FreedomBlue

HOSPITAL OUTPATIENT BILLING & REIMBURSEMENT GUIDE

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS)

FreedomBlue

(A Medicare Advantage PPO)

This Medicare Advantage OPPS Hospital Reimbursement Guide is a modified version of the CMS Medicare Outpatient Hospital Prospective Payment Billing Manual and the Hospital Manual titled “United States Government Services, LLC, Hospital Manual.” The contents have been modified to reflect the general guidelines for reimbursement under OPPS for FreedomBlue Medicare Advantage products.

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Hospital Outpatient Prospective Payment System

Introduction

FreedomBlue will reimburse providers for services rendered to beneficiaries participating in the Medicare Advantage (FreedomBlue) product using rates established by the Centers for Medicare and Medicaid (CMS). CMS adopted the Hospital Outpatient Prospective Payment System (OPPS) to reimburse outpatient hospital departments for service furnished to Medicare beneficiaries, beginning with dates of service on and after August 1, 2000.

Effective January 1, 2007, FreedomBlue will exercise the ability to adopt CMS Medicare's OPPS to reimburse hospitals for outpatient services furnished to Medicare Advantage enrollees.

This *Hospital Outpatient Billing & Reimbursement Guide (OPPS)* for Medicare Advantage is a modified version of the United Government Services Hospital Manual (January 2004). Modifications include:

- Types of hospitals that are included and excluded from OPPS reimbursement
- Types of services that are included and excluded in OPPS reimbursement
- Modifications due to FreedomBlue processing

FreedomBlue OPPS intends to follow Medicare billing requirements for billing hospital outpatient claims. The claims submission details below have been largely copied from the Medicare Claims Processing manual, Chapter 4.

Implementation

FreedomBlue intends to reimburse providers for hospital outpatient services furnished to Medicare Advantage enrollees on or after January 1, 2007, using CMS Medicare's OPPS methodology and rates.

Coverage in General

All services are subject to the members' benefits under Medicare Advantage.

Facilities reimbursed through OPPS

The OPPS applies to all West Virginia hospital outpatient departments except:

- Critical Access Hospitals (CAHs),
- Skilled Nursing Facilities (SNFs),
- Hospice Facilities,
- Psychiatric Hospitals,
- Rehabilitation Hospitals,
- Veterans Administration (VA) Hospitals.

In addition, partial hospitalization services furnished by Community Mental Health Centers (CMHCs) are not reimbursed via OPPS.

Included Services

The services reimbursed under OPPS by APC are the items and services provided in an hospital outpatient department including: Surgical procedures, radiology, radiation therapy, clinic visits, surgical pathology, chemotherapy, emergency room visits, implants, supplies and diagnostic services and tests.

Excluded Services

The following services are excluded from the scope of services paid as APCs through OPPS:

- Services already paid under fee schedules or other payment systems including, but not limited to:
  - Screening mammography,
  - End Stage Renal Disease (ESRD),
  - Professional services of physicians and non-physicians paid under the Medicare physician fee schedule,
  - Non-implantable Durable Medical Equipment (DME), orthotics, prosthetics and prosthetic devices, prosthetic implants, and take-home surgical dressings will be paid under the DME fee schedule.
- Hospital outpatient services furnished to SNF inpatients as part of his/her resident assessment or comprehensive care plan;
- Services and procedures that require inpatient care will be paid percentage of charge if services are covered and appropriate in the outpatient setting;
- Hospice service;
- Home health care services;
- Freestanding psychiatric facility services
- Freestanding substance abuse and rehabilitation facility services;

- Ambulance services, physical, speech, and occupational therapy services;
- Drugs and supplies that are used within a dialysis session where payment is not included in the composite rate; and
- Partial hospitalization services (see page 41.)

FreedomBlue will reimburse covered services indicated as “pass-through” services or items using the CMS OPPS rates.

The following table furnishes an overview by payment status code of the treatment of the service or item under OPPS.

Status Indicator - A - Paid on fee schedule [Fee] CMS Fee Schedule	**Status Indicator – G - Pass-through drugs & biologicals** [Pass Through] CMS Pass Through Rate	**Status Indicator – P-Partial hospitalization** [Per diem APC payment] **Submit under partial hospital number
Status Indicator - B-Codes not recognized under OPPS [Medicare – No Pay] [M-2 – Default] Charges x RCC	**Status Indicator - H-Pass-through devices; Brachytherapy sources; Radiopharmaceuticals** [Pass Through] Charges x RCC	**Status Indicator - S-Significant service** [APC] CMS APC Payment Rate
Status Indicator - C-Inpatient only procedure [Medicare – No Pay] [M-2 – Default] Charges x RCC	**Status Indicator - K-Non pass-through drugs & biologicals; Radiopharmaceuticals** [APC] CMS APC Payment Rate	**Status Indicator - T-Significant procedure; Multiple reduction applies** [APC] CMS APC Payment Rate
Status Indicator - D-Discontinued codes [No Pay]	**Status Indicator - L-Influenza vaccine; Pneumococcal Pneumonia vaccine** [Cost] Charges x RCC	**Status Indicator -** V-Clinic or Emergency Department visit [APC] CMS APC Payment Rate
Status Indicator - E-Non-covered service [Medicare – No Pay] [M-2 – Default] Charges x RCC	**Status Indicator - M-Items and services not billable to the Fiscal Intermediary** [No Pay]	**Status Indicator – Y-Non-implantable Durable Medical Equipment** [Fee] CMS Fee Schedule
Status Indicator - F-Corneal tissue acquisition; certain CRNA services; Hepatitis B vaccines [Cost] Charges x RCC	**Status Indicator - N-Packaged items and services** [No Pay] **Status Indicator - Q-Packaged services subject to separate payment under certain criteria**	**Status Indicator - X-Ancillary service** [APC] CMS APC Payment Rate

Coding and Billing

Outpatient Code Editor (OCE)

The OPPS OCE performs the following two major functions:

- Edit claims data to identify errors and return a series of edit flags; and
- Assign an ambulatory payment classification (APC) number for each service covered under OPPS and return information to be used as input to the Pricer program.

The following table outlines all of the OCE edits with the corresponding Medicare disposition and the action FreedomBlue will take on the Edit.

Edit No	Description	Medicare Edit Disposition	FreedomBlue Edit Disposition	FreedomBlue Action
1	Invalid diagnosis code	RTP	Off-Upfront edits apply	Pay as processed
2	Diagnosis and age conflict	RTP	Off-Upfront edits apply	Pay as processed
3	Diagnosis and sex conflict	RTP	Off-Upfront edits apply	Pay as processed
4	Medicare secondary payor alert (**V1.0 and V1.1 only**)	Suspend	Off-Not Applicable	Pay as processed
5	E-diagnosis code can not be used as principal diagnosis	RTP	Off-Process claim	Pay as processed
6	Invalid procedure code	RTP	Off	Line pays at default pricing (percentage of charge)
7	Procedure and age conflict (**Not activated**)	RTP	Off-Upfront edits apply	Pay as processed
8	Procedure and sex conflict	RTP	Off-Upfront edits apply	Pay as processed
9	Non-covered for reasons other than statute	Line item denial	On-Medicare coverage specific edit	Line pays at default pricing (percentage of charge)
10	Service submitted for verification of denial (condition code 21)	Claim denial	Off-Medicare coverage specific edit	Line pays at default pricing (percentage of charge)
11	Service submitted for FI review (condition code 20)	Suspend	Off-Medicare coverage specific edit	Line pays at default pricing (percentage of charge)
12	Questionable covered service	Suspend	Off	Pay line according to assigned APC
13	Separate payment for services is not provided by Medicare **(Active V1.0 – V6.3 only)**	Line item rejection	Off-Medicare coverage specific edit	Line pays at default pricing (percentage of charge)
14	Code indicates a site of service not included in OPPS **(Active V1.0 – V6.3 only)**	Claim RTP	Off-Medicare coverage specific edit	Line pays at default pricing (percentage of charge)
15	Service unit out of range for procedure [1]	RTP	On	Line reject
16	Multiple bilateral procedures without modifier 50 **(Active V1.0 – V6.2 only)**	RTP	Off-Not applicable	
17	Inappropriate specification of bilateral procedure	RTP	On	Line reject
18	Inpatient procedure	Line item denial	Off-Medicare coverage specific edit	Line pays at default pricing (percentage of charge)
19	Mutually exclusive procedure that is not allowed by NCCI	Line item rejection	On	Line reject

