CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2296	**Date: September 2, 2011**
	Change Request 7545

SUBJECT: October 2011 Update of the Hospital Outpatient Prospective Payment System (OPPS)

I. SUMMARY OF CHANGES: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the October 2011 OPPS update. The October 2011 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).

EFFECTIVE DATE: October 1, 2011
IMPLEMENTATION DATE: October 3, 2011

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	1/50.3.1/Background
R	1/50.3.2/Policy and Billing Instructions for Condition Code 44
R	4/10.11.1/Requirement to Calculate CCRs for Hospitals Paid under OPPS and for CMHCs
R	4/10.11.7/Methodology for Calculation of Hospital Overall CCR for Hospitals That Do Not Have Nursing and Paramedical Education Programs for Cost Reporting Periods Beginning Before May 1, 2010, Under Cost Report Form 2552-96
N	4/10.11.7.1/Methodology for Calculation of Hospital Overall CCR for Hospitals That Do Not Have Nursing and Paramedical Education Programs for Cost Reporting Periods Beginning On or After May 1, 2010, Under Cost Report 2552-10
R	4/10.11.8/Methodology for Calculation of Hospital Overall CCR for Hospitals That Have Nursing and Paramedical Education Programs for Cost Reporting Periods Beginning Before May 1, 2010, Under Cost Report Form 2552-96
N	4/10.11.8.1 - Methodology for Calculation of Hospital Overall CCR for Hospitals That Have Nursing and Paramedical Education Programs for Cost Reporting Periods Beginning On or After May 1, 2010, Under Cost Report 2552-10

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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

IV. ATTACHMENTS:
Manual Instruction
Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub.100-04	Transmittal: 2296	Date: September 2, 2011	Change Request: 7545

SUBJECT: October 2011 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Effective Date: October 1, 2011
Implementation Date: October 3, 2011

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the October 2011 OPPS update. The October 2011 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 October 2011 revisions to I/OCE data files, instructions, and specifications are provided in CR 7541, "October 2011 Integrated Outpatient Code Editor (I/OCE) Specifications Version 12.3."

B. Policy:

1. Changes to Device Edits for October 2011

Device-to-procedure edits require that a claim that contains one of a specified set of device codes be returned to the provider if it fails to contain an appropriate procedure code. We are adding procedure code 64569 (Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator) as an appropriate procedure for device code C1778 (Lead, neurostimulator) because the procedure may be appropriately reported on the same claim with the device code. We are adding it to the file with an effective date of January 1, 2011 because the procedure code is effective for services furnished on and after January 1, 2011. Any claims with dates of service after January 1, 2011 that were submitted prior to this update and returned to providers may be resubmitted.

Procedure-to-device edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code. Failure to pass these edits will result in the claim being returned to the provider. Procedures for which both a Device A and a Device B are specified require that at least one each of Device A and Device B be present on the claim (i.e., there must be some combination of a Device A with a Device B in order to pass the edit). Device B can be reported with any Device A for the same procedural HCPCS code. We are not adding C1778 as a required device for procedure code 64569 because the device is not essential to the procedure described by the code 64569.

The updated lists of both types of edits can be found under "Device, Radiolabeled Product, and Procedure Edits" at http://www.cms.gov/HospitalOutpatientPPS/.

2. New Device Pass-Through Categories

Section 1833(t)(6)(B) of the Social Security Act requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that we create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

We are establishing two new categories as of October 1, 2011. The following table provides a listing of new coding and payment information concerning the new device categories for transitional pass-through payment.

Table 1 – New Device Pass-Through Codes

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Device Offset from Payment
C1830	10-01-11	H	1830	Power bone marrow bx needle	Powered bone marrow biopsy needle	$0
C1840	10-01-11	H	1840	Telescopic intraocular lens	Lens, intraocular (telescopic)	$221.71

a. Billing Instructions for C1840: C1840, Lens, intraocular (telescopic), is to be billed and paid for, when provided, with CPT codes 66982 (Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage), or 66984 (Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)). These codes are assigned to APC 0246.

b. Device Offset from Payment: Section 1833(t)(6)(D)(ii) of the Act requires that we deduct from pass-through payments for devices an amount that reflects the portion of the APC payment amount that we determine is associated with the cost of the device (70 FR 68627-8).

