

Medicare Claims Processing Manual

Chapter 4 - Part B Hospital

(Including Inpatient Hospital Part B and OPSS)

Table of Contents

(Rev. 1777, 07-24-09)
(Rev. 1882, 12-21-09)

Transmittals for Chapter 4

Crosswalk to Old Manuals

10 - Hospital Outpatient Prospective Payment System (OPSS)

10.1 - Background

10.1.1 - Payment Status Indicators

10.2 - APC Payment Groups

10.2.1 - Composite APCs

10.3 - Calculation of APC Payment Rates

10.4 - Packaging

10.4.1 - Combinations of Packaged Services of Different Types That are Furnished on the Same Date of Service

10.5 - Discounting

10.6 - Payment Adjustments

10.6.1 – Payment Adjustment for Certain Rural Hospitals

10.6.2 – Payment Adjustment for Failure to Meet the Hospital Outpatient Quality Reporting Requirements

10.6.2.1 – Hospitals to which the Payment Reduction Applies

10.6.2.2 – Services to which the Payment Reduction Applies

10.6.2.3 – Contractor Responsibilities

10.6.2.4 – Application of the Payment Reduction Factor in Calculation of the Reduced Payment and Reduced Copayment

10.7 - Outliers

10.7.1 – Outlier Adjustments

10.7.2 – Outlier Reconciliation

10.7.2.1 – Identifying Hospitals and CMHCs Subject to Outlier Reconciliation

- 210.2 - Healthcare Common Procedural Coding System (HCPCS), Applicable Diagnosis Codes, and Procedure Codes
- 210.3 - Medicare Summary Notices (MSNs), Remittance Advice Remark Codes (RAs), and Claim Adjustment Reason Codes
- 210.4 - Advance Beneficiary Notices (ABNs)
- 230 - Billing and Payment for Drugs and Drug Administration
 - 230.1 - Coding and Payment for Drugs and Biologicals and Radiopharmaceuticals
 - 230.2 – Coding and Payment for Drug Administration
- 231 - Billing and Payment for Blood, Blood Products, and Stem Cells and Related Services Under the Hospital Outpatient Prospective Payment System (OPPS)
 - 231.1 - When a Provider Paid Under the OPSS Does Not Purchase the Blood or Blood Products That It Procures from a Community Blood Bank, or When a Provider Paid Under the OPSS Does Not Assess a Charge for Blood or Blood Products Supplied by the Provider’s Own Blood Bank Other Than Blood Processing and Storage
 - 231.2 - When a Provider Paid Under the OPSS Purchases Blood or Blood Products from a Community Blood Bank or When a Provider Paid Under the OPSS Assesses a Charge for Blood or Blood Products Collected By Its Own Blood Bank That Reflects More Than Blood Processing and Storage
 - 231.3 - Billing for Autologous Blood (Including Salvaged Blood) and Directed Donor Blood
 - 231.4 - Billing for Split Unit of Blood
 - 231.5 - Billing for Irradiation of Blood Products
 - 231.6 - Billing for Frozen and Thawed Blood and Blood Products
 - 231.7 - Billing for Unused Blood
 - 231.8 - Billing for Transfusion Services
 - 231.9 - Billing for Pheresis and Apheresis Services
 - 231.10 - Billing for Autologous Stem Cell Transplants
 - 231.11 - *Billing for Allogeneic Stem Cell Transplants*
 - 231.12* - Correct Coding Initiative (CCI) Edits
- 240 - Inpatient Part B Hospital Services
 - 240.1 - Editing of Hospital Part B Inpatient Services
 - 240.2 – Indian Health Service/ Tribal Hospital Inpatient Social Admits
- 250 - Special Rules for Critical Access Hospital Outpatient Billing

