CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2483	**Date: June 8, 2012**
	Change Request 7847

SUBJECT: July 2012 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 2012 OPPS update. It affects Chapter 4, Sections 10.12 and 180.7. CMS is updating information in these sections.

The July 2012 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 2012 revisions to I/OCE data files, instructions, and specifications are provided in CR7841, July 2012 Integrated Outpatient Code Editor (I/OCE) Specifications Version 13.2.

EFFECTIVE DATE: July 1, 2012
IMPLEMENTATION DATE: July 2, 2012

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	4/10.12/ Payment Window for Outpatient Services Treated as Inpatient Services
R	4/180.7/Inpatient-only Services

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
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: 2483	Date: June 8, 2012	Change Request: 7847

SUBJECT: July 2012 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Effective Date: **July 1, 2012**

Implementation Date: July 2, 2012

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the July 2012 OPPS update. The July 2012 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 2012 revisions to I/OCE data files, instructions, and specifications are provided in CR7841, "July 2012 Integrated Outpatient Code Editor (I/OCE) Specifications Version 13.2."

B. Policy:

1. Changes to Device Edits for July 2012

Claims for OPPS services must pass two types of device edits to be accepted for processing: procedure-to-device edits and device-to-procedure edits. Procedure-to-device edits, which have been in place for many procedures since 2005, continue to be in place. These edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code. Procedures for which both a Device A and Device B are specified require that at least one each of a 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.

Since January 1, 2007, CMS also has required 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. CMS has determined that the devices contained in this list cannot be correctly reported without one of the specified procedure codes also being reported on the same claim. Where these devices were billed without an appropriate procedure code prior to January 1, 2007, the cost of the device was being packaged into the median cost for an incorrect procedure code and therefore inflated the payment for the incorrect procedure code. In addition, hospitals billing devices without the appropriate procedure code were being incorrectly paid. The device-to-procedure edits are designed to ensure that the costs of these devices are assigned to the appropriate APC in OPPS ratesetting.

The most current edits for both types of device edits can be found under "Device, Radiolabeled Product, 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.

On April 1, 2012, HCPCS code C1882 (Cardioverter defibrillator, other than single or dual chamber (implantable)) was removed from the list of those devices required to be billed with CPT code 33249 (Insertion or replacement of permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber) on the procedure-to-device edit list, retroactive to January 1, 2012. Based on clinical input from

hospitals and other interested stakeholders, HCPCS code C1882 is being reinstated as a device code that can satisfy the edit for CPT code 33249, retroactive to January 1, 2012.

2. 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. As discussed in the CY 2006 OPPS final rule with comment period (70 FR 68567), CMS modified its process for implementing the Category III codes that the AMA releases each January for implementation in July to ensure timely collection of data pertinent to the services described by the codes; to ensure patient access to the services the codes describe; and to eliminate potential redundancy between Category III CPT codes and some of the C-codes that are payable under the OPPS and were created by CMS in response to applications for new technology services.

For the July 2012 update, CMS is implementing in the OPPS seven (7) Category III CPT codes that the AMA released in January 2012 for implementation on July 1, 2012. All seven (7) Category III CPT codes are separately payable under the hospital OPPS. The Category III CPT codes', status indicators, and APCs are shown in Table 1 below. Payment rates for these services can be found in Addendum B of the July 2012 OPPS Update that is posted on the CMS Website.

Table 1 -- Category III CPT Codes Implemented as of July 1, 2012

CPT Code	Long Descriptor	SI	APC
0302T	Insertion or removal and replacement of intracardiac ischemia monitoring system including imaging supervision and interpretation when performed and intra-operative interrogation and programming when performed; complete system (includes device and electrode)	T	0089
0303T	Insertion or removal and replacement of intracardiac ischemia monitoring system including imaging supervision and interpretation when performed and intra-operative interrogation and programming when performed; electrode only	T	0106
0304T	Insertion or removal and replacement of intracardiac ischemia monitoring system including imaging supervision and interpretation when performed and intra-operative interrogation and programming when performed; device only	T	0090
0305T	Programming device evaluation (in person) of intracardiac ischemia monitoring system with iterative adjustment of programmed values, with analysis, review, and report	S	0690
0306T	Interrogation device evaluation (in person) of intracardiac ischemia monitoring system with analysis, review, and report	S	0690
0307T	Removal of intracardiac ischemia monitoring device	T	0105
0308T*	Insertion of ocular telescope prosthesis including removal of crystalline lens	T	0234

