CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2971	**Date: May 23, 2014**
	Change Request 8776

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

I. SUMMARY OF CHANGES: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the July 2014 OPPS update. The July 2014 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this Change Request (CR).

The July 2014 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming July 2014 I/OCE CR. The attached Recurring Update Notification applies to Pub. 100-04, Chapter 16, section 30.3.

EFFECTIVE DATE: July 1, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 7, 2014

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	2/90.4/Type of Bill
R	16/30.3/Method of Payment for Clinical Laboratory Tests - Place of Service Variation
R	16/40.3/Hospital Billing Under Part B
R	16/40.3.1/Critical Access Hospital (CAH) Outpatient Laboratory Service

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

IV. ATTACHMENTS:
Recurring Update Notification

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 2971	Date: May 23, 2014	Change Request: 8776

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

EFFECTIVE DATE: July 1, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 7, 2014

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the July 2014 OPPS update. The July 2014 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this Change Request (CR).

The July 2014 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming July 2014 I/OCE CR.

B. Policy:

1. Changes to Device Edits for July 2014

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

2. New Brachytherapy Source Payment

Section 1833(t)(2)(H) of the Social Security Act mandates the creation of additional groups of covered OPD services that classify devices of brachytherapy consisting of a seed or seeds (or radioactive source) (“brachytherapy sources”) separately from other services or groups of services. The additional groups must reflect the number, isotope, and radioactive intensity of the brachytherapy sources furnished. Cesium-131 chloride solution is a new brachytherapy source.

The HCPCS code assigned to this source as well as payment rate under OPPS are listed in table 1, attachment A.

3. Category III CPT Codes

The AMA releases Category III CPT codes twice per year: in January, for implementation beginning the following July, and in July, for implementation beginning the following January. For the July 2014 update, CMS is implementing in the OPPS 27 Category III CPT codes that the AMA released in January 2014 for implementation on July 1, 2014. Of the 27, 17 Category III CPT codes are separately payable under the hospital OPPS. The status indicators and APCs for these codes are shown in table 2, attachment A. Payment rates for these services can be found in Addendum B of the July 2014 OPPS Update that is posted on the CMS web site.

4. Billing for Drugs, Biologicals, and Radiopharmaceuticals

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

In the CY 2014 OPPS/ASC final rule with comment period, CMS stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the July 2014 release of the OPPS Pricer. The updated payment rates, effective July 1, 2014 will be included in the July 2014 update of the OPPS Addendum A and Addendum B, which will be posted on the CMS Web site.

b. Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2014

Three drugs and biologicals have been granted OPPS pass-through status effective July 1, 2014. These items, along with their descriptors and APC assignments, are identified in Table 3, attachment A.

c. New HCPCS Codes Effective July 1, 2014 for Certain Drugs and Biologicals

Two new HCPCS codes have been created for reporting certain drugs and biologicals (other than new pass-through drugs and biological listed in Table 4) in the hospital outpatient setting for July 1, 2014. These codes are listed in Table 4, attachment A, and are effective for services furnished on or after July 1, 2014.

d. Revised Status Indicators for HCPCS Codes J2271 and Q2052

Effective July 1, 2014, the status indicator for HCPCS code J2271 (Injection, morphine sulfate, 100mg) will change from SI=N (Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.) to SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)).

Effective April 1, 2014, the status indicator for HCPCS code Q2052 (Services, supplies and accessories used in the home under the Medicare intravenous immune globulin (IVIG) demonstration) will change from SI=N (Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.) to SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)).

e. Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2013 through December 31, 2013

The payment rate for one HCPCS code was incorrect in the October 2013 OPPS Pricer. The corrected payment rate is listed in Table 5, attachment A, and has been installed in the July 2014 OPPS Pricer, effective for services furnished on October 1, 2013 through December 31, 2013.

f. Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2014 through March 31, 2014

The payment rate for one HCPCS code was incorrect in the January 2014 OPPS Pricer. The corrected payment rate is listed in Table 6, attachment A, and has been installed in the July 2014 OPPS Pricer, effective for services furnished on January 1, 2014 through March 31, 2014.