We have determined that we are not able to identify a portion of the APC payment amount associated with the cost of C1830, Powered bone marrow biopsy needle, in APC 0003, Bone Marrow Biopsy/Aspiration. The device offset from payment represents this deduction from pass-through payments for category C1830, when it is billed with a service included in APC 0003. Therefore, we are establishing an offset amount for C1830 of $0 and will not make any deductions from pass-through payment for category C1830.

We have determined that we are able to identify a portion of the APC payment amount associated with the cost of C1840, Lens, intraocular (telescopic), in APC 0246, Cataract Procedures with IOL Insert. The device offset for APC 0246 is $221.71. The device offset from payment represents this deduction from pass-through payments for category C1840, when it is billed with a service included in APC 0246. Therefore, we are establishing an offset amount for C1830 of $221.71.

3. Billing for Drugs, Biologicals, and Radiopharmaceuticals

Hospitals are strongly encouraged to report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. It is also of great importance that hospitals billing for these products make certain that the reported units of an item described by a reported HCPCS code are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used in the care of the patient.

More complete data from hospitals on the drugs and biologicals provided during patient encounters would enhance payment accuracy for separately payable drugs and biologicals in the future. We strongly encourage hospitals to report HCPCS codes for all drugs and biologicals furnished, if specific codes are available. Precise billing of drug and biological HCPCS codes and units, especially in the case of packaged drugs and biologicals for which the hospital receives no separate payment, is critical to the accuracy of the OPPS payment rates for drugs and biologicals each year.

We remind hospitals that under the OPPS, if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used in the care of the patient. The mixing together of two or more products does not constitute a "new" drug as regulated by the Food and Drug Administration (FDA) under the New Drug Application (NDA) process. In these situations, hospitals are reminded that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, Unclassified drug or biological, is only for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, and for which a specific HCPCS code has not been assigned.

Unless otherwise specified in the long descriptor, HCPCS descriptors refer to the non-compounded, FDA-approved final product. If a product is compounded and a specific HCPCS code does not exist for the compounded product, the hospital should report an appropriate unlisted code such as J9999 or J3490.

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective October 1, 2011

For CY 2011, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 5 percent, which provides payment for both the acquisition cost and pharmacy overhead cost associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2011, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead cost of these pass-through items. We note that for the fourth quarter of CY 2011, payment for drugs and biologicals with pass-through status is not made at the Part B Drug Competitive Acquisition Program (CAP) rate, as the CAP program was suspended beginning January 1, 2009. Should the Part B Drug CAP program be reinstituted, we would again use the Part B drug CAP rate for pass-through drugs and biologicals that are a part of the Part B drug CAP program, as required by the statute.

In the CY 2011 OPPS/ASC final rule with comment period, we 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, we will incorporate changes to the payment rates in the October 2011 release of the OPPS PRICER. The updated payment rates, effective October 1, 2011, will be included in the October 2011 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 October 1, 2011

Two drugs and biologicals have been granted OPPS pass-through status effective October 1, 2011. These items, along with their descriptors and APC assignments, are identified in Table 2 below.

Table 2 – Drugs and Biologicals with OPPS Pass-Through Status Effective October 1, 2011

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 10/1/11
C9286*	Injection, belatacept, 1 mg	9286	G
J0638	Injection, canakinumab, 1 mg	1311	G

NOTE: The HCPCS codes identified with an "*" indicate that these are new codes effective October 1, 2011.

c. Updated Payment Rate for HCPCS Code J9185 Effective July 1, 2011 through September 30, 2011

The payment rate for HCPCS code J9185 was incorrect in the July 2011 OPPS Pricer. The corrected payment rate is listed in Table 3 below and has been installed in the October 2011 OPPS Pricer, effective for services furnished on July 1, 2011, through implementation of the October 2011 update.