Edit No	Description	Medicare Edit Disposition	FreedomBlue Edit Disposition	FreedomBlue Action
	even if appropriate modifier is present			
20	Code2 of a code pair that is not allowed by NCCI even if appropriate modifier is present	Line item rejection	On	Line reject
21	Medical visit on same day as a type “T” or “S” procedure without modifier 25	Line item rejection	On	Line reject
22	Invalid modifier	RTP	On	Line reject
23	Invalid date	RTP	On-This is a system edit	RTP
24	Date out of OCE range	Suspend	On-This is a system edit	RTP
25	Invalid age	RTP	Off-Upfront edits apply	Pay as processed
26	Invalid sex	RTP	Off-Upfront edits apply	Pay as processed
27	Only incidental services reported	Claim Rejection	On	Claim reject
28	Code not recognized by Medicare; alternate code for same service may be available	Line item rejection	Off-Medicare coverage specific edit	Line pays at default pricing (percentage of charge)
	(see Partial Hospitalization Section for information on Coding and Billing. Edits 29-36, and 63-64 are turned off)			
29	Partial hospitalization service for non-mental health diagnosis	RTP	Off	Mental health not reimbursed under OPPS see Partial Hospitalization Section of this Guide
30	Insufficient services on day of partial hospitalization	Suspend	Off	Mental health not reimbursed under OPPS see Partial Hospitalization Section of this Guide
31	Partial hospitalization on same day as ECT or type T procedure **(Active V1.0 – V6.3 only)**	Suspend	Off	Mental health not reimbursed under OPPS see Partial Hospitalization Section of this Guide
32	Partial hospitalization claim spans 3 or less days with insufficient services on at least one of the days	Suspend	Off	Mental health not reimbursed under OPPS see Partial Hospitalization Section of this Guide
33	Partial hospitalization claim spans more than 3 days with insufficient number of days having mental health services	Suspend	Off	Mental health not reimbursed under OPPS

Edit No	Description	Medicare Edit Disposition	FreedomBlue Edit Disposition	FreedomBlue Action
				see Partial Hospitalization Section of this Guide
34	Partial hospitalization claim spans more than 3 days with insufficient number of days meeting partial hospitalization criteria	Suspend	Off	Mental health not reimbursed under OPPS see Partial Hospitalization Section of this Guide
35	Only Mental Health education and training services provided	RTP	Off	Mental health not reimbursed under OPPS see Partial Hospitalization Section of this Guide
36	Extensive mental health services provided on day of ECT or type T procedure **(Active V1.0 – V6.3 only)**	Suspend	Off	Mental health not reimbursed under OPPS see Partial Hospitalization Section of this Guide
37	Terminated bilateral procedure or terminated procedure with units greater than one	RTP	On	Line reject
38	Inconsistency between implanted device and implantation procedure	RTP	Off	Pay claim
39	Mutually exclusive procedure that would be allowed by NCCI if appropriate modifier were present	Line item rejection	On	Line reject
40	Code2 of a code pair that would be allowed by NCCI if appropriate modifier were present	Line item rejection	On	Line reject
41	Invalid revenue code	RTP	Off	Pay claim
42	Multiple medical visits on same day with same revenue code without condition code G0 (see Appendix B)	RTP	On	Line reject
43	Transfusion or blood product exchange without specification of blood product	RTP	On	Line reject
44	Observation revenue code on line item with non-observation HCPCS code	RTP	On	Line reject
45	Inpatient separate procedures not paid	Line item rejection	On	Line pays at default pricing (percentage of charge)
46	Partial hospitalization condition code 41 not approved for type of bill	RTP	Off	Mental health not reimbursed under OPPS

Edit No	Description	Medicare Edit Disposition	FreedomBlue Edit Disposition	FreedomBlue Action
				see Partial Hospitalization Section of this Guide
47	Service is not separately payable	Line item rejection	On	Line reject
48	Revenue center requires HCPCS	RTP	On	Line reject
49	Service on same day as inpatient procedure	Line item denial	Off-Not applicable	Line pays at default pricing (percentage of charge)
50	Non-covered based on statutory exclusion	Line item rejection	On-Medicare coverage specific edit	Line pays at default pricing (percentage of charge)
51	Multiple observations overlap in time (**Not activated**)	RTP	Not applicable	
52	Observation does not meet minimum hours, qualifying diagnoses, and/or 'T' procedure conditions **(V3.0-V6.3)**	RTP	Off-Not applicable	
53	Codes G0378 and G0379 only allowed with bill type 13x	Line item rejection	Off	
54	Multiple codes for the same service	RTP	On	Line reject
55	Non-reportable for site of service	RTP	Off-Process claim	Line pays at default pricing (percentage of charge)
56	E/M-condition not met and line item date for obs code G0244 is not 12/31 or 1/1 **(Active V4.0 – V6.3)**	RTP	Off-Edit is no longer valid	
57	E/M condition not met for separately payable observation and line item date for code G0378 is 1/1	Suspend	Off	
58	G0379 only allowed with G0378	RTP	Off	
59	Clinical trial requires diagnosis code V707 as other than primary diagnosis	RTP	On	Line reject
60	Use of modifier CA with more than one procedure not allowed	RTP	Off-Process claim	Line pays at default pricing (percentage of charge)
61	Service can only be billed to the DMERC	RTP	On	Pay with DME fee schedule
62	Code not recognized by **OPPS**; alternate code for same service may be available	RTP	On-Medicare coverage specific edit	Line pays at default pricing (percentage of charge)
63	This OT code only billed on partial hospitalization claims	RTP	Off	Mental health not

Edit No	Description	Medicare Edit Disposition	FreedomBlue Edit Disposition	FreedomBlue Action
				reimbursed under OPPS see Partial Hospitalization Section of this Guide
64	AT service not payable outside the partial hospitalization program	Line item rejection	Off	Mental health not reimbursed under OPPS see Partial Hospitalization Section of this Guide
65	Revenue code not recognized by Medicare	Line item rejection	On-Medicare coverage specific edit	Line pays at default pricing (charges times RCC)
66	Code requires manual pricing	Suspend	On-Medicare coverage specific edit	Line pays at default pricing (charges times RCC)
67	Service provided prior to FDA approval	Line item rejection	On-Medicare coverage specific edit	Line pays at default pricing (charges times RCC)
68	Service provided prior to date of National Coverage Determination (NCD) approval	Line item rejection	On-Medicare coverage specific edit	Line pays at default pricing (charges times RCC)
69	Service provided outside approval period	Line item rejection	Off-Process claim	Line pays at default pricing (charges times RCC)
70	CA modifier requires patient status code 20	RTP	Off-Process claim	Line pays at default pricing (charges times RCC)
71	Claim lacks required device code	RTP	On	Line reject
72	Service not billable to the Fiscal Intermediary	RTP	On	Line reject
73	Incorrect billing of blood and blood products	RTP	On-Medicare coverage specific edit	Line pays at default pricing (charges times RCC)
74	Units greater than one for bilateral procedure billed with modifier 50	RTP	On	RTP
75	Incorrect Billing of Modifier FB	RTP	On	RTP
76	Trauma Response Critical Care Code Without Revenue Code 068x and CPT 99291	Line item rejection	On	Line reject

Bill Types

The following bill types are subject to OPPS:

- All outpatient hospital bills (bill types 12X, 13X with condition code 41, 14X, and 13X without condition code 41);
- Comprehensive Rehabilitation Facility (CORF) claims for hepatitis B vaccines (bill type 75X);
- Home Health Agency (HHA) claims for antigens, hepatitis B vaccines, splints and casts (bill type 34X); and
- For splints, casts, and antigens when provided to hospice patients for treatment of a non-terminal illness by other than a hospital outpatient department. This requires reporting of condition code 07.

Line Item Dates of Service

Where HCPCS is required a line item date of service is also required.

Reporting of Service Units

The definition of services unit (FL 46 on the Form CMS-1450 or successor forms) where HCPCS code reporting is required is the number of times the service or procedure being reported was performed.

Example

If the following codes are performed once on a specific date of service, the entry in the services unit is as follows: The pattern remains the same for treatment times in excess of two hours. Hospitals should not bill for services performed for less than eight minutes. The expectation (based on the work values for these codes) is that a provider's time for each unit will average 15 minutes in length.

HCPCS Code	Service Units
90849-Multiple-family group psychotherapy	Units > 1
92265-Needle oculoelectromyography, one or more extraocular muscles, one or both eyes, with interpretation and report	Units > 1
95004-Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, specify number of tests	Units > 1
95861-Needle electromyography two extremities with or without related para-spinal areas	Units > 1 6 Units > 83 min. to < 98 min. 7 Units > 98 min. to < 113 min. 8 Units > 113 min. to < 128 min.

The above schedule of times is intended to provide assistance in rounding time into 15 minute increments. It does not imply that any minute until the eighth should be excluded from the total count as the timing of active treatment counted includes time.

The beginning and ending time of the treatment should be recorded in the patient's medical record along with the note describing the treatment. (The total length of the treatment to the minute could be recorded instead). If more than one CPT code is billed during a calendar day, the total number of units that can be billed is constrained by the total treatment time. For example, if 24 minutes of code 97112 and 23 minutes of code 97110 were furnished, then the total treatment time was 47 minutes; so only three units can be billed for the treatment. The correct coding is two units of code 97112 and one unit of code 97110, assigning more units to the service that took more time.

Reporting of HCPCS Codes

HCPCS includes the American Medical Association's "Current Procedural Terminology," 4th Edition (CPT-4), for physician services and CMS developed codes for certain non-physician services. All of the CPT-4 is contained within HCPCS, and is identified as Level I CPT codes consist of five numeric characters. The CMS developed codes are known as Level II. Level II codes are five-character codes that begin with an alpha character that is followed by either numeric or alpha characters.

Hospital-based and independent ESRD facilities must use HCPCS to bill for blood and blood products, and to bill for drugs and clinical laboratory services paid outside the composite rate. In addition, the hospital is required to report modifiers as applicable.