5. Operational Change to Billing Lab Tests for Separate Payment

As delineated in MLN Matters Special Edition Article (SE)1412, issued on March 5, 2014, (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1412.pdf), effective July 1, 2014 OPPS hospitals should begin

using modifier L1 on type of bill (TOB) 13X when seeking separate payment for outpatient lab tests under the Clinical Laboratory Fee Schedule (CLFS) in the following circumstances: (1) A hospital collects specimen and furnishes only the outpatient labs on a given date of service; (2) A hospital conducts outpatient lab tests that are clinically unrelated to other hospital outpatient services furnished the same day. "Unrelated" means the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services, for a different diagnosis. Hospitals should no longer use TOB 14X in these circumstances. CMS is providing related updates to The Medicare Claims Processing Manual.

6. Clarification of Payment for Certain Hospital Part B Inpatient Labs

As recently provided in Change Request (CR) 8445, Transmittal 2877, published on February 7, 2014, and CR 8666, Transmittal 182, published on March 21, 2014, when beneficiaries who have Part B coverage are treated as hospital inpatients and are not eligible for or entitled to coverage under Part A, or are entitled to Part A but have exhausted their Part A benefits, hospitals may only bill for a limited set of Part B inpatient services. CMS are clarifying our general payment policy that for hospitals paid under the OPPS these Part B inpatient services are separately payable under Part B, and are excluded from OPPS packaging, if the primary service with which the service would otherwise be bundled is not a payable Part B inpatient service. CMS have adjusted our claims processing logic to make separate payment for Laboratory services paid under the CLFS pursuant to this policy that would otherwise be OPPS-packaged beginning in 2014. Hospitals should consult their MAC for reprocessing of any 12X TOB claims with dates of service on or after January 1, 2014 that were processed incorrectly and should be paid under this policy.

7. Coverage Determinations

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

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
8776.1	Medicare contractors shall install the July 2014 OPPS Pricer.	X		X		X				BCRC
8776.2	Medicare contactors shall manually add the following HCPCS codes to their systems: • HCPCS code C2644 in table 1, attachment A, effective July 1, 2014; and • HCPCS codes listed in table 2, attachment A, effective July 1, 2014; and	X		X						BCRC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• HCPCS codes C9022 and C9134 in table 3, attachment A, effective July 1, 2014; and • HCPCS codes listed in table 4, attachment A, effective July 1, 2014; and **NOTE:** These HCPCS codes will be included with the July 2014 I/OCE update. Status and payment indicators for these HCPCS codes will be listed in the July 2014 update of the OPPS Addendum A and Addendum B on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html									
8776.3	Medicare contactors shall manually delete C9441 from their systems effective June 30, 2014. **NOTE:** This deletion will be reflected in the July 2014 I/OCE update and in the July 2014 Update of the OPPS Addendum A and Addendum B on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html	X		X						BCRC
8776.4	Medicare contractors shall adjust, as appropriate, claims brought to their attention that: 1. Have dates of service that fall on or after October 1, 2013, but prior to January 1, 2014; and 2. Contain HCPCS code J2788; and 3. Were originally processed prior to the installation of the July 2014 OPPS Pricer.	X		X						BCRC
8776.5	Medicare contractors shall adjust, as appropriate, claims brought to their attention that: 1. Have dates of service that fall on or after January 1, 2014, but prior to April 1, 2014; and 2. Contain HCPCS code J0775; and 3. Were originally processed prior to the installation of the July 2014 OPPS Pricer.	X		X						BCRC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8776.6	Medicare contractors shall adjust 12X claims for beneficiaries who are either not entitled to Part A at all, or are entitled to Part A but have exhausted their Part A benefits where the laboratory services were packaged for 2014 dates of service that are brought to their attention.	X								BCRC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8776.7	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X		

