	*	Technetium tc-99m mebrofenin
C1098	1098	TC 99M Pentetate, per vial	A9515	*	Technetium tc-99m pentetate
C1099	1099	TC 99M Pyrophosphate, per vial	A9514	*	Technetium tc99m pyrophosphate
C1188	1188	I-131 cap, per 1-5 mCi	A9517	*	I-131 sodium iodide capsule
C1202	1202	TC 99M Sulfur Colloid, dose	A9519	*	Technetium tc-99 macroag albu
C1207	1207	Octreotide Acetate Deport, 1 mg	J2352	7031	Octreotide acetate injection
C1348	1348	I-131 sol, per 1-6 mCi	A9518	1348	I-131 sodium iodide solution
C9019	9019	Caspofungin acetate, per 5 mg	J0637	9019	Caspofungin acetate
C9020	9020	Sirolimus tablet, 1 mg	J7520	9020	Sirolimus, oral
C9100	9100	Iodinated I-131 Albumin	A9524	*	Iodinated I-131 serumalbumin
C9108	9108	Thyrotropin alfa, 1.1 mg	J3240	9108	Thyrotropin injection
C9110	9110	Alemtuzumab, per 10 mg/ml	J9010	9110	Alemtuzumab injection
C9114	9114	Nesiritide, per 1.5 mg vial	J2324	9114	Nesiritide, 0.5mg **
C9115	9115	Inj, Zoledronic acid, 2 mg	J3487	9115	Zoledronic acid, 1.0 mg **

* Denotes a drug code that is packaged under OPPS; therefore, no separate payment is made for the drug.

** Note that C9114 and C9115 are replaced by J2324 and J3487 but the descriptions are different. Refer to the complete list of pass-through drugs for payment information for those codes.

B. New Pass-Through Drugs

The following drugs have been designated as pass-through drugs under the hospital OPPS effective January 1, 2003:

HCPCS Code	SI	APC	Descriptor	Payment Rate	Co-Pay
C9120	G	9120	Long Descriptor: Injection, fulvestrant, per 50 mg Short Descriptor: Injection, fulvestran	$175.16 per 50 mg	$26.18 per 50 mg
C9121	G	9121	Long Descriptor: Injection, argatroban, per 5 mg Short Descriptor: Injection, argatroban	$14.25 per 5 mg	$2.13 per 5 mg
J3315 *	G	9122	Long Descriptor: Injection, triptorelin pamoate, 3.75 mg Short Descriptor: Triptorelin pamoate	$415.24 per 3.75	$62.07 per 3.75 mg

* J3315 was only recently approved as a pass-through drug and does not appear in Addendum B of the November 1, 2002, OPPS Final Rule

C. Comprehensive List of Pass-through Drugs

The following is a list of the drugs paid as pass-through drugs as of January 1, 2003:

HCPCS	APC	Long Descriptor	2003 Payment Amount	2003 Copayment Amount
A9700	9016	Injection, Octafluropropane, per 3 ml	$118.75 per 3ml vial	$17.75 per 3 ml vial
C9111	9111	Injection, Bivalirudin, 250 mg per vial	$397.81 per vial	$56.46 per vial
C9112	9112	Injection, Perflutren lipid microsphere, per 2ml	$148.20 per 2ml	$22.15 per 2ml
C9113	9113	Injection, Pantoprazole sodium, per vial	$22.80 per vial	$3.41 per vial
C9116	9116	Injection, Ertapenem sodium, per 1 gm vial	$45.31 per 1 gram vial	$6.77 per 1 gram vial
C9119	9119	Injection, Pegfilgrastim, per 6 mg single dose vial	$2,802.50 per 6 mg	$418.90 per 6 mg
C9120	9120	Injection, Fulvestrant, per 50 mg	$175.16 per 50 mg	$26.18 per 50 mg
C9121	9121	Injection, Argatroban, per 5 mg	$14.25 per 5 mg	$2.13 per 5 mg
C9200	9200	Orcel, per 36 square centimeters	$1,135.25 per 36 sq cm	$169.69 per 36 sq cm
C9201	9201	Dermagraft, per 37.5 square centimeters	$577.60 per 37.5 sq cm	$86.34 per 37.5 sq cm
J0587	9018	Injection, Botulinum toxin, type B, per 100 units	$8.79 per 100 units	$1.31 per 100 units
J0637	9019	Injection, Caspofungin acetate, 5 mg	$34.20 per 5 mg	$5.11 per 5 mg
J2324	9114	Injection, Nesiritide, pre 0.5 mg	$144.40 per 0.5 mg	$21.58 per 0.5 mg
J3315	9122	Injection, Triptorelin pamoate, per 3.75 mg	$415.24 per 3.75 mg	$62.07 per 3.75 mg
J3487	9115	Injection, Zoledronic acid, per 1 mg	$203.39 per 1 mg	$30.40 per 1 mg
J7517	9015	Mychophenolate mofetil, oral per 250 mg	$2.53 per 250 mg	$0.38 per 250 mg
J9010	9110	Injection, Alemtuzumab, per 10 mg	$511.22 per 10 mg	$76.41 per 10 mg
J9017	9012	Injection, Arsenic trioxide, per 1 mg	$31.35 per 1 mg	$4.69 per 1 mg
J9219	7051	Implant, Leuprolide acetate, per 65 mg implant	$5,399.80 per 65 mg	$807.13 per 65 mg

D. Example of how a transitional pass-through payment is calculated for a pass-through drug furnished on or after January 1, 2003.

Note there is no pro-rata reduction to pass-through payments for drugs furnished in 2003.

APC 9120 Injection, Fulvestrant, per 50 mg

Payment Rate = $175.16 per 50 mg
Co-payment Amount = $26.18 per 50 mg

Non-pass-through portion= (5 x copay) = 5 x 26.18 = $130.90
Pass-through portion = $175.16-130.90 = $44.26
Total payment to provider for APC 9120:

Pass-through portion	$44.26
Non pass-through portion	+130.90
Total payment to provider	$175.16
Less: Beneficiary copayment	- 26.18
Total Medicare program payment	$148.98

XXIV. Non-Pass-through Drugs Under OPPS

A. Changes in Payment For Orphan Drugs

Effective January 1, 2003, the following four codes will be excluded from payment under OPPS and be paid on a reasonable cost basis. These HCPCS codes will be assigned to status indicator "F".

HCPCS Code	Status Indicator	Short Descriptor
J1785	F	Injection imiglucerase/unit
J0205	F	Alglucerase injection
J0256	F	Alpha 1 proteinase inhibitor
J9300	F	Gemtuzumab ozogamicin

B. APC for Rubidium-RB-82

The following new code and APC will be effective January 1, 2003. This code was not previously paid as a pass-through drug or an otherwise separately payable drug. This code does not appear in Addendum B of the November 1, 2002, OPPS Final Rule and is not on the HCPCS tape. Intermediaries must add Q3000 to the HCPCS file in their internal claims processing systems.

HCPCS Code	SI	APC	Descriptor	Payment Rate	Co-Pay
Q3000	K	9025	Long Descriptor: Supply of radiopharmaceutical diagnostic imaging agent, rubidium RB-82, per dose Short Descriptor: Rubidium RB-82	$133.41	$26.68

C. Changes in Payment of Influenza Virus and Pneumococcal Pneumonia Vaccine (PPV)

Effective for claims with dates of service on or after January 1, 2003, payment for influenza virus and PPV vaccines and their administration provided in a hospital outpatient department, home health agency (HHA), and comprehensive outpatient rehabilitation facility (CORF) will change. Payment will no longer be made based on the Outpatient Prospective Payment System (OPPS).

Payment will be based on the provider type. Hospitals (bill type 13X), and HHAs (bill type 34X) will be paid based on reasonable cost for the vaccines and their administration. CORFs (bill type 75X) will be paid based on the lower of the charges or 95 percent of the average wholesale price (AWP) for the vaccine and on Medicare the Physician Fee schedule for the administration.