The HCPCS codes are required for all outpatient hospital services unless exceptions are specifically noted in manual instructions. This means that codes are required on surgery, radiology, other diagnostic procedures, clinical diagnostic laboratory, durable medical equipment, orthotic-prosthetic devices, take-home surgical dressings, therapies, preventative services, immunosuppressive drugs, other covered drugs, and most other services. Claims with required HCPCS coding missing will be returned to the hospital for correction.

The following chart reflects HCPCS coding to be reported under OPPS by hospital outpatient departments. This chart is intended only as a guide to be used by hospitals to assist them in reporting services rendered. Hospitals that are currently utilizing different revenue/HCPCS reporting may continue to do so. It is not required to change the way it currently reports services to agree with this chart. Note that this chart does not represent all HCPCS coding subjects to OPPS.

Revenue Code	HCPCS Code	Description
* [1]	10040-69990	Surgical Procedure
*	92950-92961	Cardiovascular
*	96570, 96571	Photodynamic Therapy
*	99170, 99185, 99186	Other Services and Procedures
*	99291-99292	Critical Care
*	99440	Newborn Care
*	90782-90799	Therapeutic or Diagnostic Injections
*	D0150, D0240-D0274 D0277, D0460, D0472- D0999, D1510-D1550 D2970, D2999, D3460 D3999, D4260-D4264, D4270-D4273, D4355D4381, D5911-D5912, D5983D5985, D5987, D6920, D7110D7260, D7291, D7940, D9630, D9930, D9940, D9950, D9952	Dental Services
*	92502-92596, 92599	Otorhinolaryngologic Services (ENT)
0278	E0749, E0782, E0783, E0785	Implanted Durable Medical Equipment
0278	E0751, E0753, L8600, L8603, L8610, L8612, L8613, L8614, L8630, L8641, L8642, L8658, L8670, L8699	Implanted Prosthetic Devices
0302	86485-86586	Immunology
0305	85060-85102, 86077-86079	Hematology
031X	80500-80502	Pathology - Lab
0310	88300-88365, 88399	Surgical Pathology
0311	88104-88125, 88160-88199	Cytopathology
032X	70010-76092, 76094-76999	Diagnostic Radiology
0333	77261-77799	Radiation Oncology
034X	78000-79999	Nuclear Medicine
037X	99141-99142	Anesthesia
045X	99281-99285, 99291	Emergency
046X	94010-94799	Pulmonary Function
0480	93600-93790, 93799, G0166	Intra Electrophysiological Procedures and Other Vascular Studies
0481	93501-93572	Cardiac Catheterization
0482	93015-93024	Stress Test
0483	93303-93350	Echocardiography
051X	92002-92499	Ophthalmological Services
051X	99201-99215, 99241-99245, 99271-99275	Clinic Visit
0510, 0517, 0519	95144-95149, 95165, 95170, 95180, 95199	Allergen Immunotherapy
0530	98925-98929	Osteopathic Manipulative Procedures
0636	A4642, A9500, A9605	Radionuclide's
0636	90476-90665, 90675-90749	Vaccines, Toxiods
0636	90296-90379, 90385, 9038990396	Immune Globulins
073X	G0004-G0006, G0015	Event Recording ECG
0730	93005-93009, 93011-93013, 93040-93224, 93278	Electrocardiograms (ECGs)

[1] Revenue codes have not been identified for these procedures, as they can be performed in a number of revenue centers within a hospital, such as emergency room (0450), operating room (0360), or clinic (0510). Hospitals are to report these HCPCS codes under the revenue center where they were performed.

Revenue Code	HCPCS Code	Description
0731	93225-93272	Holter Monitor
074X	95812-95827, 95950-95962	Electroencephalogram (EEG)
0771	G0008-G0010	Vaccine Administration
088X	90935-90999	Non-ESRD Dialysis
0900	90801, 90802, 90865,90899	Behavioral Health Treatment/Services
0901	90870, 90871	Psychiatry
0903	90910, 90911, 90812-90815, 90823, 90824, 90826-90829	Psychiatry
0909	90880	Psychiatry
0914	90804-90809, 90816-90819, 90821, 90822, 90845, 90862	Psychiatry
0915	90853, 90857	Psychiatry
0916	90846,90847, 90849	Psychiatry
0917	90901-90911	Biofeedback
0918	96100-96117	Central Nervous System Assessments/Tests
092X	95829-95857, 95900-95937, 95970-95999	Miscellaneous Neurological Procedures
0920, 0929	93875-93990	Non Invasive Vascular Diagnosis Studies
0922	95858-95875	Electromyography (EMG)
0924	95004-95078	Allergy Test
0940	96900-96999	Special Dermatological Procedures
0940	98940-98942	Chiropractic Manipulative Treatment
0940	99195	Other Services and Procedures
0943	93797-93798	Cardiac Rehabilitation

NOTE: The listing of HCPCS codes contained in the above chart does not assure coverage on the specific service. Current cover criteria apply.

The following revenue codes when billed under OPPS without HCPCS codes are packaged services for which no separate payment is made. However, the costs of these services are included in the outlier calculations. The revenue codes for packaged service are: 0250, 0251, 0252, 0254, 0255, 0257, 0258, 0259, 0260, 0262, 0263, 0264, 0269, 0270, 0271, 0272, 0275, 0276, 0278, 0279, 0280, 0289, 0370, 0371, 0372, 0379, 0390, 0399, 0560, 0569, 0621, 0622, 0624, 0630, 0631, 0632, 0633, 0637, 0681, 0682, 0683, 0684, 0689, 0700, 0709, 0710, 0719, 0720, 0721, 0762, 0810, 0819, and 0942.

Any other revenue codes that are billable on a hospital outpatient claim must contain a HCPCS code in order to assure payment under OPPS. FreedomBlue will reject the lines with revenue codes that require HCPCS and no HCPCS is coded on the line.

Coding for Clinic and Emergency Department Visits

Hospitals code the site of the visit and the level of intensity, using the following codes:

92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99271, 99272, 99273, 99274, 99275, 99281, 99282, 99283, 99284, 99285, 99291, and G0175.

Because CPT is more descriptive of practitioner than of facility services, hospitals must use CPT guidelines when applicable, or crosswalk hospital coding structures to CPT. For example, a hospital that has eight levels of emergency and trauma care, depending on nursing ratios, should crosswalk those eight levels to the CPT codes for emergency care.

Modifiers

Refer to the appropriate CPT guide or the HCPCS Guide for the definition.

Modifiers Used for Outpatient Prospective Payment System

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

Modifier -50 may be used with diagnostic and radiology procedures as well as with surgical procedures, and should be used to report bilateral procedures that are performed at the same operative session as a single line item. Modifiers RT and LT are not used when modifier -50 applies. A bilateral procedure is reported on one line using modifier -50. Modifier -50 applies to any bilateral procedure performed on both sides at the same session.[2]

Modifiers may be applied to surgical, radiology, and other diagnostic procedures. Providers must use any applicable modifier when appropriate. Providers do not use a modifier if the narrative definition of a code indicates multiple occurrences.

Example

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

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

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

Example

- Code 11600 (Excision malignant lesion, trunks, arms, or legs; lesion diameter 0.5 cm. or less)
- Code 11640 (Excision malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 0.5 cm. or less)
- Modifiers –GN, -GO, and –GP must be used to identify the therapist performing speech language therapy, occupational therapy, and physical therapy respectively.
- Modifier -50 (bilateral) applies to diagnostic, radiological, and surgical procedures.
- Modifier -52 applies to radiological procedures.
- Modifiers -73, and -74 apply only to certain diagnostic and surgical procedures that require anesthesia.

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

1. Will the modifier add more information regarding the anatomic site of the procedure? (Example: Cataract surgery on the right or left eye).

2. Will the modifier help to eliminate the appearance of duplicate billing? (Examples: Use modifier 77 to report the same procedure performed more than once on the same date of service but at different encounters. Use modifier 25 to report significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service. Use modifier 58 to report staged or related procedure or service by the same physician during the postoperative period. Use modifier 78 to report a return to the operating room for a related procedure during the postoperative period. User modifier 79 to report an unrelated procedure or service by the same physician during the postoperative period).

3. Would a modifier help to eliminate the appearance of unbundling? (Example: CPT codes 90780 (Infusion therapy, using other than chemotherapeutic drugs, per visit) and 36000 (Introduction of needle or intra catheter, vein): If procedure 36000 was performed for a reason other than as part of the IV infusion, modifier -59 would be appropriate.

Where to Report Modifiers on the UB-92 (Form CMS-1450 or successor forms)

Modifiers are reported on the hardcopy UB-92 (Form CMS-1450 or successor forms) in FL 44 next to the HCPCS code. There is space for two modifiers on the hardcopy from (4 of the 9 positions). On the UB-92 or successor form flat file, providers use record type 61, field numbers six and seven. There is space for two modifiers, one in field six and one in field seven.

On the HIPAA X12N 837 data elements SV202-3 and SV202-4 are used to report the two modifiers. The dash that is often seen preceding a modifier should never be

reported. When it is appropriate to use a modifier, the most specific modifier should be used first. That is, when modifiers E1 through E4, FA through F9, LC, LD, RC, and TA through T9 apply, they should be used before modifiers LT, RT, or -59.