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

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

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

VI. FUNDING

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

ATTACHMENTS: 1

Chapter 2 - Admission and Registration Requirements

90.4 - Type of Bill

(Rev.2971, Issued: 05-23-14, Effective: 07-01-14, Implementation, 07-07-14)

To properly bill, *hospitals other than CAHs assign* type of bill (TOB) 13X to all bills for outpatient *hospital* services and TOB 14X for non-patient *(referred)* laboratory specimens. A non-patient is defined as a beneficiary that is neither an inpatient nor an outpatient of a hospital, but that has a specimen that is submitted for analysis to a hospital and the beneficiary is not physically present *at the hospital*.

TOB 14X should only be billed for non-patient lab specimens*, which are paid under* the *clinical* laboratory fee schedule *at* the lesser of the actual charge, the fee schedule amount, or the National Limitation Amount (NLA), (including CAHs and MD Waiver hospitals). Part B deductible and coinsurance do not apply for laboratory tests payable on the laboratory fee schedule.

TOB 14X should no longer be used for referred diagnostic services *other than laboratory services.*

CAHs should bill TOB 85X for outpatient services *(including outpatient labs), and TOB 14X for non-patient laboratory specimen tests.*

Chapter 16 - Laboratory Services

30.3 - Method of Payment for Clinical Laboratory Tests - Place of Service Variation

(Rev.2971, Issued: 05-23-14, Effective: 07-01-14, Implementation, 07-07-14)

The following apply in determining the amount of Part B payment for clinical laboratory tests:

Laboratory tests not payable on the Clinical Diagnostic Laboratory Fee Schedule (CLFS) will be based on OPPS (for hospitals subject to OPPS) and current methodology for hospitals not subject to OPPS.

Independent laboratory or a physician or medical group - Payment to an independent laboratory or a physician or medical group is the lesser of the actual charge, the fee schedule amount or the national limitation amount. Part B deductible and coinsurance do not apply.

Reference laboratory - For tests performed by a reference laboratory, the payment is the lesser of the actual charge by the billing laboratory, the fee schedule amount, or the national limitation amount (NLA). (See §50.5 for carrier jurisdiction details.) Part B deductible and coinsurance do not apply.

Outpatient of *OPPS* hospital - *For hospitals paid under the OPPS, beginning January 1, 2014 outpatient laboratory tests are generally packaged as ancillary services and do not receive separate payment. Only in the following circumstances, they are eligible for separate payment under the CLFS. It is optional for a hospital to seek separate payment under the CLFS.*

(1) Outpatient lab tests only - If the hospital only provides outpatient laboratory tests to the patient (directly or under arrangement) and the patient does not also receive other hospital outpatient services on that day. Beginning July 1, 2014 report on TOB 13X with modifier L1.

(2) Unrelated outpatient lab tests- If the hospital provides an outpatient laboratory test (directly or under arrangement) on the same date of service as other hospital outpatient services that is clinically unrelated to the other hospital outpatient services, meaning the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services, for a different diagnosis. Beginning July 1, 2014 report on TOB 13X with modifier L1.

Payment to a hospital for laboratory tests payable on the Clinical Diagnostic Laboratory Fee Schedule, furnished to an outpatient of the hospital, is the lesser of the actual charge, fee schedule amount, or the NLA. Part B deductible and coinsurance do not apply. Laboratory tests not payable on the Clinical Diagnostic Laboratory Fee Schedule will be based on OPPS (for hospitals subject to OPPS) and current methodology for hospitals not subject to OPPS.

Exception: Reasonable cost reimbursement has been provided for outpatient clinical laboratory tests furnished by hospitals with fewer than 50 beds in qualified rural areas for cost reporting periods beginning on July 1, 2004 through 2008 (per the following legislation: Section 416 of the Medicare

Modernization Act (MMA) of 2003, Section 105 of the Tax Relief and Health Care Act (TRHCA) of 2006, and Section 107 of the Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Extension Act of 2007). Section 3122 of the Patient Protection and Affordable Care Act re-institutes the above reasonable cost provisions for cost reporting periods beginning on or after July 1, 2010, through June 30, 2011. Section 109 of the Medicare and Medicaid Extenders Act extends the above reasonable cost provisions for cost reporting periods beginning on or after July 1, 2011, through June 30, 2012.

