| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-04 Medicare Claims Processing | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 2234** | **Date: May 27, 2011** |
| | **Change Request 7443** |

**SUBJECT: July 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 July 2011 OPPS update. The July 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: July 1, 2011**
**IMPLEMENTATION DATE: July 5, 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 | 4/Table of Content |
| N | 4/10.12/Payment Window for Outpatient Services Treated as Inpatient Services |
| R | 4/180.7/Inpatient-only Services |
| R | 4/200.3.4/Billing for Linear Accelerator (Robotic Image-Guided and Non-Robotic Image-Guided) SRS Planning and Delivery |
| R | 4/290.2.2/Reporting Hours of Observation |

**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: 2234 | Date: May 27, 2011 | Change Request: 7443 |
|---|---|---|---|

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

**Effective Date:** July 1, 2011

**Implementation Date:** July 5, 2011

## I. GENERAL INFORMATION

**A. Background:** This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the July 2011 OPPS update. The July 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 July 2011 revisions to I/OCE data files, instructions, and specifications are provided in CR 7443, "July 2011 Integrated Outpatient Code Editor (I/OCE) Specifications Version 12.2."

**B. Policy:**

### 1. Changes to Device Edits for July 2011

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.

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. 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 Services**

The following new services are assigned for separate payment under the OPPS, effective July 1, 2011:

**Table 1 -- New Services Assigned for Separate Payment under the OPPS Effective July 1, 2011**

| HCPCS | Effective date | SI | APC | Short Descriptor | Long descriptor | Payment | Minimum Unadjusted Copayment |
|---|---|---|---|---|---|---|---|
| C9730 | 7/1/2011 | T | 0415 | Bronchial thermo, 1 lobe | Bronchoscopic bronchial thermoplasty with imaging guidance (if performed), radiofrequency ablation of airway smooth muscle, 1 lobe | $1,971.77 | $459.92 |
| C9731 | 7/1/2011 | T | 0415 | Bronchial thermo, >1 lobe | Bronchoscopic bronchial thermoplasty with imaging guidance (if performed), radiofrequency ablation of airway smooth muscle, 2 or more lobes | $1,971.77 | $459.92 |

Effective July 1, 2011, HCPCS code C9729 will be deleted and replaced with new Category III CPT code 0275T. Category III CPT code 0275T will be added to the payable codes in the OPPS and assigned to the same status indicator and APC assignment as its predecessor HCPCS code C9729. Providers reporting the intralaminar decompression procedure should use CPT code 0275T beginning with services rendered on or after July 1, 2011. The table below summarizes the new coding information.

**Table 2 -- Coding Change for the Intralaminar Decompression Procedure Effective July 1, 2011**

| HCPCS | Effective date | SI | APC | Short Descriptor | Long descriptor | Payment | Minimum Unadjusted Copayment |
|---|---|---|---|---|---|---|---|

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| C9729 | 7/1/2011 | Deleted | Deleted | Percut lumbar lami | Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with ligamentous resection, discectomy, facetectomy and/or foraminotomy, when performed) any method under indirect image guidance, with the use of an endoscope when performed, single or multiple levels, unilateral or bilateral; lumbar | N/A | N/A |
| 0275T | 7/1/2011 | T | 0208 | Perq lamot/lam lumbar | Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; lumbar | $3,535.92 | $707.19 |

**3. Category III CPT Codes**

The AMA releases Category III CPT codes in January, for implementation beginning the following July, and in July, for implementation beginning the following January. Prior to CY 2006, we implemented new Category III CPT codes once a year in January of the following year.

As discussed in the CY 2006 OPPS final rule with comment period (70 FR 68567), we modified our 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 us in response to applications for new technology services.

For the July 2011 update, we are implementing in the OPPS 14 Category III CPT codes that the AMA released in January 2011 for implementation on July 1, 2011. Of the 14 Category III CPT codes, 12 are separately payable under the hospital OPPS. The Category III CPT codes, status indicators, and APCs are shown in Table 3 below. Payment rates for these services can be found in Addendum B of the July 2011 OPPS Update that is posted on the CMS website.