Table 3 – Updated Payment Rates for HCPCS Code J9185 Effective July 1, 2011 through September 30, 2011

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J9185	K	0842	Fludarabine phosphate inj	$104.52	$20.90

d. Correct Reporting of Biologicals When Used As Implantable Devices

When billing for biologicals where the HCPCS code describes a product that is solely surgically implanted or inserted, whether the HCPCS code is identified as having pass-through status or not, hospitals are to report the appropriate HCPCS code for the product. Units should be reported in multiples of the units included in the HCPCS descriptor. Providers and hospitals should not bill the units based on the way the implantable biological is packaged, stored, or stocked. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the implantable biological. Therefore, before submitting Medicare claims for biologicals that are used as implantable devices, it is extremely important to review the complete long descriptors for the applicable HCPCS codes. In circumstances where the implanted biological has pass-through status as a device, a separate payment for the device is made. In circumstances where the implanted biological does not have pass-through status, the OPPS payment for the biological is packaged into the payment for the associated procedure.

When billing for biologicals where the HCPCS code describes a product that may either be surgically implanted or inserted or otherwise applied in the care of a patient, hospitals should not separately report the biological HCPCS codes, with the exception of biologicals with pass-through status, when using these items as implantable devices (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures. Under the OPPS, hospitals are provided a packaged APC payment for surgical procedures that includes the cost of supportive items, including implantable devices without pass-through status. When using biologicals during surgical procedures as implantable devices, hospitals may include the charges for these items in their charge for the procedure, report the charge on an uncoded revenue center line, or report the charge under a device HCPCS code (if one exists) so these costs would appropriately contribute to the future median setting for the associated surgical procedure.

e. Correct Reporting of Units for Drugs

Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor. For example, if the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be 1. As another example, if the description for the drug code is 50 mg, but 200 mg of the

drug was administered to the patient, the units billed should be 4. Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, hospitals should bill 10 units, even though only 1 vial was administered. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

As discussed in the Medicare Claims Processing Manual, Pub.100-04, Chapter 17, Section 40, CMS encourages hospitals to use drugs efficiently and in a clinically appropriate manner. However, CMS also recognizes that hospitals may discard some drug and biological product when administering from a single use vial or package. In that circumstance, Medicare pays for the amount of drug or biological discarded *as well as* the *dose* administered, up to the amount of the drug or biological as indicated on the vial or package label. Multi-use vials are not subject to payment for discarded amounts of drug or biological.

f. Reporting of Outpatient Diagnostic Nuclear Medicine Procedures

With the specific exception of HCPCS code C9898 (Radiolabeled product provided during a hospital inpatient stay) to be reported by hospitals on outpatient claims for nuclear medicine procedures to indicate that a radiolabeled product that provides the radioactivity necessary for the reported diagnostic nuclear medicine procedure was provided during a hospital inpatient stay, hospitals should only report HCPCS codes for products they provide in the hospital outpatient department and should not report a HCPCS code and charge for a radiolabeled product on the nuclear medicine procedure-to-radiolabeled product edit list solely for the purpose of bypassing those edits present in the I/OCE.

As CMS stated in the October 2009 OPPS update, in the rare instance when a diagnostic radiopharmaceutical may be administered to a beneficiary in a given calendar year prior to a hospital furnishing an associated nuclear medicine procedure in the subsequent calendar year, hospitals are instructed to report the date the radiolabeled product is furnished to the beneficiary as the same date that the nuclear medicine procedure is performed. CMS believes that this situation is extremely rare and expects that the majority of hospitals will not encounter this situation.