Non-Patient *(Referred)* Laboratory Specimen- *A non-patient is defined as a beneficiary that is neither an inpatient nor an outpatient of a hospital, but that has a specimen that is submitted for analysis to a hospital and the beneficiary is not physically present at the hospital. All hospitals (including Maryland waiver hospitals and CAHs) bill non-patient lab tests on TOB 14X. They are paid under the clinical laboratory fee schedule at* the lesser of the actual charge, the fee schedule amount, or the NLA (including *CAH and* MD Waiver hospitals). Part B deductible and coinsurance do not apply.

Inpatient without Part A – Payment to a hospital for laboratory tests payable on the Clinical Diagnostic Laboratory Fee Schedule, is the lesser of the actual charge, fee schedule amount, or the NLA. Part B deductible and coinsurance do not apply. Laboratory tests not payable on the Clinical Diagnostic Laboratory Fee Schedule will be based on OPPS (for hospitals subject to OPPS) and current methodology for hospitals not subject to OPPS. *For hospitals subject to the OPPS, beginning January 1, 2014 Part B inpatient laboratory tests are packaged as ancillary services and do not receive separate payment unless the service with which the labs would otherwise be packaged is not a payable Part B inpatient service (see Chapter 6, Section 10 of the Medicare Benefit Policy Manual, Pub. 100-02).* Payment to a SNF inpatient without Part A coverage is made under the laboratory fee schedule.

Inpatient or SNF patient with Part A - Payment to a hospital for laboratory tests furnished to an inpatient, whose stay is covered under Part A, is included in the PPS rate for PPS facilities or is made on a reasonable cost basis for non-PPS hospitals and is made at 101 percent of reasonable cost for CAHs. Payments for lab services for beneficiaries in a Part A stay in a SNF, other than a swing bed in a CAH are included in the SNF PPS rate. For such services provided in a swing bed of a CAH, payment is made at 101 percent of reasonable cost.

Sole community hospital – *Sole community hospitals are subject to the OPPS, therefore OPPS packaging rules apply. When the OPPS exceptions for separate payment of outpatient laboratory tests under the CLFS apply, a* sole community hospital *with a qualified hospital laboratory identified on the hospital's certification in the Provider Specific File* is *paid* the least of the actual charge, the 62 percent fee schedule amount, or the 62 percent NLA. The Part B deductible and coinsurance do not apply.

Waived Hospitals - Payment for outpatient (bill type13X), to a hospital which has been granted a waiver of Medicare payment principles for outpatient services is subject to Part B deductible and coinsurance unless otherwise waived as part of an approved waiver. Specifically, laboratory fee schedules do not apply to laboratory tests furnished by hospitals in States or areas that have been granted waivers of Medicare reimbursement principles for outpatient services. The State of Maryland has been granted such *a* waiver. Payment for non-patient laboratory specimens (bill type14X) is

based on the fee schedule**.** Laboratory tests not payable on the Clinical Diagnostic Laboratory Fee Schedule will be paid based on current methodology.

Critical Access Hospital - When the CAH bills a 14X bill type as a non-patient laboratory specimen, it is paid on the laboratory fee schedule. *If the beneficiary is an outpatient of the CAH, the CAH bills using an 85x bill type and is paid based on 101 percent of reasonable cost.*

Beneficiaries are not liable for any coinsurance, deductible, co-payment, or other cost sharing amount with respect to CAH clinical laboratory services.