**Table 3 -- Category III CPT Codes Implemented as of July 1, 2011**

| CPT Code | Long Descriptor | SI | APC |
|---|---|---|---|
| 0262T | Implantation of catheter-delivered prosthetic pulmonary valve, endovascular approach | C | NA |
| 0263T | Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure including unilateral or bilateral bone marrow harvest | S | 0112 |
| 0264T | Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure excluding bone marrow harvest | S | 0112 |
| 0265T | Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; unilateral or bilateral bone marrow harvest only for intramuscular autologous bone marrow cell therapy | S | 0112 |
| 0266T | Implantation or replacement of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed) | C | NA |
| 0267T | Implantation or replacement of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed) | T | 0687 |
| 0268T | Implantation or replacement of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed) | S | 0039 |
| 0269T | Revision or removal of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed) | T | 0221 |
| 0270T | Revision or removal of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed) | T | 0687 |
| 0271T | Revision or removal of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed) | T | 0688 |
| 0272T | Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (eg, battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day) | S | 0218 |
| 0273T | Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation | S | 0218 |

| CPT Code | Long Descriptor | SI | APC |
|---|---|---|---|
| | and report (eg, battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day); with programming | | |
| 0274T | Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; cervical or thoracic | T | 0208 |
| 0275T | Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; lumbar | T | 0208 |

**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 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 July 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 third 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 July 2011 release of the OPPS Pricer. The updated payment rates, effective July 1, 2011, will be included in the July 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 July 1, 2011**

Seven drugs and biologicals have been granted OPPS pass-through status effective July 1, 2011. These items, along with their descriptors and APC assignments, are identified in Table 4 below.

**Table 4 -- Drugs and Biologicals with OPPS Pass-Through Status Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2011**

| HCPCS Code | Long Descriptor | APC | Status Indicator Effective 7/1/11 |
|---|---|---|---|
| C9283* | Injection, acetaminophen, 10 mg | 9283 | G |
| C9284* | Injection, ipilimumab, 1 mg | 9284 | G |
| C9285* | Lidocaine 70 mg/tetracaine 70 mg, per patch | 9285 | G |
| C9365* | Oasis Ultra Tri-Layer Matrix, per square centimeter | 9365 | G |
| C9406* | Iodine I-123 ioflupane, diagnostic, per study dose, up to 5 millicuries | 9406 | G |
| J1572 | Injection, immune globulin, (flebogamma/flebogamma dif), intravenous, non-lyophilized (e.g. liquid), 500 mg | 0947 | G |
| Q2044* | Injection, belimumab, 10 mg | 1353 | G |

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

**c. New HCPCS Codes Effective July 1, 2011 for Certain Drugs and Biologicals**

Three new HCPCS codes have been created for reporting certain drugs and biologicals (other than new pass-through drugs and biologicals listed above in Table 4) in the hospital outpatient setting for July 1, 2011. These codes are listed in Table 5 below and are effective for services furnished on or after July 1, 2011. HCPCS code Q2041 is replacing HCPCS code J7184 beginning on July 1, 2011, and HCPCS code Q2043 is replacing HCPCS code C9273 beginning on July 1, 2011.

**Table 5 -- New HCPCS Codes Effective for Certain Drugs and Biologicals Effective July 1, 2011**

| HCPCS Code | Long Descriptor | APC | Status Indicator Effective 7/1/11 |
|---|---|---|---|
| Q2041 | Injection, von willebrand factor complex (human), Wilate, 1 i.u. vwf:rco | 1352 | G |
| Q2042 | Injection, hydroxyprogesterone caproate, 1 mg | 1354 | K |
| Q2043 | Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion | 9273 | G |

**d. Updated Payment Rate for HCPCS Code J2505 Effective April 1, 2010 through June 30, 2010**

The payment rate for HCPCS code J2505 was incorrect in the April 2010 OPPS Pricer. The corrected payment rate is listed in Table 6 below and has been installed in the July 2011 OPPS Pricer, effective for services furnished on April 1, 2010, through implementation of the July 2010 update.

