Program Memorandum Intermediaries

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

Transmittal A-02-026 **Date: MARCH 28, 2002**

CHANGE REQUEST 2102

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

This Program Memorandum (PM) outlines changes in the OPPS for calendar year 2002. These changes were published in the **Federal Register** on November 30, 2001 and March 1, 2002. As described in PM A-01-145 and PM A-01-150, the changes for calendar year 2002 were delayed. All items covered in this PM are effective for services furnished on or after April 1, 2002, unless otherwise noted.

I. Coding and Billing for Services Furnished On or After January 1, 2002 Through March 31, 2002 That Are Payable Under the OPPS

In PM A-01-145 and PM A-01-150, we advised you that the effective date for the 2002 update of the OPPS would be delayed. In those Program Memoranda, we also instructed you that hospitals and Community Mental Health Centers (CMHC) are not to submit claims for OPPS services using new 2002 HCPCS codes (which includes new 2002 HCPCS modifiers) during the period of the delay. Instead, because of the delay, hospitals and CMHCs are to use 2001 HCPCS codes and modifiers to bill for OPPS services. As a result of the delay in the 2002 OPPS update, special billing requirements apply for services furnished on or after January 1, 2002 through March 31, 2002.

- For services furnished on or after January 1, 2002 through March 31, 2002, that are paid under the OPPS, hospitals are to use the same HCPCS codes and modifiers that they used during 2001. For services that were not covered under the OPPS in 2001, but that are covered in 2002, hospitals must use 2001 HCPCS codes and modifiers that most closely describe the services furnished in order to receive payment for this period.

- Hospitals and CMHCs are not to use 2002 HCPCS codes or modifiers to bill for services furnished on or after January 1, 2002 through March 31, 2002, that are paid under the OPPS.

- Claims that contain any new 2002 HCPCS codes or modifiers for dates of service preceding April 1, 2002 are to be returned unprocessed to the provider. When this occurs, instruct the provider to resubmit the claim within the timeframes specified in §3307 of the Medicare Intermediary Manual (MIM) utilizing a 2001 HCPCS code(s) and/or modifiers(s) that most closely describe the service(s) furnished.

- Change Requests (CRs) issued prior to December 21, 2001, that reflect a January 1, 2002 effective date for new 2002 codes payable under the OPPS, are effective April 1, 2002 for hospitals and CMHCs.

- Do not make retroactive payment for new 2002 codes for services furnished prior to April 1, 2002. Return to the provider, without processing, claims for services furnished between December 31, 2001 and April 1, 2002, that are submitted after April 1, 2002, with new 2002 codes.

- Do not reprocess claims for outpatient services with dates of service prior to April 1, 2002 that use new 2002 codes.

II. Beneficiary Copayment Changes

For calendar year 2002, the national unadjusted copayment amount for an ambulatory payment classification (APC) is limited to 55 percent of the APC payment rate established for a procedure or service. In addition the wage-adjusted copayment amount for a procedure or service cannot exceed the inpatient hospital deductible amount for 2002 of $812. These changes were implemented by changes to the OPPS PRICER effective for services furnished on or after January 1, 2002, as noted in PM A-01-145 dated December 21, 2001.

III. Extension of Election Period for Elections to Reduce Beneficiary Copayments

Generally, hospitals are required to notify their FI of their elections to reduce beneficiary copayments by no later than the December 1st preceding the calendar year for which the election is effective. Because the final rule on OPPS payment rates for 2002 was not published until March 1, 2002, providers were unable to make election decisions for 2002 by December 1 preceding the year the payment rates become effecive, the typical deadline for making such elections. The deadline for providers to make elections to reduce beneficiary copayments for 2002 is extended until April 1, 2002. The elections will be effective for services furnished on or after April 1, 2002.

IV. Transitional Corridor Payments for Children's Hospitals

Children's hospitals that are excluded from the inpatient hospital prospective payment system will receive the same transitional corridor hold-harmless protection as cancer hospitals under the OPPS. The recently published regulations were updated to reflect this change, however, this change was effective retroactively to August 1, 2000. Implementing instructions for this change were included in PM A-01-15 issued on January 29, 2001, to address a number of changes to the OPPS required under the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.