Section 148 of the Medicare Improvements for Patients and Providers Act (MIPPA)

Effective for services furnished on or after July 1, 2009, *the beneficiary* is no longer required to be physically present in a CAH at the time the specimen is collected *in order for the CAH to be paid based on 101 percent of reasonable cost*. However, the *beneficiary* must be an outpatient of the CAH, as defined at 42 CFR §410.2 and be receiving services directly from the CAH. In order for the *beneficiary* to be receiving services directly from the CAH *if he/she is not present in the CAH when the specimen is collected*, the *beneficiary* must either be receiving outpatient services in the CAH on the same day the specimen is collected, or the specimen must be collected by an employee of the CAH or of a facility provider-based to the CAH.

Dialysis facility - Effective for items and services furnished on or after January 1, 2011 Section 153b of the Medicare Improvements for Patients and Providers Act (MIPPA) requires that all ESRD-related laboratory tests be reported by the ESRD facility whether provided directly or under arrangements with an independent laboratory. When laboratory services are billed by a laboratory other than the ESRD facility and the laboratory service furnished is designated as a laboratory test that is included in the ESRD PPS (i.e., ESRD-related), the claim will be rejected or denied. The list of items and services subject to consolidated billing located at http://www.cms.gov/ESRDPayment/50_Consolidated_Billing.asp#TopOfPage includes the list of ESRD-related laboratory tests that are routinely performed for the treatment of ESRD. In the event that an ESRD-related laboratory service was furnished to an ESRD beneficiary for reasons other than for the treatment of ESRD, the supplier may submit a claim for separate payment using modifier "AY". See Pub.100-04, Chapter 8 for more information regarding Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims.

Rural Health Clinic (RHC)/Federally Qualified Health Center (FQHC) - Payment to a RHC/FQHC for laboratory tests performed for a patient of that clinic/center is not included in the all-inclusive rate and may be billed separately by either the base provider for a provider-based RHC/FQHC, or by the physician for an independent or free-standing RHC/FQHC. Payment for the laboratory service is not subject to Part B deductible and coinsurance. If the RHC/FQHC is provider-based, payment for lab tests is to the base provider (i.e., hospital). If the RHC/FQHC is independent or freestanding, payment for lab tests is made to the practitioner (physician) via the clinical lab fee schedule. (See Sections 30.1.1 and 40.5 for details on RHC/FQHC billing.)

Enrolled in Managed Care - Payment to a participating health maintenance organization (HMO) or health care prepayment plan (HCPP) for laboratory tests provided to a Medicare beneficiary who is an enrolled member is included in the monthly capitation amount.

Non-enrolled Managed Care - Payment to a participating HMO or HCPP for laboratory tests performed for a patient who is not a member is the lesser of the actual charge, or the fee schedule, or the NLA. The Part B deductible and coinsurance do not apply.

Hospice - Payment to a hospice for laboratory tests performed by the hospice is included in the hospice rate.

40.3 - Hospital Billing Under Part B

(Rev.2971, Issued: 05-23-14, Effective: 07-01-14, Implementation, 07-07-14)

Hospital laboratories, billing for either outpatient or non-patient claims, bill the FI/AB MAC.

Neither deductible nor coinsurance applies to laboratory tests paid under the *clinical laboratory* fee schedule.

Hospitals must follow requirements for submission of the *electronic* ANSI X12N 837 I or the hardcopy Form CMS-1450 (see Chapter 25 for billing requirements).

When the hospital obtains laboratory tests for outpatients under arrangements with clinical laboratories or other hospital laboratories, only the hospital can bill for the arranged services.