**Table 6 -- Updated Payment Rates for HCPCS Code J2505 Effective April 1, 2010 through June 31, 2010**

| HCPCS Code | Status Indicator | APC | Short Descriptor | Corrected Payment Rate | Corrected Minimum Unadjusted Copayment |
|---|---|---|---|---|---|
| J2505 | K | 9119 | Injection, pegfilgrastim 6mg | $2,386.39 | $477.28 |

**e. Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2010 through September 30, 2010**

The payment rates for several HCPCS codes were incorrect in the July 2010 OPPS Pricer. The corrected payment rates are listed in Table 7 below and have been installed in the July 2011 OPPS Pricer, effective for services furnished on July 1, 2010, through implementation of the October 2010 update.

**Table 7 -- Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2010 through September 30, 2010**

| HCPCS Code | Status Indicator | APC | Short Descriptor | Corrected Payment Rate | Corrected Minimum Unadjusted Copayment |
|---|---|---|---|---|---|
| J0150 | K | 0379 | Injection adenosine 6 MG | $11.47 | $2.29 |
| J2430 | K | 0730 | Pamidronate disodium /30 MG | $15.12 | $3.02 |
| J2505 | K | 9119 | Injection, pegfilgrastim 6mg | $2,423.91 | $484.78 |
| J9065 | K | 0858 | Inj cladribine per 1 MG | $25.61 | $5.12 |
| J9178 | K | 1167 | Inj, epirubicin hcl, 2 mg | $2.19 | $0.44 |
| J9200 | K | 0827 | Floxuridine injection | $34.99 | $7.00 |
| J9206 | K | 0830 | Irinotecan injection | $3.36 | $0.67 |
| J9208 | K | 0831 | Ifosfomide injection | $29.83 | $5.97 |
| J9209 | K | 0732 | Mesna injection | $4.15 | $0.83 |
| J9211 | K | 0832 | Idarubicin hcl injection | $41.14 | $8.23 |
| J9263 | K | 1738 | Oxaliplatin | $4.35 | $0.87 |
| J9293 | K | 0864 | Mitoxantrone hydrochl / 5 MG | $44.38 | $8.88 |

**f. Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2010 through December 31, 2010**

The payment rates for several HCPCS codes were incorrect in the October 2010 OPPS Pricer. The corrected payment rates are listed in Table 8 below and have been installed in the July 2011 OPPS Pricer, effective for services furnished on October 1, 2010, through implementation of the January 2011 update.

**Table 8 -- Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2010 through December 31, 2010**

| HCPCS Code | Status Indicator | APC | Short Descriptor | Corrected Payment Rate | Corrected Minimum Unadjusted Copayment |
|---|---|---|---|---|---|
| J0150 | K | 0379 | Injection adenosine 6 MG | $9.59 | $1.92 |
| J2430 | K | 0730 | Pamidronate disodium /30 MG | $11.81 | $2.36 |
| J9065 | K | 0858 | Inj cladribine per 1 MG | $24.97 | $4.99 |
| J9178 | K | 1167 | Inj, epirubicin hcl, 2 mg | $9.17 | $1.83 |
| J9185 | K | 0842 | Fludarabine phosphate inj | $158.16 | $31.63 |
| J9200 | K | 0827 | Floxuridine injection | $32.17 | $6.43 |
| J9206 | K | 0830 | Irinotecan injection | $4.68 | $0.94 |
| J9208 | K | 0831 | Ifosfomide injection | $31.54 | $6.31 |
| J9209 | K | 0732 | Mesna injection | $4.62 | $0.92 |
| J9211 | K | 0832 | Idarubicin hcl injection | $84.06 | $16.81 |
| J9263 | K | 1738 | Oxaliplatin | $4.60 | $0.92 |
| J9266 | K | 0843 | Pegaspargase injection | $2,675.40 | $535.08 |
| J9293 | K | 0864 | Mitoxantrone hydrochl / 5 MG | $33.48 | $6.70 |

**g. Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2011 through March 31, 2011**

The payment rates for several HCPCS codes were incorrect in the January 2011 OPPS Pricer. The corrected payment rates are listed in Table 9 below and have been installed in the July 2011 OPPS Pricer, effective for services furnished on January 1, 2011, through implementation of the April 2011 update.