A new status indicator (SI) of "L" (L – *Paid reasonable cost; not subject to deductible or coinsurance)* will be assigned to influenza and PPV vaccines and their administration in the Outpatient Code Editor (OCE). The applicable HCPCS codes are 90657, 90658, 90659, 90732, G0008 and G0009.

As a result of this payment change, the Standard System Maintainers are required upon receipt of the SI "L" from the OCE to make the appropriate payment determination (reasonable cost or AWP) based on the type of bill submitted.

Although the effective date of the change to payment for influenza and PPV vaccines and their administration is January 1, 2003, due to the need for shared systems changes, the change will not be implemented by the standard system maintainers (SSMs) in January. As a result, if you receive claims with dates of service January 1, 2003, through June 30, 2003, containing any of the HCPCS for the influenza and PPV vaccines and their administration, hold the claims and do not release them for processing until your SSM has implemented the July release. Advise your hospitals, CORFs, and HHAs that claims containing these HCPCS will be held and not processed until the system change is completed.

For vaccines furnished during the period January 1, 2003, through June 30, 2003, if a hospital, CORF or HHA furnishes additional services that would be reported on the same claim as the vaccines, they may wish to remove the vaccine and administration charges from the claim in order to receive payment for the remaining services. In this instance an adjustment bill would need to be submitted to include the vaccine and administration charges after the SSM implements the July release.

When releasing the held claims for payment, apply applicable interest and enter condition code 15 to indicate the claims are clean claims in which payment was delayed due to a CMS processing delay and are therefore not subject to contractor performance evaluation for claims processing timeliness.

Note: Payment to all other providers for these vaccines will remain the same. In addition, payment for hepatitis B vaccine will also remain the same.

D. Summary of Policy Affecting Payment for Drugs Under the OPPS

1. General

In accordance with section 1861(s)(2)(B) of the Act and related Medicare regulations and program issuances, drugs and biologicals that are not usually self-administered by the patient are payable under the OPPS when furnished incident to a physician service. Under OPPS, Medicare makes separate payment for certain drugs and biologicals and packages payment for others into the procedure with which they are billed.

The fact that a drug has a HCPCS code and a payment rate under the OPPS does not imply that the drug is covered by the Medicare program, but indicates only how the drug may be paid if it is covered by the program. Intermediaries must determine whether the drug meets all program requirements for coverage; for example, that the drug is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment because it is usually self-administered.

Neither the OPPS nor other Medicare payment rules regulate the provision or billing by hospitals of non-covered drugs to Medicare beneficiaries. However, a hospital's decision not to bill the beneficiary for non-covered drugs potentially implicates other statutory and regulatory provisions, including the prohibition on inducements to beneficiaries, section 1128A(a)(5) of the Act, or the anti-kickback statute, section 1128B(b) of the Act.

2. Drugs Treated as Supplies

Certain drugs are so integral to a treatment or procedure that the treatment or procedure could not be performed without them. Because such drugs are so clearly an integral component part of the procedure or treatment, they are packaged as supplies under the OPPS into the APC for the procedure or treatment. Consequently, payment for them is included in the APC payment for the procedure or treatment of which they are an integral part. Examples include:

- Sedatives administered to patients while they are in the preoperative area being prepared for a procedure are supplies that are integral to being able to perform the procedure.
- Mydriatic drops instilled into the eye to dilate the pupils, anti-inflammatory drops, antibiotic ointments, and ocular hypotensives that are administered to the patient immediately before, during, or immediately following an ophthalmic procedure are considered an integral part of the procedure without which the procedure could not be performed.
- Barium or low osmolar contrast media are supplies that are integral to a diagnostic imaging procedure.
- Topical solution used with photodynamic therapy furnished at the hospital to treat non-hyperkeratotic actinic keratosis lesions of the face or scalp.
- Local anesthetics such as marcaine, lidocaine (with or without epinephrine).
- Antibiotic ointments such as bacitracin, placed on a wound or surgical incision at the completion of a procedure.