*HCPCS code C9732 (Insertion of ocular telescope prosthesis including removal of crystalline lens) was deleted June 30, 2012, and replaced with CPT code 0308T effective July 1, 2012.

3. New Instructions for Device Pass-Through Category C1840

Effective July 1, 2012, device pass-through category C1840 must be billed with CPT code 0308T (Insertion of ocular telescope prosthesis including removal of crystalline lens) to receive pass-through payment, because C9732 is deleted effective June 30, 2012. CPT code 0308T is assigned to APC 0234 (Level IV Anterior Segment Eye Procedures), as was C9732, so no change in the device offset for C1840 is necessary. See the OPPS Web page at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/ for the CY 2012 device offset for APC 0234.

4. 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 service of the reported HCPCS codes are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used in the care of the patient.

Hospitals are reminded 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 for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a 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 July 1, 2012

For CY 2012, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 4 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2012, 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 costs of these pass-through items. Note that for the third quarter of CY 2012, 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 sometime during CY 2012, CMS would again use the Part B drug CAP rate for pass-through drugs and biologicals if they are a part of the Part B drug CAP program, as required by the statute.

In the CY 2012 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 2012 release of the OPPS PRICER. The updated payment rates, effective July 1, 2012 will be included in the July 2012 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, 2012

Two drugs and biologicals have been granted OPPS pass-through status effective July 1, 2012. 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 July 1, 2012

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 7/1/12
C9368*	Grafix core, per square centimeter	9368	G
C9369*	Grafix prime, per square centimeter	9369	G

NOTE: The HCPCS codes identified with an "*" indicate that these are new codes effective July 1, 2012.

c. New HCPCS Codes Effective July 1, 2012 for Certain Drugs and Biologicals

Six new HCPCS codes have been created for reporting certain drugs and biologicals (other than new pass-through drugs and biologicals listed above in Table 2) in the hospital outpatient setting for July 1, 2012. These codes are listed in Table 3 below and are effective for services furnished on or after July 1, 2012.

Table 3 -- New HCPCS Codes Effective for Certain Drugs and Biologicals Effective July 1, 2012

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 7/1/12
Q2045*	Injection, human fibrinogen concentrate, 1 mg	1414	K
Q2046**	Injection, aflibercept, 1 mg	1420	G
Q2047	Injection, Peginesatide, 0.1 MG (for ESRD on Dialysis)	N/A	A
Q2048***	Injection, doxorubicin hydrochloride, liposomal, doxil, 10 mg	7046	K
Q2049	Injection, doxorubicin hydrochloride, liposomal, imported lipodox, 10 mg	1421	K
Q2034	Influenza virus vaccine, split virus, for intramuscular use (Agriflu)	N/A	L

*Level II HCPCS code J1680 (Injection, human fibrinogen concentrate, 100 mg) will be replaced with HCPCS code Q2045 effective July 1, 2012. The status indicator for HCPCS code J1680 will change to E, "Not Payable by Medicare", effective July 1, 2012.

**Level II HCPCS code C9291 (Injection, aflibercept, 2 mg vial) will be deleted June 30, 2012, and replaced with HCPCS code Q2046 effective July 1, 2012.

***Level II HCPCS code J9001 (Injection, doxorubicin hydrochloride, all lipid formulations, 10 mg) will be replaced with HCPCS code Q2048 effective July 1, 2012. The status indicator for HCPCS code J9001 will change to E, "Not Payable by Medicare", effective July 1, 2012.

d. Adjustment to the Status Indicator for Certain HCPCS Codes Effective April 1, 2012

Effective April 1, 2012, the status indicators for several HCPCS codes listed in Table 4 below will change from SI=E (not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=K (paid under OPPS; separate APC payment). For the remainder of CY 2012, these HCPCS codes will be separately paid and the price will be updated on a quarterly basis.