Where a hospital or a nonhospital location, administers a diagnostic radiopharmaceutical product for a different hospital providing the nuclear medicine scan, hospitals should comply with the OPPS policy that requires that radiolabeled products be reported and billed with the nuclear medicine scan. In these cases, the first hospital or nonhospital location may enter into an arrangement under section 1861(w)(1) of the Act, and as discussed in 42 CFR 410.28(a)(1) and defined in 42 CFR 409.3, where the second hospital that administers the nuclear medicine scan both bills Medicare for the administration of the nuclear medicine scan with diagnostic radiopharmaceutical and pays the first hospital or nonhospital location that administers the diagnostic radiopharmaceutical some amount for administration of the diagnostic radiopharmaceutical. CMS notes that it considers the radiolabeled product and the nuclear medicine scan to be part of one procedure and would expect both services to be performed together.

g. Use of HCPCS Code C9399

As stated in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 17, Section 90.3, hospitals are to report HCPCS code C9399, Unclassified drug or biological, solely for new outpatient drugs or biologicals that are approved by the FDA on or after January 1, 2004 and that are furnished as part of covered outpatient department services for which a product-specific HCPCS code has not been assigned. It is not appropriate to report HCPCS code C9399 for drugs and biologicals that are defined as usually self-administered drugs by the patient as defined in the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, Section 50.2.

4. Calculation of Overall CCR for Cost Reporting Periods On or After May 1, 2010 based on Form CMS-2552-10

This instruction updates the Medicare Claims Processing Manual, Pub. 100-04, Chapter 4, Section 10.11 "Calculation of Overall Cost to Charge Ratios (CCRs) for Hospitals Paid Under the Outpatient Prospective Payment System (OPPS) and Community Mental Health Centers (CMHCs) Paid Under the Hospital OPPS." Specifically, Sections 10.11.7.1 and 10.11.8.1 are added which contain Worksheet/Column/line edits and reflect the new Hospital and Hospital Health Care Complex Cost Report, Form CMS-2552-10. This does not replace Sections 10.11.7 and 10.11.8 as these existing instructions are relevant for cost report Form CMS-2552-96.

5. Clarifications to Condition Code 44 Policy (When a Patient's Status may be Changed from Inpatient to Outpatient)

This instruction clarifies several of CMS' manual requirements for changing a patient's status from inpatient to outpatient (using Condition Code 44). We are clarifying that the practitioner who is responsible for the care of the patient must concur with any decision by the hospital's Utilization Review committee to change a patient's status from inpatient to outpatient. Also we are clarifying that the Condition Code 44 policies apply to critical access hospitals as well as other types of hospitals.

6. 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. Fiscal Intermediaries (FIs)/Medicare Administrative Contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, FIs/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

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)						
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers	OTHER

							FISS	MCS	VMS	CWF	
7545.1	Medicare contractors shall install the October 2011 OPPS Pricer.	X		X		X	X				COBC
7545.2	Medicare contactors shall manually add the following HCPCS codes to their systems: • All HCPCS codes listed in table 1, and • C9286 Note: These HCPCS codes will be included with the October 2011 IOCE update. They are currently not on the 2011 HCPCS file; however, they will be listed on the CMS Web site at http://www.cms.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp#TopOfPage. Status and payment indicators for these HCPCS codes will be listed in the October 2011 update of the OPPS Addendum A and Addendum B on the CMS Web site.	X		X		X	X				COBC
7545.3	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have date of service that fall on or after January 1, 2011 but prior to October 1, 2011; 2) Have HCPCS code C1778 but no CPT code 64569; and 3) Were originally processed prior to the installation of the October 2011 IOCE update.	X		X		X					COBC
7545.4	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service that fall on or after July 1, 2011, but prior to October 1, 2011; 2) Contain HCPCS code listed in Table 3; and 3) Were originally processed prior to the installation of the October 2011 OPPS Pricer.	X		X		X					COBC
7545.5	Medicare contractors shall calculate the cost to charge ratios (CCRs) required by the Medicare Claims Processing Manual, Pub. 100-04, Chapter 4, Section 10.11 using the instructions contained in new sections 10.11.7.1 and 10.11.8.1 if the cost report used to calculate the CCR is filed on the CMS 2552-10 cost reporting forms.	X		X							COBC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)

		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7545.6	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/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 site 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 your 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		X					COBC

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	None

Section B: For all other recommendations and supporting information, use this space:

Please refer to CR 7541 “October 2011 Integrated Outpatient Code Editor (I/OCE) Specifications Version 12.3” for supporting information.