Use of Modifiers -50, -LT, and –RT

- Modifier -50 is used to report bilateral procedures that are performed at the same operative session as a single line item. Do not use modifiers RT and LT when modifier 50 applies. Do not submit two line items to report a bilateral procedure using modifier 50.
- Modifier -50 applies to any bilateral procedure performed on both sides at the same operative session.
- The bilateral modifier -50 is restricted to operative sessions only.
- Modifier -50 may not be used:
  - To report surgical procedures identified by their terminology as “bilateral”, or
  - To report surgical procedures identified by their terminology as “unilateral or bilateral”

The unity entry to use when modifier -50 is reported is one.

Modifiers –LT and –RT

Modifiers –LT and –RT apply to codes, which identify procedures, which can be performed on paired organs (e.g., ears, eyes, nostrils, kidneys, lungs, and ovaries).

Modifiers –LT and –RT should be used whenever a procedure is performed on only one side. Hospitals use the appropriate –RT and –LT modifier to identify which of the paired organs was operated upon. These modifiers are required whenever it is appropriate.

Use of Modifiers for Discontinued Services

A. General

Modifiers provide a way for hospitals to report and be paid for expenses incurred in preparing a patient for surgery and scheduling a room for performing the procedure where the service is subsequently discontinued. This instruction is applicable to both outpatient hospital departments and to ambulatory surgical centers.

Modifier -73 is used by the facility to indicate that a surgical or diagnostic procedure requiring anesthesia was terminated due to extenuating circumstances or circumstances that threatens the well being of the patient after the patient has been prepared for the procedure (including pre-medication when provided), and has been take to the room where the procedure will be performed, but prior to administration of anesthesia. For purposes of billing for services furnished in the hospital outpatient department, anesthesia is defined to include local, regional block(s), moderate sedation/analgesia (“conscious sedation”), deep sedation/analgesia, or general anesthesia. This modifier code was created so that cost incurred by the hospital to prepare the patient for the procedure and the resources expended in the procedure room and recovery room (if necessary), could be recognized for payment even though the procedure was

discontinued. Prior to January 1, 1999, modifier -52 was used for reporting these discontinued services.

Modifier -74 is used by the facility to indicate that a surgical or diagnostic procedure requiring anesthesia was terminated after the induction of anesthesia or after the procedure was started (e.g., incision made, intubation started, scope inserted), due to extenuating circumstances or circumstances that threatens the well being of the patient. For purpose of billing for services furnished in the hospital outpatient department, anesthesia is defined to include local, regional block(s), moderated sedation/analgesia ("conscious sedation"), deep sedation/analgesia, and general anesthesia. This modifier code was created so that the costs incurred by the hospital to initiate the procedure (preparation of the patient, procedure room, recovery room) could be recognized for payment even though the procedure was discontinued prior to completion. Prior to January 1, 1999, modifier -53 was used for reporting these discontinued services.

Modifiers -52 and -53 are no longer accepted as modifiers for certain diagnostic and surgical procedures under the hospital outpatient prospective payment system. Coinciding with the addition of the modifiers -73 and -74 modifiers -52 and -53 were revised. Modifier -52 is used to indicate partial reduction or discontinuation of radiology procedures and other services that do not require anesthesia. The modifier provides a means for reporting reduced services without disturbing the identification of the basic service. Modifier -53 is used to indicate discontinuation of physician services and is not approved for use for outpatient hospital services. The elective cancellation of a procedure should not be reported.

Modifiers -73 and -74 are used to indicate discontinued surgical and certain diagnostic procedures only. They are not used to indicate discontinued radiology procedures.

B. Effect on Payment

Surgical or certain diagnostic procedures that are discontinued after the patient has been prepared for the procedure and taken to the procedure room for which modifier -73 is coded, will be paid at 50 percent of the full OPPS payment amount.

Surgical or certain diagnostic procedures that are discontinued after the procedure has been initiated and/or the patient has received anesthesia for which modifier -74 is coded, will be paid at the full OPPS payment amount.

C. Termination Where Multiple Procedures Planned

When one or more of the procedures planned is completed, the completed procedures are reported as usual. The other(s) that were planned, and not started, are not reported. When none of the procedures that were planned are completed, and the patient has been prepared and taken to the procedure room, the first procedure that was planned, but not completed is reported with modifier -73. If the first procedure has been started (scope inserted, intubation started, incision made, etc.) and/or the patient has received anesthesia, modifier -74 is used. The other procedures are not reported.

If the first procedure is terminated prior to the induction of anesthesia and before the patient is wheeled into the procedure room, the procedure should not be reported. The patient has to be taken to the room where the procedure is to be performed in order to report modifier -73 or -74.

Modifiers for Repeat Procedures

Two repeat procedure modifiers are applicable for hospital use:

- Modifier -76 is used to indicate that the same physician repeated a procedure or service in a separate operative session on the same day.
- Modifier -77 is used to indicate that another physician repeated a procedure or service in a separate operative session on the same day.

If there is a question regarding who the ordering physician was and whether or not the same physician ordered the second procedure, the code selected is based on whether or not the physician performing the procedure is the same. The procedure must be the same procedure. It is listed once and then listed again with the appropriate modifier.

Modifiers for Radiology Services

Modifiers -52 (Reduced Services), -59, -76, and -77, and the Level II modifiers apply to radiology services. When a radiology procedure is reduced, the correct reporting is to code to the extent of the procedure performed. If no code exists for what has been done, report the intended code with modifier -52 appended.

Example

Code 71020 (Radiologic examination, chest, two views, frontal and lateral) is ordered. Only one view is performed. Code 71010 (Radiologic examination, chest; single view, frontal) is reported. Code 71020-52 is not reported.

Payment is not reduced for radiology services reported with modifier -52 (Reduced Services)

CA Modifier

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

HCPCS Level II Modifiers

Generally, these codes are required to add specificity to the reporting of procedures performed on eyelids, fingers, toes, and arteries. It may be appended to CPT codes. If more than one Level II modifier applies, the HCPCS code is repeated on another line with the appropriate Level II modifier.

Example

Code 26010 (drainage of finger abscess; simple) done on the left thumb and second finger would be coded:

- 26010FA
- 26010F1

Condition Code G0

Hospitals should report Condition Code G0 on FLs 24-30 (or the corresponding electronic location) when multiple medical visits occurred on the same day in the same revenue center but the visits were distinct and constituted independent visits. An example of such a situation would be a beneficiary going to the emergency room twice on the same day, in the morning for a broken arm and later for chest pain.

Multiple medical visits on the same day in the same revenue center may be submitted on separate claims. Hospitals should report Condition Code G0 on the second claim. Appropriate reporting of Condition Code G0 allows for accurate payment under OPPS in this situation. The OCE contains an edit that will reject multiple medical visits on the same day with the same revenue code without the presence of Condition G0. To further illustrate, the following table describes actions the OCE takes when multiple medical visits occur on the same day in the same revenue code center:

Evaluation and Management (E&M)	Revenue Center	Condition Code	OCE Action
2 or more	Two or more E&M codes have the same revenue center	No G0	Assign medical APC to each line item with E&M code and deny all line items with E&M code except the line item with the highest APC payment
2 or more	Two or more E&M codes have the same revenue center	G0	Assign medical APC to each line with E&M code.

Observation Services

Observation Services:

The policy for paying for observation services is distinct to Medicare Advantage benefits, coverage and medical management. Generally, observation services are paid for up to 48 hours unless the claim also contains a line for a surgical service. The observation service line is, at that point, considered bundled with surgery and is not separately reimbursable.

Drugs and Biologicals

Coding and Payment for Drugs and Biologicals

This section provides hospitals with coding instructions and payment information for drugs paid under OPPS.

- ***Separately Payable Drugs***-Hospitals must report all appropriate HCPCS codes and charges for separately payable drugs in addition to reporting the applicable drug administration codes. Drugs are to be billed in multiples of the dosage identified by the billing code, and rounded up if necessary.
- ***Packaged Drugs***-FreedomBlue requests that hospitals voluntarily report to HCPCS codes and charges for drugs that are packaged into payments for the corresponding drug administration service. Historical hospital cost data may assist with future packaging decisions for such drugs.
- ***Pass-Through Drugs-***Section 1833(t)(6) of the Social Security Act provides for temporary additional or "pass-through" payments for certain drugs, devices, and biological agents that meet identified criteria. Under the statue, transitional pass-through payments can be made for at least two years, but no more than three years.
- ***Non Pass-Through Drugs***-Drugs, biologicals (including blood and blood products), and radiopharmaceuticals that do not have pass-through status are either packaged into existing Ambulatory Payment Classification (APC) payments for service or receive separate APC payment. To find a listing of HCPCS codes used to bill for drugs and biologicals, reference Addendum B of the OPPS Final Rule (updated annually) or the CMS Web Site: http:/www.cms.hhs.gov/
- ***Coding and Payment for Drug Administration***

A. ***Overview***-Certain drug administration services furnished under the Hospital Outpatient Prospective Payment System (OPPS) prior to January 1, 2005 were reported using HCPCS alphanumeric codes: Q0081, Infusion therapy other than chemotherapy, per visit; Q0083, Administration of chemotherapy by any route other than infusion, per visit; Q0084, Administration of chemotherapy by infusion only, per visit; in combination with applicable CPT codes for administration of non-infused, non-chemotherapy drugs.[3]

These same drug administration services furnished by hospital outpatient departments to Medicare beneficiaries during CY 2005 were reported using CPT codes 90780, 90781, and 96400-96459. Payments for these drug administration services in 2005 continued to be made on a per visit

[3] (NOTE: HCPCS code Q0085, administration of anti-neoplastic drugs by both infusion and a route other than infusion, per visit, was discontinued in 2004.)

basis (rather than a per-service basis) due to the per-day 2003 cost data available to set CY 2005 payment rates.