**Table 9 -- Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2011 through March 31, 2011**

| HCPCS Code | Status Indicator | APC | Short Descriptor | Corrected Payment Rate | Corrected Minimum Unadjusted Copayment |
|---|---|---|---|---|---|
| J9065 | K | 0858 | Inj cladribine per 1 MG | $24.93 | $4.99 |
| J9178 | K | 1167 | Inj, epirubicin hcl, 2 mg | $1.90 | $0.38 |
| J9200 | K | 0827 | Floxuridine injection | $37.92 | $7.58 |
| J9206 | K | 0830 | Irinotecan injection | $5.31 | $1.06 |
| J9208 | K | 0831 | Ifosfomide injection | $33.40 | $6.68 |
| J9211 | K | 0832 | Idarubicin hcl injection | $118.41 | $23.68 |
| J9265 | K | 1309 | Paclitaxel injection | $6.95 | $1.39 |
| J9266 | K | 0843 | Pegaspargase injection | $2,701.13 | $540.23 |
| J9293 | K | 0864 | Mitoxantrone hydrochl / 5 MG | $33.36 | $6.67 |

**h. 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, either as a biological or a device, a separate payment for the biological or 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.

**i. 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.

**j. 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.

**k. 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.

**5. Reporting Hours of Observation**

Under current OPPS payment policy, observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy). We are revising our billing instructions to state that in situations where such a procedure interrupts observation services, hospitals may determine the most appropriate way to account for this time. For example, a hospital may record for each period of observation services the beginning and ending times during the hospital outpatient encounter and add the length of time for the periods of observation services together to reach the total number of units reported on the claim for the hourly observation services HCPCS code G0378 (Hospital observation service, per hour). A hospital may also deduct the average length of time of the interrupting procedure, from the total duration of time that the patient receives observation services. CMS is updating the Medicare Claims Processing Manual, Pub.100-04, Chapter 4, Section 290.2.2 to reflect the revised observation reporting guidelines.

**6. Reporting Critical Care Services under the OPPS**

Beginning January 1, 2011, under revised AMA CPT Editorial Panel guidance, hospitals that report in accordance with the CPT guidelines will begin reporting all of the ancillary services and their associated charges separately when they are provided in conjunction with critical care (CPT codes 99291 and 99292). CMS continues to recognize the existing CPT codes for critical care services and has established a payment rate based on its historical data, into which the cost of the ancillary services is intrinsically packaged. The I/OCE logic conditionally packages payment for the ancillary services that are reported on the same date of service as critical care services in order to avoid overpayment. The payment status of the ancillary services does not change when they are not provided in conjunction with critical care services. Hospitals may use HCPCS

modifier -59 to indicate when an ancillary procedure or service is distinct or independent from critical care when performed on the same day but in a different encounter.

Effective January 1, 2011, National Correct Coding Initiative edits for the hospital OPPS that disallow the reporting of critical care services with ancillary services will be deleted retroactive to January 1, 2011. The I/OCE generates CCI edits for OPPS hospitals. Providers whose claims contained lines that were denied or rejected due to the critical care CCI edits for ancillary services from January 1, 2011 through June 30, 2011, may request contractor adjustment of the previously processed claims.

**7. Payment Window for Outpatient Services Treated as Inpatient Services**

The payment window for outpatient services treated as inpatient services policy, specifically described in Transmittal 796, CR 7142, issued on October 29, 2010, states that a hospital (or an entity that is wholly owned or wholly operated by the hospital) must include on the claim for a beneficiary's inpatient stay, the diagnoses, procedures, and charges for all outpatient diagnostic services and admission-related outpatient non-diagnostic services provided during the payment window. Hospitals may attest to specific non-diagnostic services as being unrelated to the inpatient stay (that is, the preadmission non-diagnostic services are clinically distinct or independent from the reason for the beneficiary's admission) by adding condition code 51 (definition "51 – Attestation of Unrelated Outpatient Non-diagnostic Services) to the separately billed outpatient non-diagnostic services claim starting April 1, 2011, for outpatient claims that have a date of service on or after June 25, 2010. We are adding section 10.12 to the Medicare Claims Processing Manual, Pub. 100-04, Chapter 4, to reflect the regulatory and statutory policy changes outlined in CR 7142. We are also revising section 180.7 of the Claims Processing Manual, Pub. 100-04, Chapter 4, to clarify that CMS will not pay for "inpatient-only" procedures that are provided to a patient in the outpatient setting on the date of the patient's inpatient admission or 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.