As discussed in section 30.3 ("Place of Service Variation, Critical Access Hospitals") of this chapter, when the CAH bills a 14X bill type as a non-patient laboratory specimen, it is paid on the clinical laboratory fee schedule. For CAHs, payment for clinical diagnostic laboratory tests is made at 101 percent of reasonable cost only if the *beneficiary is an* outpatient of the CAH (85X *TOB*), as defined in 42 CFR 410.2, and *is* physically present in the CAH at the time the specimen *is* collected, for dates of service prior to July 1, 2009. However, for dates of service on or after July 1, 2009, the *beneficiary* do*es* not have to be physically present in the CAH at the time the specimen is collected as long as certain criteria are met per Section 148 of the MIPPA *(i.e. other outpatient services are received by the beneficiary in the CAH on the same day the specimen is collected, or the specimen is collected by an employee of the CAH or of a facility provider-based to the CAH)* (see Section 30.3 above, Critical Access Hospital). Clinical diagnostic laboratory tests performed for *a beneficiary* who *is* not physically present at the CAH when the specimen *is* collected by a non-CAH employee or who are not receiving other outpatient services in the CAH on the same day the specimen is collected, are paid *for under the clinical lab fee schedule*. Similarly, for Maryland waiver hospitals, the waiver is limited to services to inpatients and registered outpatients as defined in 42 CFR 410.2. Therefore payment for non-patients (specimen only, TOB 14X) who are not registered outpatients at the time of specimen collection will be made on the clinical laboratory fee schedule.

Section 416 of the Medicare Prescription, Drug, Improvement, and Modernization Act (MMA) of 2003 also eliminates the application of the clinical laboratory fee schedule for hospital outpatient laboratory testing by a hospital laboratory with fewer than 50 beds in a qualified rural area for cost reporting periods beginning during the 2-year period beginning on July 1, 2004. Payment for these hospital outpatient laboratory tests will be reasonable costs without

coinsurance and deductibles during the applicable time period. A qualified rural area is one with a population density in the lowest quartile of all rural county populations.

The reasonable costs are determined using the ratio of costs to charges for the laboratory cost center multiplied by the PS&R's billed charges for outpatient laboratory services for cost reporting periods beginning on or after July 1, 2004 but before July 1, 2006.

In determining whether clinical laboratory services are furnished as part of outpatient services of a hospital, the same rules that are used to determine whether clinical laboratory services are furnished as an outpatient critical access hospital service will apply.

40.3.1 - Critical Access Hospital (CAH) Outpatient Laboratory Service

(Rev.2971, Issued: 05-23-14, Effective: 07-01-14, Implementation, 07-07-14)

Effective for services furnished on or after the enactment of *the* Balanced Budget Refinement Act of 1999 (BBRA), Medicare beneficiaries are not liable for any coinsurance, deductible, co-payment, or other cost sharing amount with respect to clinical laboratory services furnished as a CAH outpatient service. This change is effective for claims with dates of service on or after November 29, 1999.

*F*or CAH bill type 85X, the laboratory fees are paid at 101 percent of *reasonable* cost. When the CAH bills a 14X bill type as a non-patient laboratory specimen, it is paid on the *clinical* laboratory fee schedule.

Attachment A. − Tables for the Policy Section

Table 1—New Brachytherapy Source Code Effective July 1, 2014

HCPCS	Effective date	SI	APC	Short Descriptor	Long descriptor	Payment	Minimum Unadjusted Copayment
C2644	7/01/2014	U	2644	Brachytx cesium-131 chloride	Brachytherapy source, cesium-131 chloride solution, per millicurie	$18.97	$3.80

Table 2 -- Category III CPT Codes Implemented as of July 1, 2014

CY 2014 CPT Code	CY 2014 Long Descriptor	July 2014 OPPS Status Indicator	July 2014 OPPS APC
0347T	Placement of interstitial device(s) in bone for radiostereometric analysis (RSA)	Q2	0420
0348T	Radiologic examination, radiostereometric analysis (RSA); spine, (includes, cervical, thoracic and lumbosacral, when performed)	X	0261
0349T	Radiologic examination, radiostereometric analysis (RSA); upper extremity(ies), (includes shoulder, elbow and wrist, when performed)	X	0261
0350T	Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies), (includes hip, proximal femur, knee and ankle, when performed)	X	0261
0351T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; real time intraoperative	N	N/A
0352T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; interpretation and report, real time or referred	B	N/A
0353T	Optical coherence tomography of breast, surgical cavity; real time intraoperative	N	N/A
0354T	Optical coherence tomography of breast, surgical cavity; interpretation and report, real time or referred	B	N/A
0355T	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation	T	0142