Examples of cases where a drug is not directly related and integral to a procedure or treatment and would not be considered a packaged supply include:

- Cases where drugs are given to a patient for their continued use at home after leaving the hospital.
- In the situation where a patient who is receiving an outpatient chemotherapy treatment develops a headache, any medication given the patient for the headache would not meet the conditions necessary to be treated as a packaged supply.
- In the situation where a patient who is undergoing surgery needs his or her daily insulin or hypertension medication, the medication would not be treated as a packaged supply.

Hospitals may not separately bill beneficiaries for items whose costs are packaged into the APC payment for the procedure with which they are used (except for the copayment that applies to the APC). Note that drugs treated as supplies should be reported under the revenue code associated with the cost center under which the hospital accumulates the costs for the drugs.

3. OPPS Policy on Payment for the Unused Portion of a Drug

Once a drug is reconstituted in the hospital's pharmacy, it may have a limited shelf life. Since an individual patient may receive less than the fully reconstituted amount, hospitals are encouraged to schedule patients in such a way that the hospital can use the drug most efficiently. However, if the hospital must discard the remainder of a vial after administering part of it to a Medicare patient, the provider may bill for the amount of drug discarded along with the amount administered. In the event that a drug is ordered and reconstituted by the hospital's pharmacy, but not administered to the patient, payment may not be made under OPPS.

Example 1: Drug X is available only in a 100-unit size. A hospital schedules three Medicare patients to receive drug X on the same day within the designated shelf life of the product. An appropriate hospital staff member administers 30 units to each patient. The remaining 10 units are billed to OPPS on the account of the last patient. Therefore, 30 units are billed on behalf of

the first patient seen and 30 units are billed on behalf of the second patient seen. Forty units are billed on behalf of the last patient seen because the hospital had to discard 10 units at that point.

Example 2: An appropriate hospital staff must administer 30 units of drug X to a Medicare patient, and it is not practical to schedule another patient who requires the same drug. For example, the hospital has only one patient who requires drug X, or the hospital sees the patient for the first time and does not know the patient's condition. The hospital bills for 100 units on behalf of the patient, and OPPS pays for 100 units.

4. Hospital Billing Instructions for Drugs with Status Indicator "K" or "N"

In order to receive separate payment for any drug having a status indicator of "K", hospitals must bill for the drug using revenue code 636 "Drugs requiring detail coding" and report the appropriate HCPCS code for the drug.

Hospitals should bill for drugs with status indicator "N" using any of the drug revenue codes that are packaged revenue codes under OPPS: 250, 251, 252, 254, 255, 257, 258, 259, 631, 632, 633, or under revenue code 636. Hospitals may but are not required to use HCPCS codes when billing for packaged drugs. (Note, however, that revenue code 636 does require HCPCS coding) Although hospitals are not required to report the HCPCS codes for these drugs, it is essential that hospitals bill charges for packaged drugs by including the charge for packaged drugs in the charge for the procedure or service for which the drug is used or as a separate drug charge. This is critical because the costs of the packaged drugs are used for calculating the hospital's outlier and transitional corridor payments and used in the annual update of APC payments rates for the procedures and services with which the drugs are furnished.

XXV. Changes to the OPPS PRICER Logic

The following list contains a description of all OPPS PRICER logic changes that are effective beginning January 1, 2003.

A. New OPPS wage indexes will be effective January 1, 2003. These are the same wage indexes that were implemented on October 1, 2002 for inpatient hospitals. Some corrections have been made since the publication of the inpatient rule and we are using the corrected wage indexes where applicable.

B. Inpatient hospitals considered reclassified on October 1, 2002, will be considered reclassified for OPPS on January 1, 2003.

C. Section 401 designations and floor MSA designations will be considered effective for OPPS on January 1, 2003.

D. New payment rates and coinsurance amounts will be effective for OPPS on January 1, 2003. Some APCs have coinsurance amounts limited to 55 percent of the payment rate effective January 1, 2003. Some APCs have a coinsurance limit equal to the inpatient deductible of $840 effective January 1, 2003.