Effective January 1, 2006, some of the CPT codes that were used for drug administration services under the OPPS throughout CY 2005 are replaced with more detailed CPT codes incorporating specific procedural concepts, as defined and described by the CPT manual, such as "initial," "concurrent," and "sequential."

In order to facilitate the transition to more specific CPT codes within the hospital environment and to assist hospitals in ensuring continued correct coding concepts, drug administration services provided in CY 2006 under the OPPS will be billed using a combination of CPT codes and C-codes that were created to be consistent with some aspects of the CY 2005 CPT coding structure.

Hospitals are reminded to bill a separate Evaluation and Management code (with modifier 25) only if a significant, separately identifiable E/M service is performed in the same encounter with OPPS drug administration services.

B. ***Billing for Infusions and Injections***

First Hour of Infusion-Hospitals are to report first hour infusion codes (e.g., C8950, C8954, 96422) after 15 minutes of infusion. Infusions lasting 15 minuets or less should be billed as intravenous (or intra-arterial) pushes and must be coded accordingly. If hospitals provide different types of infusions (1) that could be reported with separate first hour infusion codes (e.g., chemotherapy and non-chemotherapy intravenous infusions, or intra-arterial and intravenous chemotherapy infusions) in the same encounter and (2) that also meet the time requirements for billing an hour of each type of infusion, then hospitals may report a first hour for each different type of infusion provided.

Subsequent Infusion Hours-Hospitals are to report additional hours of infusion (e.g. C8951, C8955, 96423), either a continuing infusion of the same substance or drug or a sequential infusion of a different substance or drug, beyond the first hour, and only after more than 30 minutes have passed from the end of the previously billed hour. Therefore, to bill an additional hour of infusion after the first hour, more than 90 minutes of infusion services must be provided. One unit of the appropriate code is to be reported for each additional hour of infusion.

Concurrent Infusions-Concurrent infusions through the same vascular access site of the same type are not separately reportable under the OPPS. Hospitals are to include the charges associated with concurrent infusions in their charges for the infusion service billed.

Infusion Time-Hospitals are to report HCPCS codes that describe the actual time over which the infusion is administered to the beneficiary for time-specific drug administration codes (e.g., C8950, C8951, C8954, C8955, 96422, 96423). Hospitals should not include in their reporting the time that may elapse between establishment of vascular access and initiation of the infusion.

Intravenous or Intra-Arterial Push-Hospitals are to bill push codes (e.g. C8952, C8953, 96420) for services that meet either of the following criteria:

- A healthcare professional administering an injection is continuously present to administer and observe the patient; or
- An infusion lasting 15 minutes or less.

Hospitals are to bill for additional IV pushes of different substances or drugs using multiple units of the appropriate push code. Additional IV pushes of the same substance or drug are not separately reported with multiple units of a push code because the number of units reported with the IV push code is to indicate the number of separate substances or drugs administered by IV push.

Included Services-Hospitals are instructed that the following items and services, when performed to facilitate an infusion or injection, are not separately billable. However, hospitals have one of two choices: (1) Continue to report separate charges so long as the charges are reported without a CPT/HCPCS code but, rather are reported with an appropriate packaged revenue code or; (2) Do not report any separate charges but include the charges for the items and services as part of the charge for the procedure in which the items/services are supplied.

- Use of local anesthesia;
- IV start;
- Access to indwelling IV, subcutaneous catheter or port;
- Flush at conclusion of infusion;
- Standard tubing, syringes and supplies; and
- Preparation of chemotherapy agent(s).

Fluid used to administer drug(s) is considered incidental hydration and a separate non-chemotherapy infusion service should not be reported.

Example

A non-chemotherapy infusion lasts three hours and seven minutes. The hospital bills one unit of C8950 (for the first hour) and two units of C8951 (for the second and third hour). Hospitals can not bill push codes for carryover infusion services not otherwise eligible for billing of a subsequent infusion hour. Payment will be one unit of APC 0120.

C. ***Use of Modifier 59-***With respect to chemotherapy administration and non-chemotherapy drug infusion, the use of Modifier 59 indicates a distinct encounter on the same date of service. In the case of chemotherapy administration or non-chemotherapy infusion, Modifier 59 is appended to drug administration HCPCS codes that meet the following criteria:

- The drug administration occurs during a distinct encounter on the same date of services of previous drug administration services; and
- The same HCPCS code has already been billed for service provided during a separate and distinct encounter earlier on that same day; or
- A distinct and separate drug administration service is provided on the same day as a procedure when there is an OPPS National Correct Coding Initiative edit for the drug administration service and procedure code pair that may be bypassed with a modifier, and the use of the modifier is clinically appropriate.

The CPT modifier 59 is NOT to be used when a beneficiary receives infusion therapy at more than one vascular access site of the same type (intravenous or intra-arterial) in the same encounter or when an infusion is stopped and then started again in the same encounter. In the instance where infusion is stopped and then started again in the same encounter. In the instance where infusions of the same type (e.g., chemotherapy, non-chemotherapy, intra-arterial) are provided through two vascular access sites of the same type in one encounter, hospitals may report two units of the appropriate first hour infusion code for the initial infusion hours without modifier 59.

The Outpatient Code Editor (OCE) will pay one unit of the corresponding APC for each separate encounter of an appropriately billed drug administration service, up to the daily maximum listed in Table 1. Units of service exceeding daily maximum allowances will be packaged and no additional payment will be made.

Example 1

A beneficiary receives infused non anti-neoplastic drugs for 2 hours. The hospital reports one unit of HCPCS code C8950 and one unit of HCPCS code C8951 for the services in the encounter. The beneficiary leaves the hospital and returns for a second encounter in which the beneficiary again receives infused non anti-neoplastic drugs for two hours. For the second encounter on the same date of service, the hospital reports one unit of HCPCS code C8950 with modifier 59 and one unit of HCPCS code C8951 with modifier 59. The OCE will pay two units of APC 0120 (i.e., one unit for each encounter).

Example 2

A beneficiary receives one injection of non-hormonal anti-neoplastic drugs and two hours of an infusion of anti-neoplastic drugs in the first encounter. The hospital reports one unit of 96401 and one unit each of C8954 and C8955. The OCE will pay one unit of APC 0116 (for one unit of 96401) and one unit of APC 0117 (for the one unit each of C8954 and C8955). Later on the same date of service, the beneficiary returns to the hospital and receives two injections of non-hormonal anti-neoplastic drugs. For the second encounter, the hospital reports one unit of 96401 with modifier 59, and one unit of 96401 without modifier 59. The hospital will be paid one unit of APC 0116 for two units of 96401 (as the second unit of 96401 provided during the second encounter is bundled with the first unit of 96401 provided during the second encounter).

Example 3

A beneficiary receives three injections of non-hormonal anti-neoplastic drugs and two hours of infusion of anti-neoplastic drugs in one encounter. The beneficiary returns to the hospital in a separate encounter on the same date for administration of hydrating solution provided via infusion over two hours to treat dehydration and vomiting. For services in the first encounter, the hospital reports CPT codes as three units of 96401, one unit of C8954, and one unit of C8955 (all without modifier 59). For services in the second encounter, the hospital reports one unit of HCPCS code C8950 and one unit of HCPCS code C8951. The OCE pays one unit of APC 0116 (for the three units of 96401), one unit of APC 0117 (for the one unit of C8954 and C8955). No modifiers are needed when billing for services in the second encounter as these services were not provided during the first encounter on that day.

Example 4

A beneficiary receives three injections of anti-neoplastic drugs and two hours of infusion of anti-neoplastic drugs in one encounter. The beneficiary has a second encounter on the same date of service in which the beneficiary receives three injections of non-hormonal anti-neoplastic drugs and one hour of infusion of drugs other than anti-neoplastic drugs (includes hydrating solution). For the first encounter the hospital reports the following: Three units of 96401, one unit of C8954, and one unit of C8955 (without modifier 59). For the second encounter, the hospital bills three units of CPT code 96401 (one unit with modifier 59, two units without modifier 59), and one unit of CPT code 8950(without modifier 59). The OCE pays two units of APC 0116 (one for each encounter-three units of 96401 during the first encounter and three units during the second), one unit of APC 0117 (for the one unit each of C8954 and C8955 during the first encounter) and one unit of APC 0120 (for the one unit of C8950 during the second encounter).