The payment rates for these HCPCS codes are listed in Table 4 below and have been installed in the July 2012 OPPS Pricer effective for services furnished on April 1, 2012 through the implementation of the July 2012 update.

Table 4 -- Adjustment to Status Indicators for Certain Drugs and Biologicals Effective April 1, 2012

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 4/1/12	Payment Rate	Minimum Unadjusted Copayment Rate
90581	Anthrax vaccine, for subcutaneous or intramuscular use	1422	K	$112.86	$22.57
J2265	Injection, minocycline hydrochloride, 1 mg	1423	K	$0.57	$0.11
J8650	Nabilone, oral, 1 mg	1424	K	$22.99	$4.60
Q0174	Thiethylperazine maleate, 10 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	1425	K	$0.80	$0.16
Q4123	Alloskin rt, per square centimeter	1427	K	$13.77	$2.75
Q4125	Arthroflex, per square centimeter	1428	K	$123.61	$24.72
Q4128	Flexhd or allopatch hd, per square centimeter	1429	K	$39.93	$7.99
Q4129	Unite biomatrix, per sqaure centimeter	1430	K	$35.49	$7.10

e. Correct Reporting of Biologicals When Used As Implantable Devices

When billing for products that are used as either a surgically implanted or inserted biological or as a skin substitute, hospitals should report the appropriate HCPCS code for the product. Implantable biologicals with pass-through status receive separate payment, but for those that do not have pass-through status, the OPPS payment for the implanted biological is packaged into the payment for the associated procedure. Products that can be used as either a skin substitute or as an implantable biological will only be separately paid when billed with a skin substitute application procedure. 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, if different from the HCPCS descriptor. 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.

5. Inpatient Only List

Section 1833(t)(1)(B)(i) of the Act allows CMS to define the services for which payment under the OPPS is appropriate and the Secretary has determined that the services designated to be "inpatient only" services are not appropriate to be furnished in a hospital outpatient department. Medicare billing instructions in Pub. 100-04, chapter 4, sections 10.12 and 180.7, for inpatient only reporting guidelines are being clarified to state that procedures removed from the "inpatient only" list may be appropriately furnished in both the inpatient and outpatient settings and such procedures continue to be payable when furnished in the inpatient setting.

6. Corrected OPPS Payment Rates for July 2012

CMS made corrections to the CY 2012 OPPS payment rates issued in the CY 2012 OPPS/ASC final rule with comment period (CMS-1525-FC), in a correction notice published in the Federal Register on January 4, 2012, (CMS-1525-CN). CMS made additional corrections to CMS-1525-FC, in a correction notice published in the Federal Register on April 24, 2012. The July 2012 addenda A and B are impacted by these corrections and reflect the corrected rates. These payment rates are retroactive to dates of service beginning with January 1, 2012. To view the revised OPPS payment rates, see the July 2012 addenda posted on the CMS Website at: http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html. Providers who think they may have received an incorrect payment between January 1, 2012 and June 30, 2012, may request contractor adjustment of the previously processed claims.

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. 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.
Use "Should" to denote an optional 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	
7847.04.1	Medicare contractors shall install the July 2012 OPPS Pricer.	X		X		X	X				COBC
7847.04.2	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service that fall on or after January 1, 2012, but prior to July 1, 2012 and; 2) Were originally processed prior to the installation of the July 2012 OPPS Pricer.	X		X		X					COBC
7847.04.3	Medicare contactors shall manually add the following HCPCS codes to their systems: • All CPT and HCPCS codes listed in tables 1, 2, and 3 effective July 1, 2012; and • G8907-G8918 listed in CR7841 effective April 1, 2012; **Note:** These HCPCS codes will be included with the July 2012 IOCE update. Status and payment indicators for these HCPCS codes will be listed in the July 2012 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		X	X				COBC
7847.04.4	Medicare contractors shall adjust, as appropriate, claims brought to their attention that: 1) Have dates of service that fall on or after April 1, 2012, but prior to July 1, 2012; 2) Contain HCPCS codes listed in Table 4; and 3) Were originally processed prior to the installation of the July 2012 OPPS Pricer.	X		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	
7847.04.5	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: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

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

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

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),* include the following statement:

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.