		product available
P9017	Plasma 1 donor frz w/in 8 hr	Freezing and thawing codes not separately billable
P9019	Platelets, each unit	Freezing and thawing are separately billable
P9020	Platelet rich plasma unit	Freezing and thawing are separately billable
P9021	Red blood cells unit	Alternative P-code for frozen/thawed product available
P9022	Washed red blood cells unit	Freezing and thawing are separately billable
P9023	Frozen plasma, pooled, sd	Freezing and thawing codes not separately billable
P9031	Platelets leukocytes reduced	Freezing and thawing are separately billable
P9032	Platelets, irradiated	Freezing and thawing are separately billable
P9033	Platelets leukoreduced irradiated	Freezing and thawing are separately billable
P9034	Platelets, pheresis	Freezing and thawing are separately billable
P9035	Platelet pheres leukoreduced	Freezing and thawing are separately billable
P9036	Platelet pheresis irradiated	Freezing and thawing are separately billable
P9037	Plate pheres leukoreduced irradiated	Freezing and thawing are separately billable
P9038	RBC irradiated	Freezing and thawing are separately billable
P9039	RBC deglycerolized	Freezing and thawing codes not separately billable
P9040	RBC leukoreduced irradiated	Alternative P-code for frozen/thawed product available
P9043	Plasma protein fract,5%,50ml	Concept not applicable
P9044	Cryoprecipitate reduced plasma	Freezing and thawing codes not separately billable
P9048	Plasmaprotein fract,5%,250ml	Concept not applicable
P9050	Granulocytes, pheresis unit	Concept not applicable
P9051	Blood, l/r, cmv-neg	Freezing and thawing are separately billable
P9052	Platelets, hla-m, l/r, unit	Freezing and thawing are separately billable
P9053	Plt, pher, l/r cmv-neg, irr	Freezing and thawing are separately billable
P9054	Blood, l/r, froz/degly/wash	Freezing and thawing codes not separately billable
P9055	Plt, aph/pher, l/r, cmv-neg	Freezing and thawing are separately billable
P9056	Blood, l/r, irradiated	Freezing and thawing are separately billable
P9057	RBC, frz/deg/wsh, l/r, irradiated	Freezing and thawing codes not separately billable
P9058	RBC, l/r, cmv-neg, irradiated	Freezing and thawing are separately billable
P9059	Plasma, frz between 8-24hour	Freezing and thawing codes not separately billable
P9060	Fr frz plasma donor retested	Freezing and thawing codes not separately billable

231.7 - Billing for Unused Blood

(Rev. 1487, Issued: 04-08-08, Effective: 04-01-08, Implementation: 04-07-08)

When blood or blood products which the OPPS provider has collected in its own blood bank or received from a community blood bank are not used, processing and storage costs incurred by the community blood bank and the OPPS provider cannot be charged to

the beneficiary. However, certain patient-specific blood preparation costs incurred by the OPPS provider (e.g., blood typing and cross-matching) can be charged to the beneficiary under Revenue Code Series 30X or 31X. Patient-specific preparation charges should be billed on the dates the services were provided.

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

Where blood or a blood product is split or irradiated specifically with the intent of transfusion to a beneficiary but is not then used, the hospital may bill for the services of splitting or irradiating the unit of blood, but may not bill for the HCPCS code for the blood product that was not transfused. The date of service must be the date on which the decision not to use the blood was made and indicated in the patient's medical record. Where the unit of blood is split or irradiated and stored without specific intention to administer it to a Medicare beneficiary at the time of splitting or irradiation and is not subsequently transfused, there is no service to be reported.

231.8 - Billing for Transfusion Services

(Rev. 496, Issued: 03-04-05, Effective: 07-01-05, Implementation: 07-05-05)

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

231.9 - Billing for Pheresis and Apheresis Services

(Rev. 496, Issued: 03-04-05, Effective: 07-01-05, Implementation: 07-05-05)

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

231.10 - Billing for Autologous Stem Cell Transplants

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

The hospital bills and shows all charges for autologous stem cell harvesting, processing, and transplant procedures based on the status of the patient (i.e., inpatient or outpatient) when the services are furnished. It shows charges for the actual transplant, described by the appropriate ICD-9-CM procedure or CPT codes, in revenue center code 0362 (*Operating Room Services; Organ Transplant, Other than Kidney*) or another appropriate cost center.

The CPT codes describing autologous stem cell harvesting procedures may be billed and are separately payable under the Outpatient Prospective Payment System (OPPS) when provided in the hospital outpatient setting of care. Autologous harvesting procedures are distinct from the acquisition services described in Pub. 100-04, Chapter 3, §90.3.3 *and §231.11 of this chapter* for allogeneic stem cell transplants, which include services provided when stem cells are obtained from a donor and not from the patient undergoing the stem cell transplant.

The CPT codes describing autologous stem cell processing procedures also may be billed and are separately payable under the OPPS when provided to hospital outpatients.

