Program Memorandum Intermediaries

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal A-01-145 **Date: DECEMBER 21, 2001**

CHANGE REQUEST 2008

SUBJECT: Delay of the 2002 Update to the Outpatient Prospective Payment System (OPPS)

NOTE: CMS is retracting recently issued Program Memoranda A-01-139, A-01-140, and A-01-143. The three transmittal numbers will not be re-used in the future.

General Information

In order to ease confusion and minimize disruptions in outpatient care, it has been determined that the effective date of the 2002 update to the Medicare OPPS will be delayed. This delay allows CMS to implement the CY 2002 OPPS update without disrupting the flow of payments to providers and without impacting the ability of providers to collect the proper amounts of coinsurance and deductible from our beneficiaries. This delay will also help insure that Medicare beneficiaries receive the outpatient care that they need.

Hospitals and Community Mental Health Centers (CMHCs) will be paid for outpatient services they provide to Medicare beneficiaries at the 2001 rates until the new 2002 rates are made effective.

Coinsurance

We will implement two statutory provisions effective with dates of service on or after January 1, 2002. Section 1833(t)(8)(C)(i) of the Social Security Act (the Act) limits the copayment amount for a procedure performed in a year to no more than the inpatient hospital deductible for that year. The inpatient hospital deductible for 2002 will be $812. We will implement the limit of $812 on the copayment for a single procedure effective with dates of service on or after January 1, 2002. Section 1833(t)(8)(C)(i)(II) of the Act provides that, for services furnished in 2002, the national unadjusted coinsurance for an Ambulatory Payment Classification (APC) cannot exceed 55 percent. (The limit was 57 percent in 2001.) We will also implement the 55 percent limit on the national unadjusted coinsurance for each APC on January 1, 2002.

Claims Processing Instructions

The delay affects only the following types of bills (TOBs) with the exception of claims from the hospitals noted below:

12X – Hospital Inpatient Part B
13X – Hospital Outpatient
14X – Hospital Referred Diagnostic Tests
76X – Community Mental Health Center (CMHC)

Until further notice, these bill types will continue to be processed and paid using 2001 OPPS rates. Transitional pass-through payments will continue to be paid in the same manner as in 2001.

Exceptions: TOBs 12X, 13X, 14X, and 85X received from Critical Access Hospitals, Indian Health Service Hospitals, U.S.Virgin Island Hospitals, Maryland Hospitals, and those hospitals located in the Pacific (American Samoa, Guam, and Saipan) should continue to be processed in the normal manner as they are not affected by the delay.

In addition, Part B services furnished to inpatients of hospitals that do no other Medicare billing for hospital outpatient services are also an exception. (See below under 'Routing of Claims' for more detail.)

Routing of Claims

Until further notice, Standard System Maintainers will continue to route the following bill types to the non-OPPS Outpatient Code Editor (OCE):

22X – Skilled Nursing Facility (SNF) Inpatient Part B
23X – SNF/Outpatient
24X – SNF Part B
32X – Home Health Agency (HHA) visits under a Part B Plan of Treatment (POT)
33X – HHA visits under Part A POT
34X – HHA visits not under a POT
71X – Rural Health Clinic
72X – Hospital Based or Independent Renal Dialysis Facility
73X – Federally Qualified Health Center
74X – Other Rehabilitation Facilities
75X – Comprehensive Outpatient Rehabilitation Facility (CORF)
81X – Hospice (non-hospital based)
82X – Hospice (hospital based)

In addition, claims from Virgin Island Hospitals with dates of service on or after January 1, 2002 should be directed to the Non-OPPS OCE since they are excluded under OPPS.

Also excluded from payment under the OPPS are covered Part B services furnished to inpatients, who have either exhausted their Part A benefits or who are not entitled to Part A benefits, when they are furnished by a hospital that does no other Medicare billing for hospital outpatient services under Part B. The Part B services (TOB 12X) furnished by these hospitals on or after January 1, 2002, should be directed to the non-OPPS OCE and payment and coinsurance for these services will be based on the method that was applicable to the hospital prior to OPPS (e.g., all-inclusive rate). Instructions will be used in a separate Program Memorandum (PM) on how these hospitals will be identified for the purpose of being excluded under OPPS.

Revisions to Software and Handling of 2002 HCPCS Codes

OPPS OCE

We expect a test version of the OPPS OCE to be available to the maintainers on January 10, 2002. A revised version of the OPPS OCE with all recent revisions is expected on or about January 24, 2002, to be tested and installed for implementation at a later date as determined by CMS.

Revised PRICER

A new OPPS PRICER for 2002 was released on December 19, 2001. This OPPS PRICER contains the new outpatient coinsurance limit of $812 for 2002 and new outpatient coinsurance rates limited to 55 percent of the Medicare payment amount for 2002. This PRICER will be used for outpatient claims with dates of service on or after January 1, 2002, until the 2002 rates are effective. New rates, wage indexes, and payment algorithms, will be programmed into another OPPS PRICER to be effective at that time.

Revised and Deleted Codes

One of the largest impacts on provider billing as a result of the delay will be the upcoming HCPCS changes. For outpatient services rendered on or after January 1, 2002, hospitals and CMHCs should continue to utilize the 2001 HCPCS codes and definitions. In a subsequent PM, we will announce when the new 2002 HCPCS may be used.

New Codes

Claims containing new 2002 HCPCS codes will not be able to process to payment, as the OCE will not recognize these codes as valid. As a result, instruct your hospitals and CMHCs not to submit a claim containing any new 2002 HCPCS codes for outpatient services. They should submit the claim with the 2001 code if available and the service is covered.

Refer to latest HCPCS update tape for the CY2002 HCPCS codes and to PM AB-01-127 for how to retrieve the codes.

NOTE: Hospital physicians billing the carrier for any new 2002 HCPCS code will receive payment for the code beginning January 1, 2002. In addition, other provider types, (TOBs 22X, 23X, 24X, 32X, 33X, 34X, 71X, 72X, 73X, 74X, 75X, 81X, 82X and hospitals not paid under OPPS will also receive payment for the new codes beginning January 1, 2002). Therefore, these entities are not restricted in the use of reporting the new codes.

Provider Notification

Post a notice on your website regarding this information and include it in your next regular scheduled bulletin. If you have electronic bulletin boards or listservs that are used to communicate with your provider community, post this message to your providers using that facility. We will be providing to you, in the next several days, a standard article to be used for these purposes.

The *effective date* for this PM is *January 7, 2002.*

The *implementation date* for this PM is *January 7, 2002*.

This PM may be discarded after January 7, 2003.

If you have any questions, contact your regional office.