E. If a claim has more than 1 service with a status indicator (SI) of T (SI of S has been removed from this rule) and any lines with SI T have less than $1.01 as charges, charges for all T lines will be summed and the charges will then be divided up proportionately to the payment rate for each T line. The new charge amount will be used in place of the submitted charge amount in the line item outlier calculation.

e.g., SI	Charges	Payment Rate	New Charges Amount
T	$19,999	$6,000	$12,000

T	$1	$3,000	$6,000
T	$0	$1,000	$2,000
	$20,000	$10,000	$20,000

Because total charges here are $20,000 and the first SI of T gets 6,000 of 10,000 total payment, the new charge for that line is 6,000/10,000 x $20,000 = $12,000.

F. For outliers, we will change the factor multiplied times the total line item payments from 3.5 to 2.75 and the factor used to multiply the difference between line item payments and costs from .50 to .45. We will eliminate the cost to charge ratio adjustment factor of .981956 from outlier and device calculations.

G. Any claim having one or more APCs that match those listed in the Device Offset Table (Table 11) published in the November 1, 2002, **Federal Register** and a HCPCS code with status indicator (SI) H, will have all applicable APC offset amounts (multiplied by the number of units and the multiple procedure discount factor applicable to that line item) summed and wage adjusted. If there are more units of APCs with offset amounts than there are units of SI H devices that have an active (non-deleted) device category HCPCS code beginning with a C, i.e., those codes listed in section XXII B. of this PM, the total wage adjusted offset amount will be multiplied by the number of units of SI H devices that have a HCPCS code beginning with a C and then divided by the number of units of APCs with offset amounts. The total wage adjusted offset amount will then be subtracted proportionately from the charges reduced to costs for any SI H devices that have a HCPCS code beginning with a C.

H. The pro rata reduction of 63.6 percent applicable to all SI G and/or H payments is eliminated.

XXVI. Processing of CCI Edits for OPPS Claims

The CCI edits in the OCE are updated on a quarterly basis but are delayed one quarter. As such, CCI edit changes from one quarter to the next will appear one quarter later in the OCE than in the Carrier System. From now on, CCI changes will be applied with reference to the date of service on the claim since processing claims based on the date of service is consistent with our long-standing policy of processing claims. For those instances where an edit has been deleted retroactively, intermediaries are advised to readjudicate claims resubmitted after the change has been implemented in the appropriate version of the OCE.

For example, for code pair 74230/G0196, the CCI edit was in existence for the July 2002 quarter but not for the April 2002 or the October 2002 quarters. In the CCI update for the October OCE, the edit was deleted retroactive to its effective date. In this instance, if a claim is re-submitted after the January OCE update with this code pair with a date of service in April 2002 or July 2002, the edit will not appear.

XXVII. Provider Notification

Intermediaries must post a notice on your Web site within two weeks regarding this information and include it in your next scheduled bulletin. If you have an electronic bulletin board or listserv that are used in communicating with your provider community, post this message to our providers using that facility.

XXVIII. Provider Education and Training

Palmetto GBA, on behalf of CMS, is developing training resources for intermediary staff to use in training providers about the OPPS. The train-the-trainer process for OPPS will not include in-person instruction for intermediaries. Instead, CMS will provide various educational resources for intermediaries to learn about OPPS. In turn, **intermediaries will train providers in their service areas.**

CMS will provide the following OPPS education resources for intermediaries:

- A training guide will be available on http://www.cms.hhs.gov/medlearn
- A training video will be shipped to intermediaries
- A PowerPoint presentation for training providers will be available on http://www.cms.hhs.gov/medlearn
- An e-mail mailbox will be established to address your questions
- Biweekly Conference Call Questions & Answers (Q & A) Sessions with OPPS policy and claims processing staff will begin in February 2003

A PM is forthcoming with dates for the Conference Call Q & A Sessions and availability of the above-mentioned and other educational resources.

The *effective date* for this PM is January 1, 2003, unless otherwise noted.

The *implementation date* for this PM is January 6, 2003, unless otherwise noted.

These instructions should be implemented within your current operating budget.

This PM may be discarded after December 31, 2003.

If you have any questions, contact the appropriate Regional Office.