V. CONTACTS

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

Post-Implementation Contact(s): Contact your Contracting Officer’s Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs)*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: ***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.

Medicare Claims Processing Manual

Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

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(Rev. 2296, issued 09-02-11)

10.11.7.1 - Methodology for Calculation of Hospital Overall CCR for Hospitals That Do Not Have Nursing and Paramedical Education Programs for Cost Reporting Periods Beginning On or After May 1, 2010, Under Cost Report 2552-10

10.11.8.1 - Methodology for Calculation of Hospital Overall CCR for Hospitals That Have Nursing and Paramedical Education Programs for Cost Reporting Periods Beginning On or After May 1, 2010, Under Cost Report 2552-10

10.11.1 - Requirement to Calculate CCRs for Hospitals Paid under OPPS and for CMHCs

(Rev. 2296, Issued: 09-02-11, Effective: 10-01-11, Implementation: 10-03-11)

Medicare contractors must calculate overall cost-to-charge ratios for hospitals paid under OPPS and for CMHCs using the provider's most recent full year cost reporting period, whether tentatively settled or final settled, in accordance with the instructions in §§10.11.7, *10.11.7.1,* 10.11.8, *10.11.8.1* or 10.11.9 as applicable. The contractor must calculate a provider overall CCR whenever a more recent full year cost report becomes available. If a CCR is calculated based on the tentatively settled cost report, the contractor must calculate another overall CCR when the cost report is final or when a cost report for a subsequent cost reporting period is tentatively settled, whichever occurs first. If a CCR is based on a final settled cost report, the contractor must calculate the CCR when a cost report for a subsequent cost reporting period is tentatively settled.

10.11.7 - Methodology for Calculation of Hospital Overall CCR for Hospitals That Do Not Have Nursing and Paramedical Education Programs *for Cost Reporting Periods Beginning Before May 1, 2010, Under Cost Report Form 2552-96*

(Rev. 2296, Issued: 09-02-11, Effective: 10-01-11, Implementation: 10-03-11)

10.11.7.1 - Methodology for Calculation of Hospital Overall CCR for Hospitals That Do Not Have Nursing and Paramedical Education Programs for Cost Reporting Periods Beginning On or After May 1, 2010, Under Cost Report 2552-10

(Rev. 2296, Issued: 09-02-11, Effective: 10-01-11, Implementation: 10-03-11)

In calculating the hospital's costs or charges, do not include departmental CCRs and charges for services that are not paid under the OPPS such as physical, occupational and speech language therapies, clinical diagnostic laboratory services, ambulance, rural health clinic services, non-implantable DME, etc. See §10.11.10 for the location of the list of exact cost centers that shall be included in the calculation of the overall CCR.

***Step 1 – Determining Overall Costs**:*

Calculate costs for each cost center by multiplying the departmental CCR for each cost center (and subscripts thereof) that reflect services subject to the OPPS from Form CMS 2552-10, Worksheet C, Part I, Column 9 by the Medicare outpatient charges for that cost center (and subscripts thereof) from Worksheet D, Part V, Columns 2, 3, and 4,. Sum the costs calculated for each cost center to arrive at Medicare outpatient cost of services subject to OPPS.