D. ***Payments For Drug Administration Services-***Payment for drug administration services in CY 2006 will again be based on a per-visit basis due to the per-visit claims data available with which to set CY 2006 payment rates. The OCE includes claims processing logic that accesses each OPPS claim and assigns APC payments to HCPCS codes as appropriate. OCE logic allows for drug administration APC payments as noted in Table 1 below.

Table 1: OCE Parameters for Drug Administration APC Payments

APC	Maximum Number of Units Without Modifier -59	Maximum Number of Units With Modifier -59
0116	1	2
0117	1	2
0120	1	4

The OCE groups each HCPCS code appearing on a claim into one of these three APCs based on their APC assignment in Addendum B of the OPPS final rule with comment period. If none of the reported drug administration HCPCS codes contain modifier -59, the OCE will provide a single per-encounter APC payment for each APC that has a corresponding HCPCS code billed on the claim. If modifier-59 does appear on the claim, the OCE can assign one additional payment per incidence of the modifier, with an upper limit of APC payments listed above in Table 1.

For CY 2006 APC payment rates, refer to Addendum B on the CMS Web site at www.cms.hhs.gov/providers/hopps.asp.

E. ***Infusions Started Outside the Hospital-***Hospitals may receive Medicare beneficiaries for outpatient services who are in the process of receiving an infusion at their time of arrival at the hospital (e.g., a patient who arrives via ambulance with an ongoing intravenous infusion initiated by paramedics during transport). Hospitals are reminded to bill for all services provided using the HCPCS code(s) that most accurately describe the service(s) they provided. This includes hospital billing C8950 or C8954 for the first hour of intravenous infusion that the patient receives while at the hospital, even if the hospital did not initiate the infusion, and HCPCS codes for additional hours of infusion if needed.

Administration of Drugs Via Implantable or Portable Pumps
Table 2: CY 2006 OPPS Drug Administration Codes for Implantable or Portable Pumps

2005 CPT	2005 CPT Description	2006 CPT	Final CY 2006 OPPS Description	Status Indicator	APC
n/a	n/a	C8957	Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump	S	0120
96414	Chemotherapy administration, intravenous; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of portable or implantable pump	S	0117
96425	Chemotherapy administration, infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump)	96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	S	0117
96520	Refilling and maintenance of portable pump	96521	Refilling and maintenance of portable pump	T	0125
96530	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic [e.g. Intravenous, intra-arterial]	96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous, intra-arterial)	T	0125
n/a	n/a	96523	Irrigation of implanted venous access device for drug delivery systems	N	

Hospitals are to report HCPCS code C8957 and CPT codes 96416 and 96425 to indicate the initiation of a prolonged infusion that requires the use of an implantable or portable refilling and maintenance of drug delivery systems or irrigation of implanted venous access devices for such systems, and may be reported for the servicing of devices used for therapeutic drugs other than chemotherapy.

- **Chemotherapy Drug Administration**

A. Overview-AMA chemotherapy administration instructions for CPT codes 96401-96549 additionally apply to HCPCS codes C8954, C8955, and C8953. Therefore, hospitals are to report chemotherapy drug administration HCPCS codes when providing non-radionuclide anti-neoplastic drugs to treat cancer and when administering non-radionuclide anti-neoplastic drugs, anti-neoplastic agents, monoclonal antibody agents, and biologic response modifiers for treatment of non-cancer diagnoses.

Medicare's general policy regarding physician supervision within hospital outpatient departments meets the physician supervision requirements for use of CPT codes 96401-96549.

B. Administration of Chemotherapy Drugs by Intravenous Infusion- Effective for services furnished on or after January 1, 2006 hospitals paid under the OPPS (12x and 13x bill types) are to report an appropriate HCPCS code for chemotherapy drug administration by intravenous infusion as listed in Table 3.

Table 3: CY 2006 OPPS Chemotherapy Drug Administration – Intravenous Infusion Technique

2005 CPT	2005 CPT Description	HCPCS Code	Final CY 2006 OPPS Description	Status Indicator	APC
96410	Chemotherapy administration, intravenous; infusion technique, up to one hour	C8954	Chemotherapy administration, intravenous; infusion technique, up to one hour	S	0117
96412	Chemotherapy administration, intravenous; infusion technique, one to 8 hours, each additional hour (List separately in addition to code for primary procedure)	C8955	Chemotherapy administration, intravenous; infusion technique, each additional hour (List separately in addition to C8954)	N	
96414	Chemotherapy administration, intravenous; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of portable or implantable pump	S	0117

For services furnished in hospital outpatient departments prior to January 1, 2005, chemotherapy drug infusions were reported using HCPCS alphanumeric code Q0084, Administration of Chemotherapy by Infusion only, per visit. Chemotherapy infusion services furnished in hospital outpatient departments during CY 2005 were reported using CPT codes 96401, 96412, and 96414.

Table 3 maps CY 2005 chemotherapy administration via intravenous infusion CPT codes to OPPS drug administration codes effective January 1, 2006.

HCPCS code C8955 is an add-on code. HCPCS code C8955 should be used by hospitals to report the total number of additional infusion hours after the first hour of chemotherapy infusion. Additional hours of chemotherapy infusion beyond nine hours will no longer need to be reported on separate lines, as there in no hour limit associated with this code.

The OCE logic assumes that all services for chemotherapy infusions billed on the same date of service where provided during the same encounter. In those unusual cases where the beneficiary makes two separate visits to the hospital for chemotherapy infusions in the same day, the hospital reports modifier 59 for chemotherapy infusion codes during the second encounter that were also furnished in the first encounter. The OCE identifies modifier 59 and pays up to a maximum number of units per day, as listed in Table 1.

Example 1

A beneficiary receives one injection of non-hormonal anti-neoplastic drugs and an infusion of two hours of anti-neoplastic drugs in one encounter. The patient leaves the hospital and later that same day returns to the hospital for two injections of non-hormonal anti-neoplastic drugs. To bill for the first encounter, the hospital reports one unit of 96401 (without modifier 59), one unit of C8954, and one unit of C8955 (without modifier 59). To bill for the second encounter, the hospital reports one unit of 96401 (with modifier 59) and one unit of 96401 (without modifier 59). The hospital will be paid two units of APC 0116 (once for each encounter with 96401-one unit in the first, two units in the second) and one unit of APC 0117 (for the one unit of C8954 and the one unit of C8955). (NOTE: See §230.1 for drug billing instructions).

Example 2

A beneficiary receives an infusion of anti-neoplastic drugs for two hours using a hydrating solution to which the anti-neoplastic drug has been added, without a specific medically necessary order for hydration. The hospital reports one unit of C8954 and one unit of C8955. The OCE will pay one unit of APC 0117 (for the unit each of C8954 and C8955). (NOTE: See §230.1 for drug billing instructions).

C. Administration of Chemotherapy Drugs by a Route Other Than Intravenous Infusion-Effective for services furnished on or after January 1, 2006, hospitals paid under the OPPS (12x and 13x bill types) are to report an appropriate HCPCS code for chemotherapy drug administration by route other than infusion as listed in Table 4.

Table 4: CY 2006 OPPS Chemotherapy Drug Administration – Route Other Than Intravenous Infusion

2005 CPT	2005 CPT Description	HCPCS Code	Final CY 2006 OPPS Description	Status Indicator	APC
96408	Chemotherapy administration, intravenous; push technique	C8953	Chemotherapy administration, intravenous; push technique	S	0116

2005 CPT	2005 CPT Description	HCPCS Code	Final CY 2006 OPPS Description	Status Indicator	APC
96400	Chemotherapy administration, subcutaneous or intramuscular, with or without local anesthesia	96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic	S	0116
96400	Chemotherapy administration, subcutaneous or intramuscular, with or without local anesthesia	96402	Chemotherapy administration, subcutaneous or intramuscular; hormonal anti neoplastic	S	0116
96405	Chemotherapy administration, intra-lesional; up to and including 7 lesions	96405	Chemotherapy administration; intra-lesional, up to and including 7 lesions	S	0116
96406	Chemotherapy administration, intra-lesional; more than 7 lesions	96406	Chemotherapy administration; intra-lesional, more than 7 lesions	S	0116
96420	Chemotherapy administration, intra-arterial; push technique	96420	Chemotherapy administration, intra-arterial; push technique	S	0116
96422	Chemotherapy administration, infusion technique up to one hour	96422	Chemotherapy administration, intra-arterial; infusion technique, up to one hour	S	0117
96445	Chemotherapy administration into	96445	Chemotherapy administration into	S	0116
96440	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis pleural cavity, requiring and including thoracentesis	96440	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis pleural cavity, requiring and including thoracentesis	S	0116
96450	Chemotherapy administration, into CNS (e.g. Intrathecal) requiring and including spinal puncture	96450	Chemotherapy administration, into CNS (e.g., intrathecal), requiring and including spinal puncture	S	0116
96542	Chemotherapy injection, subarachnoid or intra-ventricular via subcutaneous reservoir, single or multiple agents	96542	Chemotherapy injection, subarachnoid or intra-ventricular via subcutaneous reservoir, single or multiple agents	S	0116
96549	Unlisted chemotherapy procedure	96549	Unlisted chemotherapy procedure	S	0116
96423	Chemotherapy administration, infusion technique, one to 8 hours, each additional hour (List separately in addition to code for primary procedure)	96423	Chemotherapy administration, intra-arterial; infusion technique, each additional hour up to 8 hours (List separately in addition to code for primary procedure)	N	

Chemotherapy drug administration services other intravenous infusions that were furnished in hospital outpatient departments during CY 2005 were reported using CPT codes 96420-96549.