**8. Billing for Linear Accelerator (Robotic Image-Guided and Non-Robotic Image-Guided) SRS Planning and Delivery**

CMS is updating the Medicare Claims Processing Manual, Pub. 100-04, Chapter 4, Section 200.3.4 to correct a typographical error citing HCPCS code G0039 rather than G0339.

**9. Changes to OPPS Pricer Logic**

a. Rural sole community hospitals and essential access community hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in CY 2011. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with section 1833(t)(13)(B) of the Act, as added by section 411 of Pub. L. 108-173. However, the rural SCH and EACH 7.1 percent payment increase does not apply to services billed on a non-patient bill type 14X.

b. Effective for claims with a date of service on or after January 1, 2011, the OPPS Pricer will not apply Deductible and Coinsurance amounts for Preventive care services waived by Section 4104 of the Patient Protection and Affordable Care Act (the Affordable Care Act) as appropriate.

**10. 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 | |
| 7443.1 | Medicare contractors shall install the July 2011 OPPS Pricer. | X | | X | | X | X | | | | COBC |
| 7443.2 | Medicare contactors shall manually add the following HCPCS codes to their systems:<br>• all HCPCS codes listed in table 1, 3, and 5, and<br>• C9283, C9284, C9285, C9365, C9406, Q2044, and<br>• K0741, K0742, K0743, K0744, K0745, and K0746 (listed in CR7439)<br><br>Note: These HCPCS codes will be included with the July 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 July 2011 update of the OPPS Addendum A and Addendum B on the CMS Web site. | X | | X | | X | X | | | X | COBC |
| 7443.3 | Medicare contractors shall adjust as appropriate claims brought to their attention that:<br>1) Have dates of service that fall on or after April 1, 2010, but prior to July 1, 2010;<br>2) Contain HCPCS code listed in Table 6; and<br>3) Were originally processed prior to the installation of the July 2011 OPPS Pricer. | X | | X | | X | | | | | COBC |
| 7443.4 | Medicare contractors shall adjust as appropriate claims brought to their attention that: | X | | X | | X | | | | | COBC |

| 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 | |
| | 1) Have dates of service that fall on or after July 1, 2010, but prior to October 1, 2010;<br>2) Contain HCPCS codes listed in Table 7; and<br>3) Were originally processed prior to the installation of the July 2011 OPPS Pricer. | | | | | | | | | | |
| 7443.5 | Medicare contractors shall adjust as appropriate claims brought to their attention that:<br>1) Have dates of service that fall on or after October 1, 2010, but prior to January 1, 2011;<br>2) Contain HCPCS codes listed in Table 8; and<br>3) Were originally processed prior to the installation of the July 2011 OPPS Pricer. | X | | X | | X | | | | | COBC |
| 7443.6 | Medicare contractors shall adjust as appropriate claims brought to their attention that:<br>1) Have dates of service that fall on or after January 1, 2011, but prior to April 1, 2011;<br>2) Contain HCPCS codes listed in Table 9; and<br>3) Were originally processed prior to the installation of the July 2011 OPPS Pricer. | X | | X | | X | | | | | COBC |
| 7443.7 | Medicare contractors shall adjust as appropriate claims brought to their attention that:<br>1) Have dates of service that fall on or after January 1, 2011, but prior to July 1, 2011;<br>2) Include CPT codes 99291 and/or 99292;<br>3) Were originally processed prior to the installation of the revised July 2011 I/OCE. | X | | X | | X | | | | | COBC |
| 7443.8 | Medicare contractors shall adjust as appropriate claims brought to their attention that:<br>1) Have dates of service that fall on or after January 1, 2006, but prior to July 1, 2011;<br>2) Provider is a rural Sole-Community Hospital that received the 7.1% add-on for laboratory services;<br>3) Contain the Type of Bill 14X; and<br>4) Were originally processed prior to the installation of the July 2011 OPPS Pricer. | X | | X | | X | | | | | COBC |

| 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 | |
| | | | | | | | | | | | |

## 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 | |
| 7443.9 | 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.<br>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: |
|---|---|
| | |

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

## 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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*290.2.2 - Reporting Hours of Observation*

## *10.12 –Payment Window for Outpatient Services Treated as Inpatient Services*

***(Rev. 2234, Issued: 05-27-11, Effective: 07-01-11, Implementation: 07-05-11)***

*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 three calendar days (or one 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 (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.*

*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 on the date of the patient's inpatient admission or 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. 2234, Issued: 05-27-11, Effective: 07-01-11, Implementation: 07-05-11)***

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.