231.11 - Billing for Allogeneic Stem Cell Transplants

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

1. Definition of Acquisition Charges for Allogeneic Stem Cell Transplants

Acquisition charges for allogeneic stem cell transplants include, but are not limited to, charges for the costs of the following services:

- National Marrow Donor Program fees, if applicable, for stem cells from an unrelated donor;*
- Tissue typing of donor and recipient;*
- Donor evaluation;*
- Physician pre-procedure donor evaluation services;*
- Costs associated with harvesting procedure (e.g., general routine and special care services, procedure/operating room and other ancillary services, apheresis services, etc.);*
- Post-operative/post-procedure evaluation of donor; and*
- Preparation and processing of stem cells.*

Payment for these acquisition services is included in the OPPS APC payment for the allogeneic stem cell transplant when the transplant occurs in the hospital outpatient

setting, and in the MS-DRG payment for the allogeneic stem cell transplant when the transplant occurs in the inpatient setting. The Medicare contractor does not make separate payment for these acquisition services, because hospitals may bill and receive payment only for services provided to the Medicare beneficiary who is the recipient of the stem cell transplant and whose illness is being treated with the stem cell transplant. Unlike the acquisition costs of solid organs for transplant (e.g., hearts and kidneys), which are paid on a reasonable cost basis, acquisition costs for allogeneic stem cells are included in prospective payment.

Acquisition charges for stem cell transplants apply only to allogeneic transplants, for which stem cells are obtained from a donor (other than the recipient himself or herself). Acquisition charges do not apply to autologous transplants (transplanted stem cells are obtained from the recipient himself or herself), because autologous transplants involve services provided to the beneficiary only (and not to a donor), for which the hospital may bill and receive payment (see Pub. 100-04, Chapter 3, §90.3.3 and §231.10 of this chapter for information regarding billing for autologous stem cell transplants).

2. Billing for Acquisition Services

The hospital bills and shows acquisition charges for allogeneic stem cell transplants based on the status of the patient (i.e., inpatient or outpatient) when the transplant is furnished. See Pub. 100-04, Chapter 3, §90.3.3 for instructions regarding billing for acquisition services for allogeneic stem cell transplants that are performed in the inpatient setting.

When the allogeneic stem cell transplant occurs in the outpatient setting, the hospital identifies stem cell acquisition charges for allogeneic bone marrow/stem cell transplants separately in FL 42 of Form CMS-1450 (or electronic equivalent) by using revenue code 0819 (Other Organ Acquisition). Revenue code 0819 charges should include all services required to acquire stem cells from a donor, as defined above.

The transplant hospital keeps an itemized statement that identifies the services furnished, the charges, the person receiving the service (donor/recipient), and whether this is a potential transplant donor or recipient. These charges will be reflected in the transplant hospital's stem cell/bone marrow acquisition cost center. For allogeneic stem cell acquisition services in cases that do not result in transplant, due to death of the intended recipient or other causes, hospitals include the costs associated with the acquisition services on the Medicare cost report.

In the case of an allogeneic transplant in the hospital outpatient setting, the hospital reports the transplant itself with the appropriate CPT code, and a charge under revenue center code 0362 or another appropriate cost center. Selection of the cost center is up to the hospital.

231.12 - Correct Coding Initiative (CCI) Edits

(Rev. 1882, Issued: 12-21-09; Effective Date: 01-01-10; Implementation Date: 01-04-10)

The OPSS providers should be aware that certain CCI edits may apply when billing for blood and blood product services. The OPSS providers should consult the most current list of CCI edits to determine whether they apply to the services or HCPCS blood product codes being reported. A file with the most current list of CCI edits applicable to Medicare Part B services paid by fiscal intermediaries under the OPSS is available at: <http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHOPSS/list.asp>

240 - Inpatient Part B Hospital Services

(Rev. 1628, Issued: 11-03-08, Effective: 01-01-09, Implementation: 01-05-09)

Inpatient Part B services which are paid under OPSS include:

- Diagnostic x-ray tests, and other diagnostic tests (excluding clinical diagnostic laboratory tests);
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;
- Surgical dressings applied during an encounter at the hospital and splints, casts, and other devices used for reduction of fractures and dislocations (splints and casts, etc., include dental splints);
- Implantable prosthetic devices;
- Hepatitis B vaccine and its administration, and certain preventive screening services (pelvic exams, screening sigmoidoscopies, screening colonoscopies, bone mass measurements, and prostate screening.)
- Bone Mass measurements;
- Prostate screening;
- Immunosuppressive drugs;
- Oral anti-cancer drugs;
- Oral drug prescribed for use as an acute anti-emetic used as part of an anti-cancer chemotherapeutic regimen; and
- Epoetin Alfa (EPO)

When a hospital that is not paid under the OPSS furnishes an implantable prosthetic device that meets the criteria for coverage in Medicare Benefits Policy Manual, Pub.100-