Table 4 maps CY 2005 chemotherapy administration via routes other than intravenous infusion CPT codes to OPPS drug administration HCPCS codes effective January 1, 2006.

CPT code 96423 is an add-on code to indicate the total number of hours of intra-arterial infusion that are provided in addition to the first hour of administration. CPT code 96423 should be used by hospitals to report the total number of additional infusion hours. Additional hours of infusion beyond eight should be reported on another separate line with CPT code 96423 and the appropriate number of hours.

OCE logic assumes that all services for chemotherapy drug administration by a route other than infusion that are billed on the same date of service were provided during the same encounter. In those unusual cases where the beneficiary makes two separate visits to the hospital for chemotherapy treatment in the same day, hospitals are instructed to report modifier 59 for chemotherapy drug administration (by a route other than infusion) codes during the second encounter that were also furnished in the first encounter. The OCE identifies modifier 59 and pays up to a maximum number of units per day, as listed in Table 1.

- **Non-Chemotherapy Drug Administration**

A. Administration of Non-Chemotherapy Drugs by Intravenous Infusion

Table 5: CY 2006 OPPS Non-Chemotherapy Drug Administration –Intravenous Infusion Technique

2005 CPT	2005 CPT Description	HCPCS Code	Final CY 2006 OPPS Description	Status Indicator	APC
90780	Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour	C8950	Intravenous infusion for therapy/diagnosis; up to 1 hour	S	0120
90781	Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)	C8951	Intravenous infusion for therapy/diagnosis; each additional hour (List separately in addition to C8950)	N	
n/a	n/a	C8957	Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump	S	0120

Hospitals are to report HCPCS code C8950 to indicate an infusion of

drugs other than anti-neoplastic drugs furnished on or after January 1, 2006. HCPCS code C8951 should be used to report all additional infusion hours, with no limit on the number of hours billed per line. Medically necessary separate therapeutic or diagnostic hydration services should be reported with C8950 and C8951, as these considered intravenous infusions for therapy/diagnosis.

HCPCS codes C8950 and C8951 should not be reported when the infusion is a necessary and integral part of a separately payable OPPS procedure.

When more than one non-chemotherapy drug is infused, hospitals are to code HCPCS codes C8950 and C8951 (if necessary) to report the total duration of an infusion, regardless of the number of substances or drugs or drugs infused. Hospitals are reminded to bill separately for each drug infused, in addition to the drug administration services.

The OCE pays one APC for each encounter reported by HCPCS code C8950, and only pays one APC for C8950 per day (unless Modifier 59 is used). Payment for additional hours of infusion reported by HCPCS code C8951 is packaged into the payment for the initial infusion. While no separate payment will be made for units of HCPCS code C8951. hospitals are instructed to report all codes that appropriately describe the services provided and the corresponding charges so that CMS may capture specific historical hospital cost data for future payment rate setting activities.

OCE logic assumes that all services for non-chemotherapy infusions billed on the same date of service were provided during the same encounter. Where a beneficiary makes two separate visits to the hospital for non-chemotherapy infusions in the same day, hospitals are to report modifier 59 for non-chemotherapy infusion codes during the second encounter that were also furnished in the first encounter. The OCE identifies modifier 59 and pays up to a maximum number of units per day, as listed in Table 1.

Example 1

A beneficiary receives infused drugs that are not anti-neoplastic drugs (including hydrating solutions) for two hours. The hospital reports one unit of HCPCS code C8950 and one unit of HCPCS code C8951. The OCE will pay one unit of APC 0120. Payment for the unit of HCPCS code C8951 is packaged into the payment for one unit of APC 0120.

Example 2

A beneficiary receives infused drugs that are not anti-neoplastic drugs (including hydrating solutions) for 12 hours. The hospital reports one unit of HCPCS code C8951. The OCE will pay one unit of APC 0120. Payment for the 11 units of HCPCS code C8951 is packaged into the payment for one unit of APC 0120.

Example 3

A beneficiary experiences multiple attempts to initiate an intravenous infusion before a successful infusion is started 20 minutes after the first attempt. Once started, the infusion lasts one hour. The hospital reports one unit of HCPCS code C8950 to identify the one hour of infusion time. The 20 minutes spent prior to the infusion attempting to establish an IV line are not separately billable in the OPPS. The OCE pays one unit of APC 0120.

B. Administration of Non-Chemotherapy Drugs by a Route Other Than Intravenous Infusion

Table 6: CY 2006 OPPS Non-Chemotherapy Drug Administration –Route Other Than Intravenous Infusion

2005 CPT	2005 CPT Description	2006 CPT	Final CY 2006 OPPS Description	Status Indicator	APC
90784	Therapeutic, prophylactic or diagnostic injection (specify material injected); intravenous	C8952	Therapeutic, prophylactic or diagnostic injection; intravenous push	X	0359
90782	Therapeutic, prophylactic or diagnostic injection (specify material injected); subcutaneous or intramuscular	90772	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	X	0353
90783	Therapeutic, prophylactic or diagnostic injection (specify material injected); intra-arterial	90773	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intra-arterial	X	0359
90779	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial, injection or infusion	90779	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion	X	0352

Pass Through Services

Billing for Blood and Blood Products

When a Provider Paid Under the OPPS Does Not Purchase the Blood or Blood Products That It Procures from a Community Blood Bank, or When a Provider Paid Under the OPPS Does Not Assess a Charge for Blood or Blood Products Supplied by the Provider's Own Blood Bank Other Than Blood Processing and Storage

When an OPPS provider furnishes blood or a blood product collected by its own blood bank for which only processing and storage costs are assessed, or when an OPPS provider procures blood or a blood product from a community blood bank for which it is charged only the processing and storage costs incurred by the community blood bank, the OPPS provider bills the processing and storage charges using Revenue Code 0390 (Blood Processing/Storage) or 0399 (Blood Processing /Storage; Other Processing and Storage), along with the appropriate blood HCPCS code, the number of units transfused, and the line item date of service (LIDOS). Processing and storage costs may include blood product collection, safety testing, retyping, pooling, irradiating, leukocyte-reducing, freezing, and thawing blood products, along with the costs of blood delivery, monitoring, and storage. In general, such categories of processing costs are not patient-specific. There are specific blood HCPCS codes for blood products that have been processed in varying ways, and these codes are intended to make payment for the variable resource costs of blood products that have been processed differently.

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

If an OPPS provider pays for the actual blood or blood product itself, in addition to paying for processing and storage costs when blood or blood products are supplied by either a community blood bank or the OPPS provider's own blood bank,, the OPPS provider must separate the charge for the unit(s) of blood or blood product(s) from the charge for processing and storage services. The OPPS provider reports charges for the blood or blood product itself using Revenue Code series 038X with the LIDOS, the number of units transfused, and the appropriate blood product HCPCS code and HCPCS modifier BL. The OPPS provider reports charges for processing and storage services on a separate line using Revenue Code 0390 or 0399 with the LIDOS, the number of units transfused, and the appropriate blood product HCPCS code and HCPCS modifier BL.

Whenever an OPPS provider reports a charge for blood or blood products using Revenue Code 038X, the OPPS provider must also report a charge for processing and storage services on a separate line using Revenue Code 0390 or 0399. Further, the same LIDOS, the same number of units, the same HCPCS code, and HCPCS modifier BL must be reported on **both** lines.

Effective for services furnished on or after July 1, 2005, the Outpatient Code Editor (OCE) will return to providers any claim that reports a charge for blood or blood products using Revenue Code 038X without a separate line for processing and storage services using Revenue Code 0390 or 0399. Moreover, in order to process to payment, both lines must report the same line item date of service, the same number of units, and the same HCPCS code accompanied by modifier BL.

Payment for blood and blood products is based on the Ambulatory Payment Classification (APC) Group to which its HCPCS code is assigned, multiplied by the number of units transfused.

Units of whole blood or packed red cells for which only processing and storage charges are reported are not subject to the blood deductible. The Medicare blood deductible is applicable only if the OPPS provider purchases whole blood or packed red cells from a community blood blank or if the OPPS provider assesses a charge that reflects more than blood processing and storage for whole blood or packed red cells collected by its owns blood bank If the beneficiary has not already fulfilled the annual blood deductible or replaced the blood, OPPS payment will be made for processing and storage costs only. The beneficiary is liable for the blood portion of the payment as the blood deductible.

Whenever a charge for blood or blood products is reported using Revenue Code series 038X, a corresponding charge for the processing and storage must also be reported using Revenue Code 0390 or 0399, showing the same LIDOS, the same number of units the same HCPCS code, and HCPCS modifier BL as reported on the line with Revenue Code 038X.

Example

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

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

Billing for Autologous Blood (Including Salvaged Blood) and Directed Donor Blood

In general, when autologous (pre-deposited or obtained through intra- or postoperative salvage) or directed-donor transfusion is performed, OPPS providers should bill for the transfusion service and the number of units of the appropriate HCPCS code that describes the blood product. Payment for the product is intended to cover the costs associated with providing the autologous or directed donor blood product service (e.g., collection, processing, transportation, and storage). OPPS providers should bill the transfusion service and the blood product HCPCS code on the date that the transfusion took place and not on the date when the autologous blood was collected.