There is no payment under the OPPS for services that CMS designates to be "inpatient-only" services. These services have OPPS status indicator "C" in 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 www.cms.gov/HospitalOutpatientPPS.

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 www.cms.gov/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 on the date of the patient's inpatient admission or 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.*

## 200.3.4 - Billing for Linear Accelerator (Robotic Image-Guided and Non-Robotic Image-Guided) SRS Planning and Delivery

***(Rev. 2234, Issued: 05-27-11, Effective: 07-01-11, Implementation: 07-05-11)***

Effective for services furnished on or after January 1, 2006, hospitals must bill using existing CPT codes that most accurately describe the service furnished for both robotic and non-robotic image-guided SRS planning. For robotic image-guided SRS delivery, hospitals must bill using HCPCS code *G0339* for the first session and HCPCS code G0340 for the second through the fifth sessions. For non-robotic image-guided SRS delivery, hospitals must bill G0173 for delivery if the delivery occurs in one session, and G0251 for delivery per session (not to exceed five sessions) if delivery occurs during multiple sessions.

| Linear Accelerator-Based Robotic Image-Guided SRS | |
|---|---|
| Planning | Use existing CPT codes |
| Delivery | G0339 (complete, 1st session)<br>G0340 (2nd – 5th session) |

| Linear Accelerator-Based Non-Robotic Image-Guided SRS | |
|---|---|
| Planning | Use existing CPT codes |
| Delivery | G0173 (single session)<br>G0251 (multiple) |

| HCPCS Code | Long Descriptors |
|---|---|
| G0173 | Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, complete course of treatment in one session, all lesions. |
| G0251 | Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum 5 sessions per course of treatment. |
| G0339 | Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment. |
| G0340 | Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment |

## 290.2.2 - Reporting Hours of Observation

***(Rev. 2234, Issued: 05-27-11, Effective: 07-01-11, Implementation: 07-05-11)***

Observation time begins at the clock time documented in the patient's medical record, which coincides with the time that observation care is initiated in accordance with a physician's order. Hospitals should round to the nearest hour. For example, a patient who began receiving observation services at 3:03 p.m. according to the nurses' notes and was discharged to home at 9:45 p.m. when observation care and other outpatient services were completed, should have a "7" placed in the units field of the reported observation HCPCS code.

General standing orders for observation services following all outpatient surgery are not recognized. Hospitals should not report as observation care, services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours), which should be billed as recovery room services. Similarly, in the case of patients who undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished prior to the testing and recovery afterwards are included in the payments for those diagnostic services.

Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy). In situations where such a procedure interrupts observation services, hospitals *may determine the most appropriate way to account for this time. For example, a hospital may* record for each period of observation services the beginning and ending times during the hospital outpatient encounter and add the length of time for the periods of observation services together to reach the total number of units reported on the claim for the hourly observation services HCPCS code G0378 (Hospital observation service, per hour). *A hospital may also deduct the average length of time of the interrupting procedure, from the total duration of time that the patient receives observation services.*

Observation time ends when all medically necessary services related to observation care are completed. For example, this could be before discharge when the need for observation has ended, but other medically necessary services not meeting the definition of observation care are provided (in which case, the additional medically necessary services would be billed separately or included as part of the emergency department or clinic visit). Alternatively, the end time of observation services may coincide with the time the patient is actually discharged from the hospital or admitted as an inpatient. Observation time may include medically necessary services and follow-up care provided after the time that the physician writes the discharge order, but before the patient is discharged. However, reported observation time would not include the time patients remain in the hospital after treatment is finished for reasons such as waiting for transportation home.

If a period of observation spans more than 1 calendar day, all of the hours for the entire period of observation must be included on a single line and the date of service for that line is the date that observation care begins.