***Step 2 – Determining Overall Charges**: Calculate charges by summing the Medicare outpatient charges from Form CMS 2552-10, Worksheet D, Part V, Columns 2, 3, and 4, (and for each cost center (and subscripts thereof) that reflect services subject to the OPPS.*

***Step 3 – Calculating the Overall CCR**: Divide the costs from Step 1 by the charges from Step 2 to calculate the hospital's Medicare outpatient CCR.*

10.11.8 - Methodology for Calculation of Hospital Overall CCR for Hospitals That Have Nursing and Paramedical Education Programs *for Cost Reporting Periods Beginning Before May 1, 2010, Under Cost Report Form 2552-96*

(Rev. 2296, Issued: 09-02-11, Effective: 10-01-11, Implementation: 10-03-11)

10.11.8.1 - Methodology for Calculation of Hospital Overall CCR for Hospitals That Have Nursing and Paramedical Education Programs for Cost Reporting Periods Beginning On or After May 1, 2010, Under Cost Report 2552-10

(Rev. 2296, Issued: 09-02-11, Effective: 10-01-11, Implementation: 10-03-11)

Do not include departmental CCRs and charges for services not subject to the OPPS (such as physical, occupational and speech language therapies, clinical diagnostic laboratory services, ambulance, rural health clinic services, non-implantable DME, etc.) in calculating the hospital's costs or charges. See §10.11.10 for the location of the list of the exact cost centers that should be included in the overall CCR.

***Step 1 -- Determining costs for each department**:*
From Worksheet B, Part 1 – Column 26, deduct the nursing and paramedical education costs found on the applicable line in Columns -20, and 23 of Worksheet B, Part I to calculate a cost for each cost center.
Exception: The costs for 9200 are not calculated on this worksheet. For cost center 9200, Observation Beds (Non-Distinct Part), use the cost reported on Worksheet D-1, Part IV, line 89, and deduct the nursing and paramedical education costs found on Worksheet D-1, Part IV, line 93 and subscripts, column 5. See Step 3 below.

***Step 2 – Determining charges for each department**: From worksheet C, Part 1 – Column 8 (sum of columns 6 and 7), identify —total charges.*

***Step 3 – Determining the CCRs for each department without nursing and paramedical education costs**: For each line, divide the costs from Step1 by the charges from Step 2 to acquire CCRs for each line, without inclusion of nursing and paramedical education costs. Exception: For cost center 9200, Observation Beds (Non-Distinct Part), use the cost reported on Worksheet D-1, Part IV, line 89, and deduct the nursing and paramedical education costs found on Worksheet D-1, Part IV, line 93 and subscripts, column 5.*

***Step 4 – Determining Overall Costs**: Multiply the CCR in step 3 by the Medicare outpatient charges for that cost center (and subscripts thereof) from Worksheet D Part V, Columns 2, 3, and 4,. Sum the costs calculated for each cost center to arrive at Medicare outpatient cost of services subject to OPPS.*

***Step 5 – Determining Overall Charges**: Calculate charges by summing the Medicare outpatient charges from Form CMS 2552-10, Worksheet D, Part V, Columns 2, 3, and 4, for each cost center (and subscripts thereof) that reflect service subject to the OPPS.*

***Step 6 – Calculating the Overall CCR**: Divide the costs from Step 4 by the charges from step 5 to calculate the hospital's Medicare outpatient CCR.*

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

(Rev. 2296, issued 09-02-11)

50.3.1 - Background

(Rev. 2296, Issued: 09-02-11, Effective: 10-01-11, Implementation: 10-03-11)

Payment is made under the hospital Outpatient Prospective Payment System (OPPS) for Medicare Part B services furnished by hospitals subject to the OPPS, and under the applicable other payment methodologies for hospitals not subject to the OPPS. "Outpatient" means a person who has not been admitted as an inpatient but who is registered on the hospital or critical access hospital (CAH) records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH.

Under the hospital Condition of Participation (CoP) at 42 C.F.R. §482.12(c), patients are admitted to the hospital *or CAH* as inpatients only on the recommendation of a physician or licensed practitioner permitted by the State to admit patients to a hospital. *In addition, every Medicare patient must be under the care of a physician or other type of practitioner listed in the regulation ("the practitioner responsible for care of the patient").* In some instances, a *practitioner* may order a beneficiary to be admitted as an inpatient, but upon reviewing the case, the hospital's utilization review (UR) committee determines that an inpatient level of care is not *medically necessary*.