V. Change in Services Covered Within the Scope of the OPPS

We are excluding from payment under the OPPS, covered Part B-only services furnished to inpatients when they are furnished by a hospital that does no other Medicare billing for hospital outpatient services under Part B. The Part B-only services, which are payable for hospital inpatients who have either exhausted their Part A benefits or who are not entitled to Part A benefits are specified in §3110 Part A of the MIM, and in §228 of the Medicare Hospital Manual. These services include, but are not limited to, diagnostic tests; x-ray and radioactive isotope therapy; surgical dressings; limb braces and trusses, and artificial limbs and eyes. Medicare payment for excluded Part B-only services furnished by these hospitals will be determined using the method under which the hospital was paid prior to OPPS.

Advise your hospitals to notify you if they do not submit claims for outpatient Part B services, so that their claims can be excluded from the OPPS. Once a hospital notifies you that they furnish only inpatient Part B services, advise the hospital that they must also notify you in the future if their situation changes and they begin to furnish Part B outpatient services. Implementing instructions will be issued in a separate PM.

VI. Change in Hospitals Excluded from the OPPS

The OPPS final rule for 2002 clarified that we are excluding from the OPPS, hospitals that are located outside the 50 States or the District of Columbia or Puerto Rico; that is, hospitals in Guam, Saipan, American Samoa, and the Virgin Islands. This policy is consistent with their current exclusion from the inpatient PPS and will also save these hospitals from billing system revisions. Although we discussed exclusion of hospitals located in Guam, Saipan and American Samoa in PM A-00-36 issued in June 2000, we failed to discuss the exclusion of hospitals located in the Virgin Islands. These hospitals are to be excluded from OPPS effective January 1, 2002.

VII. Outlier Payments Calculated on a Service-by Service Basis

Since the beginning of the OPPS on August 1, 2000, we have calculated outlier payments in the aggregate for all OPPS services that appear on a claim. However, beginning April 1, 2002, the OPPS PRICER will calculate outlier payments based on each individual OPPS service. In calculating outlier payments, billed charges will continue to be converted to costs using a single overall hospital-specific cost-to-charge ratio. The costs attributable to all packaged items and services that appear on a claim will be allocated to all the OPPS services that appear on the claim. The amount allocated to each OPPS service is based on the percent the Ambulatory Payment Classification (APC) payment rate for that service bears to the total APC rates for all OPPS services on the claim. To illustrate, assume the cost of all packaged services on the claim is $100, and the 3 APC payment amounts paid for OPPS services on the claim are $200, $300 and $500 (total APC payments of $1000). The first OPPS service or line item will be allocated $20 or 20 percent of the costs of packaged services, because the APC payment for that services represents 20 percent ($200/$10000) of total APC payments on the claim. The second OPPS service will be allocated $30 or 30 percent of the costs of packaged services and the third OPPS service will be allocated $50 or 50 percent of the cost of packaged services.

When a hospital performs several surgical procedures during the same operative session, it is an acceptable billing practice to show the entire charge for use of the operating room or treatment room on the line with one of the surgical HCPCS codes and from zero up to $1.00 in charges on the lines with the remaining surgical HCPCS codes. We do not intend to require that hospitals change this practice. Hospitals will continue to have the option of splitting out the charges for the operating room or treatment room among the individual surgical procedures based on the resources that are attributable to each procedure or they may show a single combined operating room or treatment room charge with one of the surgical HCPCS codes and from zero up to $1.00 in charges with the remaining surgical HCPCS codes. If the hospital chooses the latter option, in calculating outliers on a service–by-service basis, the OPPS PRICER will allocate the combined operating or treatment room charge among all of the surgical procedures on the claim. This charge will be allocated to each surgical procedure based on the proportion that the APC payment for the procedure bears to the total APC payments for all surgical procedures performed on that claim.

In addition to calculating outlier payments on a service-by-service basis, beginning April 1, 2002, the outlier threshold is increased from 2.5 to 3.5 and the outlier payment percentage is decreased from 75 percent to 50 percent. Outlier payments will be made if the cost of providing a service exceeds 3.5 times the OPPS payments for the service and the amount of the outlier payment will be 50 percent of the amount by which the provider's costs exceed 3.5 times the OPPS payments.