10.12 – Payment Window for Outpatient Services Treated as Inpatient Services

(Rev. 2483, Issued: 06-08-12, Effective: 07-01-12, Implementation: 07-02-12)

The policy for the payment window for outpatient services treated as inpatient services is discussed in §40.3, of Chapter 3 of the Medicare Claims Processing Manual. The policy requires payment for certain outpatient services provided to a beneficiary on the date of an inpatient admission or during the 3 calendar days (or 1 calendar day for a non-IPPS hospital) prior to the date of an inpatient admission to be bundled (i.e., included) with the payment for the beneficiary‘s inpatient admission if those outpatient services are provided by the admitting hospital or an entity that is wholly owned or wholly operated by the admitting hospital. The policy applies to all diagnostic outpatient services and non-diagnostic *services* (i.e., therapeutic) that are related to the inpatient stay. Ambulance and maintenance renal dialysis services are not subject to the payment window.

All diagnostic services provided to a Medicare beneficiary by a hospital (or an entity wholly owned or wholly operated by the hospital) on the date of the beneficiary’s inpatient admission or during the 3 calendar days (or, in the case of a non-subsection (d) hospital, 1 calendar day) immediately preceding the date of admission are required to be included on the bill for the inpatient stay.

Outpatient non-diagnostic services that are related to an inpatient admission must be bundled with the billing for the inpatient stay. An outpatient service is related to the admission if it is clinically associated with the reason for a patient’s inpatient admission. In accordance with section 102 of Pub. L. 111-192, for services furnished on or after June 25, 2010, all outpatient non-diagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the date of a beneficiary’s inpatient admission are deemed related to the admission, and thus, must be billed with the inpatient stay. Also, outpatient non-diagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the first, second, and third calendar days for a subsection (d) hospital paid under the IPPS (first calendar day for non-subsection (d) hospitals) preceding the date of a beneficiary‘s inpatient admission are deemed related to the admission, and thus, must be billed with the inpatient stay, unless the hospital attests to specific non-diagnostic services as being unrelated to the hospital claim (that is, the preadmission non-diagnostic services are clinically distinct or independent from the reason for the beneficiary‘s admission). Outpatient non-diagnostic services provided during the payment window that are unrelated to the admission, and are covered by Part B, may be separately billed to Part B. The June 25, 2010, effective date of section 102 of Pub. L. 111-192 applies to outpatient services provided on or after June 25, 2010.

In the event that there is no Part A coverage for the inpatient stay, there is no inpatient service into which outpatient services (i.e., services provided to a beneficiary on the date of an inpatient admission or during the 3 calendar days (or 1 calendar day for a non-IPPS

hospital) prior to the date of an inpatient admission) must be bundled. Therefore services provided to the beneficiary prior to the point of admission (i.e., the admission order) may be separately billed to Part B as the outpatient services that they were.

A hospital may attest to specific non-diagnostic services as being unrelated to the hospital claim (that is, the preadmission non-diagnostic services are clinically distinct or independent from the reason for the beneficiary's admission) by adding a condition code 51 (definition "51 - Attestation of Unrelated Outpatient Non-diagnostic Services") to the separately billed outpatient non-diagnostic services claim. Providers may submit outpatient claims with condition code 51 starting April 1, 2011, for outpatient claims that have a date of service on or after June 25, 2010. Outpatient claims with a date of service on or after June 25, 2010, that did not contain condition code 51 received prior to April, 1, 2011, will need to be adjusted by the provider if they were rejected by FISS or CWF.