Taking this into consideration, CMS obtained a condition code from the National Uniform Billing Committee (NUBC), effective April 1, 2004, that specifies:

Condition Code 44--Inpatient admission changed to outpatient – For use on outpatient claims only, when the physician ordered inpatient services, but upon internal utilization review performed before the claim was originally submitted, the hospital determined that the services did not meet its inpatient criteria.

The *utilization review requirements for hospitals and CAH are found in their respective CoPs at §482.30 or §485.641.* The hospital must ensure that all the UR activities, including the review of medical necessity of hospital admissions and continued stays *required by §482.30(d)*, are fulfilled as described in *the regulation. Section 482.30(d) delineates requirements that hospitals must follow when making the determination as to whether an admission or discharge of a patient is or was medically necessary.* Review of admissions may be performed before, at, or after hospital admission. More information about the hospital CoP may be found in Pub.100-07, State Operations Manual, Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals. *Section 485.641 requires CAHs to have a similar program for the evaluation of all services they furnish, including the quality and appropriateness of diagnoses and treatments furnished by their staff physician and non-physician practitioners. If in addition to making a medical necessity determination (or evaluating the appropriateness of diagnosis and treatment in a CAH) a hospital or CAH wishes to change a patient's status from inpatient to outpatient, the following requirements apply.*

CMS set the policy for the use of Condition Code 44 to address those relatively infrequent occasions, such as a late-night weekend admission when no case manager is on duty to offer guidance, when internal review subsequently determines that an inpatient admission does not meet hospital criteria and that the patient would have been registered as an outpatient under ordinary circumstances. The State Operations Manual states that in no case may a non-physician make a final determination that a patient's stay is not medically necessary or appropriate (see Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals). However, CMS encourages and expects hospitals to employ case management staff to facilitate the application of hospital admission protocols and criteria, to facilitate communication between practitioners and the UR committee or Quality Improvement Organization (QIO), and to assist the UR committee in the decision-making process. Use of Condition Code 44 is not intended to serve as a substitute for adequate staffing of utilization management personnel or for continued education of physicians and hospital staff about each hospital's existing policies and admission protocols. As education and staffing efforts continue to progress, the need for hospitals to correct inappropriate admissions and to report *C*ondition *C*ode 44 should become increasingly rare.

50.3.2 - Policy and Billing Instructions for Condition Code 44

(Rev. 2296, Issued: 09-02-11, Effective: 10-01-11, Implementation: 10-03-11)

In cases where a hospital *or a CAH's UR* committee determines that an inpatient admission does not meet the hospital's inpatient criteria, the hospital *or CAH* may change the beneficiary's status from inpatient to outpatient and submit an outpatient claim (bill type 13x or 85x) for medically necessary Medicare Part B services that were furnished to the beneficiary, provided all of the following conditions are met:

1. The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital;
2. The hospital has not submitted a claim to Medicare for the inpatient admission;
3. *The practitioner responsible for the care of the patient and the UR committee* concur with the *decision*; and
4. The concurrence of the *practitioner* responsible for the care of the patient *and* the *UR* committee is documented in the patient's medical record.

While typically the full UR committee makes the decision for the committee that a change in patient status under Condition Code 44 is warranted, in accordance with §482.30(d)(1) one physician member of the UR committee may make *the decision for the committee, provided he or she is* a different person from *the concurring practitioner who is responsible for the care of the patient.*

When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be billed as an outpatient episode of care on a 13x *or 85x* bill type and outpatient services that were ordered and furnished should be billed as appropriate.

Refer to Pub. 100-04, Medicare Claims Processing Manual; Chapter 30, Financial Liability Protections; Section 20, Limitation On Liability (LOL) Under §1879 Where Medicare Claims Are Disallowed, for information regarding financial liability protections.