CY 2014 CPT Code	CY 2014 Long Descriptor	July 2014 OPPS Status Indicator	July 2014 OPPS APC
	and report		
0356T	Insertion of drug-eluting implant (including punctal dilation and implant removal when performed) into lacrimal canaliculus, each	S	0698
0358T	Bioelectrical impedance analysis whole body composition assessment, supine position, with interpretation and report	Q1	0340
0359T	Behavior identification assessment, by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report	V	0632
0360T	Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; first 30 minutes of technician time, face-to-face with the patient	V	0632
0361T	Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; each additional 30 minutes of technician time, face-to-face with the patient (List separately in addition to code for primary service)	N	N/A
0362T	Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; first 30 minutes of technician(s) time, face-to-face with the patient	V	0632
0363T	Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and	N	N/A

CY 2014 CPT Code	CY 2014 Long Descriptor	July 2014 OPPS Status Indicator	July 2014 OPPS APC
	report, administered by physician or other qualified health care professional with the assistance of one or more technicians; each additional 30 minutes of technician(s) time, face-to-face with the patient (List separately in addition to code for primary procedure)		
0364T	Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; first 30 minutes of technician time	S	0322
0365T	Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; each additional 30 minutes of technician time (List separately in addition to code for primary procedure)	N	N/A
0366T	Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; first 30 minutes of technician time	S	0325
0367T	Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; each additional 30 minutes of technician time (List separately in addition to code for primary procedure)	N	N/A
0368T	Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; first 30 minutes of patient face-to-face time	S	0322
0369T	Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; each additional 30 minutes of patient face-to-face time (List separately in addition to code for primary procedure)	N	N/A
0370T	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)	S	0324
0371T	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without	S	0324

CY 2014 CPT Code	CY 2014 Long Descriptor	July 2014 OPPS Status Indicator	July 2014 OPPS APC
	the patient present)		
0372T	Adaptive behavior treatment social skills group, administered by physician or other qualified health care professional face-to-face with multiple patients	S	0325
0373T	Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technicians' time, face-to-face with patient	S	0323
0374T	Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); each additional 30 minutes of technicians' time face-to-face with patient (List separately in addition to code for primary procedure)	N	N/A

Table 3 – Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2014

HCPCS Code	Long Descriptor	APC	Status Indicator
C9022*	Injection, elosulfase alfa, 1mg	1480	G
C9134*	Factor XIII (antihemophilic factor, recombinant), Tretten, per 10 i.u.	1481	G
J1446	Injection, tbo-filgrastim, 5 micrograms	1447	G

NOTE: The HCPCS codes identified with an "*" indicate that these are new codes effective July 1, 2014.

Table 4 – New HCPCS Codes for Certain Drugs and Biologicals Effective July 1, 2014

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 7/1/14
Q9970*	Injection, ferric carboxymaltose, 1 mg	9441	G
Q9974**	Injection, Morphine Sulfate, Preservative-Free For Epidural Or Intrathecal Use, 10 mg	N/A	N

*HCPCS code C9441 (Injection, ferric carboxymaltose, 1 mg) will be deleted and replaced with HCPCS code Q9970 effective July 1, 2014.
** HCPCS code J2275 (Injection, morphine sulfate (preservative-free sterile solution), per 10 mg) and will be replaced with HCPCS code Q9974 effective July 1, 2014. The status indicator for HCPCS code J2275 will change to E, "Not Payable by Medicare", effective July 1, 2014.

Table 5– Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2013 through December 31, 2013

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J2788	K	9023	Rho d immune globulin 50 mcg	$25.15	$5.03

Table 6 – Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2014 through March 31, 2014

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J0775	K	1340	Collagenase, clost hist inj	$38.49	$7.70