As stated in §180.7, "inpatient-only" procedures that are provided to a patient in the outpatient setting during the 3 calendar days (or 1 calendar day for a non-subsection (d) hospital) preceding the date of the inpatient admission that would otherwise be deemed related to the admission are not paid for by CMS. Providers should bill for these services on a no-pay claim (Type of Bill (TOB) 110). If there are covered services/procedures provided during the same outpatient encounter as the non-covered inpatient-only procedure (see the two exceptions listed in §180.7), providers are then required to submit two claims:

- One claim with covered service(s)/procedure(s) on a TOB 11X (with the exception of 110), and,

- The other claim with the non-covered service(s)/procedure(s) on a TOB 110 (no-pay claim).

NOTE: Both the covered and non-covered claim must have a matching Statement Covers Period.

180.7 - Inpatient-only Services

(Rev. 2483, Issued: 06-08-12, Effective: 07-01-12, Implementation: 07-02-12)

Section 1833(t)(1)(B)(i) of the Act allows CMS to define the services for which payment under the OPPS is appropriate and the Secretary has determined that the services designated to be "inpatient only" services are not appropriate to be furnished in a hospital outpatient department. "Inpatient only" services are generally, but not always, surgical services that require inpatient care because of the nature of the procedure, the typical underlying physical condition of patients who require the service, or the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged. An example of an "inpatient only" service is CPT code 33513, "Coronary artery bypass, vein only; four coronary venous grafts." The designation of services to be "inpatient-only" is open to public comment each year as part of the annual rulemaking process. *Procedures removed from the "inpatient only" list may be appropriately*

furnished in either the inpatient or outpatient settings and such procedures continue to be payable when furnished in the inpatient setting.

There is no payment under the OPPS for services that CMS designates to be "inpatient-only" services. These services have an OPPS status indicator of "C" in the OPPS Addendum B and are listed together in Addendum E of each year's OPPS/ASC final rule. For the most current Addendum B and for Addendum E published with the OPPS notices and regulations, see http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html.

Excluding the handful of exceptions discussed below, CMS does not pay for an "inpatient-only" service furnished to a person who is registered in the hospital as an outpatient and reports the service on the outpatient hospital bill type (TOB 13X). CMS also does not pay for all other services on the same day as the "inpatient only" procedure.

There are two exceptions to the policy of not paying for outpatient services furnished on the same day with an "inpatient-only" service that would be paid under the OPPS if the inpatient service had not been furnished:

Exception 1: If the "inpatient-only" service is defined in CPT to be a "separate procedure" and the other services billed with the "inpatient-only" service contain a procedure that can be paid under the OPPS and that has an OPPS SI=T on the same date as the "inpatient-only" procedure, then the "inpatient-only" service is denied but CMS makes payment for the separate procedure and any remaining payable OPPS services. The list of "separate procedures" is available with the Integrated Outpatient Code Editor (I/OCE) documentation. See http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/.

Exception 2: If an "inpatient-only" service is furnished but the patient expires before inpatient admission or transfer to another hospital and the hospital reports the "inpatient only" service with modifier "CA", then CMS makes a single payment for all services provided on that day, including the "inpatient only" procedure, through one unit of APC 0375, (Ancillary outpatient services when the patient expires.) Hospitals should report modifier CA on only one procedure.

As stated in §10.12, inpatient only procedures that are provided to a patient in the outpatient setting during the 3 calendar days (or 1 calendar day for a non-subsection (d) hospital) preceding the date of the inpatient admission that would otherwise be deemed related to the admission are not paid for by CMS and must be submitted on a no-pay claim (Type of Bill (TOB) 110). If there are covered services/procedures provided during the same stay as the non- covered inpatient only procedure (see the two exceptions stated above), hospitals are then required to submit two claims:

- One claim with covered service(s)/procedure(s) on a TOB 11X (with the exception of 110), and,

- The other claim with the non-covered service(s)/procedure(s) on a TOB 110 (no-pay claim).

NOTE: Both the covered and non-covered claim must have a matching Statement Covers Period.