When the hospital submits a 13x or 85x bill for services furnished to a beneficiary whose status was changed from inpatient to outpatient, the hospital is required to report Condition Code 44 on the outpatient claim in one of Form Locators 24-30, or in the ANSI X12N 837 I in Loop 2300, HI segment, with qualifier BG, on the outpatient claim. Additional information may be found in Chapter 25 of this manual, (Completing and Processing the Form CMS-1450 Data Set). Condition Code 44 is used by CMS and QIOs to track and monitor these occurrences. The reporting of Condition Code 44 on a claim does not affect the amount of hospital outpatient payment that would otherwise be made for a hospital outpatient claim that did not require the reporting Condition Code 44.

One of the requirements for the use of Condition Code 44 is concurrence *by the practitioner who is responsible for the care of the patient* with the determination that an inpatient admission does not meet the hospital's admission criteria and that the patient should have been registered as an outpatient. This prerequisite for use of Condition Code 44 is consistent with the requirements in the CoP in §482.30 (d) of the regulations. This paragraph provides that the practitioner or practitioners responsible for the care of the patient must be consulted and allowed to present their views before the UR committee or QIO makes its determination that an admission is not medically necessary. It may also be appropriate to include the practitioner who admitted the patient if this is a different person than the practitioner responsible for the care of the patient.

If the conditions for use of Condition Code 44 are not met, the hospital may submit a 12x bill type for covered "Part B Only" services that were furnished to the inpatient. Medicare may still make payment for certain Part B services furnished to an inpatient of a hospital when payment cannot be made under Part A because an inpatient admission is determined not to be medically necessary. Information about "Part B Only" services is located in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 6, Section 10. Examples of such services include, but are not limited to, diagnostic x-ray tests, diagnostic laboratory tests, surgical dressings and splints, prosthetic devices, and certain other services. The Medicare Benefit Policy Manual includes a complete list of the payable "Part B Only" services.

Entries in the medical record cannot be expunged or deleted and must be retained in their original form. Therefore, all orders and all entries related to the inpatient admission must be retained in the record in their original form. If a patient's status changes in accordance with the requirements for use of Condition Code 44, the change must be fully documented in the medical record, complete with orders and notes that indicate why the change was made, the care that was furnished to the beneficiary, and the participants in making the decision to change the patient's status.

When Condition Code 44 is appropriately used, the hospital reports on the outpatient bill the services that were ordered and provided to the patient for the entire patient encounter. However, in accordance with the general Medicare requirements for services furnished to beneficiaries and billed to Medicare, even in Condition Code 44 situations, hospitals may not report observation services using HCPCS code G0378 (Hospital observation service, per hour) for observation services furnished during a hospital encounter prior to a physician's order for observation services. Medicare does not permit retroactive orders or the inference of physician orders. Like all hospital outpatient services, observation services must be ordered by a physician. The clock time begins at the time that observation services are initiated in accordance with a physician's order.

While hospitals may not report observation services under HCPCS code G0378 for the time period during the hospital encounter prior to a physician's order for observation services, in Condition Code

44 situations, as for all other hospital outpatient encounters, hospitals may include charges on the outpatient claim for the costs of all hospital resources utilized in the care of the patient during the entire encounter. For example, a beneficiary is admitted as an inpatient and receives 12 hours of monitoring and nursing care, at which point the hospital changes the status of the beneficiary from inpatient to outpatient and the physician orders observation services, with all criteria for billing under Condition Code 44 being met. On the outpatient claim on an uncoded line with revenue code 0762, the hospital could bill for the 12 hours of monitoring and nursing care that were provided prior to the change in status and the physician order for observation services, in addition to billing HCPCS code G0378 for the observation services that followed the change in status and physician order for observation services. For other rules related to billing and payment of observation services, see Chapter 4, Section 290 of this manual, and Chapter 6, Section 20.6 of the Medicare Benefit Policy Manual, Pub.100-02.