When an autologous blood product is collected but not transfused, OPPS providers should bill CPT 86890 (autologous blood or component, collection, processing, and storage; pre-deposited) or 86891 (autologous blood or component, collection, processing, and storage; intra- or postoperative salvage) and the number of units collected but not transfused. CPT 86890 and 86891 are intended to provide payment for the additional resources needed to provide these services, which are not captured when a blood product HCPCS code is not billed. Because billing 86890 or 86891 is only indicated when autologous blood is collected but not transfused, the OPPS provider should bill 86890 or 86891 on the date when the OPPS provider is certain the blood will not be transfused (i.e., date of a procedure or date of outpatient discharge), rather than on the date of the product's collection or receipt from the supplier.
When a directed donor blood product is collected but not transfused to the initial targeted recipient or to any other patient, refer to the section 231.7 titled "Billing for Unused Blood."

Billing for Split Unit of Blood

HCPCS code P9011 was created to identify situations where one unit of blood or a blood product is split and some portion of the unit is transfused to one patient and the other portions are transfused to other patients or to the same patient at other times. When a patient receives a transfusion of a split unit of blood or blood product, OPPS providers should bill P9011 for the blood product transfused, as well as CPT 86985 (Splitting, blood products) for each splitting procedure performed to prepare the blood product for a specific patient.

Example

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

In billing for the services for Patient X and Patient Y, the OPPS provider should report the charges by billing P9011 and 86985 in addition to the CPT code for the transfusion service, because a specific splitting service was required to prepare a split unit for transfusion to each of those patients. However, the OPPS provider should report only P9011 and the CPT code for the transfusion service for Patient Z because no additional splitting was necessary to prepare the split unit for transfusion to Patient Z.

Billing for Irradiation of Blood Products

In situations where a beneficiary receives a medically reasonable and necessary transfusion of an irradiated blood product, an OPPS provider may bill the specific HCPCS code which describes the irradiated product, if a specific code exists, in addition to the CPT code for the transfusion. If a specific HCPCS code for the irradiated blood product does not exist, then the OPPS provider should bill the appropriate HCPCS code for the blood product, along with CPT code 86945 (irradiation of blood product, each unit).

Example

If an OPPS provider transfuses the product described by P9040 (red blood cells, leukocytes reduced, irradiated, each unit), it would not be appropriate to bill an additional CPT code for irradiation of the blood product since charges for irradiation should be included in the charge for P9040.

Billing for Frozen and Thawed Blood and Blood Products

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

Example

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

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

Billing for Unused Blood

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

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

Billing for Transfusion Services

To report charges for transfusion services, OPPS providers should bill the appropriate CPT code for the specific transfusion service provided under Revenue Code 391 (Blood Administration). Transfusion services codes are billed on a per service basis, and not by the number of units of blood product transfused. For payment, a blood product HCPCS code is required when billing a transfusion service code. A transfusion APC will be paid to the OPPS provider for transfusing blood products once per day, regardless of the number of units or different types of blood products transfused.

Billing for Pheresis and Aphaeresis Services

Aphaeresis/pheresis services are billed on a per visit basis and not on a per unit basis. OPPS providers should report the charge for an Evaluation and Management (E&M) visit only if there is a separately identifiable E&M service performed which extends beyond the evaluation and management portion of a typical aphaeresis/pheresis service. If the OPPS provider is billing an E&M visit code in addition to the aphaeresis/pheresis service, it may be appropriate to use the HCPCS modifier -25.

Billing for Devices

Hospitals submitting bill types 12x and 13x that report procedure codes that require the use of devices must also report the applicable HCPCS codes and charges for all devices that are used to perform the procedures where such codes exist.

Partial Hospitalization Services

Partial hospitalization services involve a distinct and organized intensive psychiatric outpatient day treatment program. These services are furnished in lieu of an inpatient admission.

Hospitals which provide partial hospitalization outpatient mental health services should bill using the distinct and separate Blue Shield number assigned for such services. Hospitals which submit claims for partial hospitalization outpatient mental health services under a Blue Shield number other then the distinct and separate number noted above will have the claim returned to provider. After May 23, 2007, providers should bill their National Provider Identification (NPI) number.

Procedures for Submitting Late Charges V. Adjustments

Hospitals may not submit a late charge bill (code "5" in the third position of the bill type) for bill types 12X, 13X, and 14X. They must submit an adjustment bill for any services required to be billed with HCPCS codes, units and line item dates of service. A "7" in the third position of the bill type indicates an adjustment.

Payment

APC Payments

Payment for service under the OPPS is calculated based on grouping outpatient services into ambulatory payment classification (APC) groups. Services within an APC are similar clinically and require similar resource use. The payment rate and coinsurance amount calculated for an APC apply to all of the services within the APC. APCs require no changes to the billing form; however, hospitals are required to include HCPCS codes for all services paid under OPPS. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting.

Discounting

- Multiple surgical procedures furnished during the same operative session are discounted;
- The full amount is paid for the surgical procedure with the highest weight;
- Fifty percent is paid for any other surgical procedure(s) performed at the same time;
- Similar discounting occurs now under the physician fee schedule and the payment system for ASCs;
- Surgical procedures terminated after a patient is prepared for surgery but before induction of anesthesia are paid at 50 percent of the APC payment; and
- When multiple surgical procedures are performed during the same operative session, beneficiary coinsurance is discounted in proportion to the APC payment.

Fee Schedule Services

Items subject to payment via a fee schedule are:

- Laboratory tests;
- Physical, Speech, and Occupational Therapy Services;
- Mammography screening exams; and
- DME

Fee schedule paid services should be billed using the appropriate HCPCS code and service units (the number of times the procedure was performed). Theses services must be billed on separate lines by date of service. Fee schedule items are subject to the edits contained in the OCE.

Outlier Payments

The OPPS reimbursement methodology provides for payments in addition to the basic prospective payments for services incurring extraordinarily high costs. To qualify for outlier payments, a service or item at the line level must meet two threshold criteria. (A threshold is a dollar amount by which the costs of an item or service must exceed payments in order to qualify for outliers.) The service or item must have costs above a fixed cost threshold amount AND a multiple of the APC payment amount.

Only items and services reimbursed under APCs are available for the outlier calculation. Therefore, items and services reimbursed under fee schedules (Status indicator A) are not eligible. In addition, no outlier payment is calculated for Status Indicators G, N, or H.

Billed charges are converted to costs using a single overall hospital-specific cost-to-charge ratio. The costs attributable to all packaged items and services that appear on a claim are allocated to all the OPPS services that appear on the claim. The amount allocated to each OPPS service is based on the percent the Ambulatory Payment Classification (APC) payment rate for that service bears to the total APC rates for all OPPS services on the claim.

To illustrate, assume the cost of all packaged services on the claim is $100, and the three APC payment amounts paid for OPPS services on the claim are $200, $300, and $500 (total APC payments of $1000). The first OPPS service or line item will be allocated $20 or 20 percent of the costs of packaged services, because the APC payment for that service/line item represents 20 percent ($200/$1000) of total APC payments on the claim. The second OPPS service will be allocated $30 or 30 percent of the costs of packaged services and the third OPPS service will be allocated $50 or 50 percent of the cost of packaged services.

If a claim has more than one service with a status indicator (SI) of S or T and any lines with SI of S or T have less than $1.01 as charges, charges for all S and/or T lines are summed and the charges are then divided up proportionately to the payment rate for each S or T line. The new charge amount is used in place of the submitted charge amount in the line item outlier calculation.

All bundled services with a status indicator of N on a claim are summed and divided proportionately to the payment rate for all status indicators of S, T, V, or X before determining the line-by-line outlier calculation.

Update Process

Medicare's periodic updates will be implemented and adopted by FreedomBlue if they are applicable to coding and edits that affect APC assignment, bundling and/or pass-through determination. FreedomBlue will follow the same schedule of implementation of the periodic updates as adopted by CMS (currently these updated occur quarterly and annually) subject to an approximate 120 day delay to allow for system updates.

General

Mountain State Provider Manual

This Hospital Outpatient Billing and Reimbursement Guide (OPPS) is not intended to replace the Mountain State Blue Cross Blue Shield (MSBCBS) Provider Manual. Please use these tools together when submitting claims for HHIC FreedomBlue.

National Provider Identification Number

After May 23, 2007, providers should bill using the National Provider Identification Number (NPI). Providers should submit their NPIs to MSBCBS. If providers have not yet submitted NPIs to MSBCBS, please submit as soon as possible. There are three options available when submitting the NPI which include emailing to MSNPIupdate@msbcbs.com, faxing to 304-424-7713, or mailing to PO Box 1948 Attn: Providers Relations, Parkersburg, WV 26102. When sending in the NPI, please include the facility tax identification number and provider number.

Website References and Updates Number

Providers may receive electronic copies of the guide at www.msbcbs.com using the provider drop down box. The guide posted at this site will contain the most current updates. Please refer to the web site for updates.