VIII. Billing for Intensity Modulated Radiation Therapy (IMRT) and Stereotactic Radiosurgery (SR)

A. Billing for IMRT Planning and Delivery

Effective for services furnished on or after April 1, 2002, codes G0174 and G0178 are no longer valid codes. Hospitals must use CPT code 77301 for IMRT planning and CPT code 77418 for IMRT delivery. Any of the CPT codes 77401 through 77416 or 77418 may be reported on the same day as long as the services are furnished at a separate treatment sessions. In these cases, modifier –59 must be appended to the appropriate codes.

B. Billing for Multi-source Photon Stereotatic Radiosurgery (SR) Planning and Delivery

Effective for services furnished on or after April 1, 2002, hospitals must bill for multi-source photon SR planning and delivery using HCPCS codes G0242 for planning and G0243 for delivery. Services represented by CPT codes 77401 through 77416 should never be reported on the same day as code G0243, unless the services were furnished at a separate treatment session.

G0242 Multi-source Photon Stereotactic Radiosurgery (Cobalt 60 multi-source converging beams) plan, including dose volume histograms for target and critical structure tolerances, plan optimization

performed for highly conformal distributions, plan positional accuracy and dose verification, all lesions treated, per course of treatment.

G0243 Multi-source Photon Stereotactic Radiosurgery, delivery including collimator changes and custom plugging, complete course of treatment, all lesions.

C. Billing for Linear Accelerator (gantry or image directed) SR Planning and Delivery

Effective for services furnished on or after April 1, 2002, hospitals must bill for gantry or image directed linear accelerator SR using G0242 for planning. Hospitals must bill G0173 for delivery if the delivery occurs in one session, and G0251 for delivery per session (not to exceed 5 sessions) if delivery occurs during multiple sessions.

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.

NOTE: Although Code G0251 is effective on April 1, 2002, the Outpatient Code Editor or the OPPS PRICER will not recognize the code until July 1, 2002. Therefore, instruct your hospitals to either hold all bills that contain this code and submit the bills after July 1, 2002, or submit bills but omit this code and submit an adjustment bill reflecting this service after July 1, 2002.

D. Additional Billing Instructions

Payment for the services identified by CPT codes 77280 through 77295, 77300, and 77305 through 77321, 77336 and 77370 are included in the APC payment for IMRT and SR planning. These codes should not be billed in addition to 77301 and G0242.

Payment for IMRT and SR planning does not include payment for services described by CPT codes 77332 through 77334. When provided, these services should be billed in addition to the IMRT and SR planning codes 77301 and G0242.

Payment for CPT code 20660 is included in G0243; therefore, hospitals should not report 20660 separately.

IX. Changes to Pass-Through Drugs and Biologicals from the March 1, 2002 Final Rule

As we indicated in the OPPS Proposed Rule dated August 24, 2001, we update the payment rates for the pass-through drugs and biologicals annually. For calendar year 2002 we used the July 2001 Redbook. The following represents substantive changes that have been made in the March 1, 2002 Final Rule. This list does not negate the need to read the March 1, 2002 Final Rule for all changes.

A. HCPCS Codes Replacements

The HCPCS codes listed in the left column have been retired effective December 31, 2001, however, because of the delay in using new 2002 codes, these codes are in effect for hospital outpatient billing for drugs furnished through March 31, 2002. Beginning April 1, 2002, these codes are no longer reportable under the hospital OPPS. These codes have been replaced with new HCPCS codes indicated in the column titled “New HCPCS Code” effective April 01, 2002, and will be reportable under the hospital OPPS.

The latest payment rates associated with each APC number listed below may be found in the OPPS PRICER file available on our website, as well as in Addendum A and B of OPPS Final Rule.

Old Code	APC	Short Descriptor	New HCPCS Code	APC	Short Descriptor
A4642	0704	Satumomab, pendetide, per dose	**C1066**	**1066**	**IN 111 satumomab pendetide**
C9001	9001	Linezolid inj, 200 mg	**J2020**	**9001**	**Linezolid injection**
C9002	9002	Tenecteplase, 50mg/vial	**J3100**	**9002**	**Tenecteplase injection**
C9004	9004	Gemtuzumab ozogaminicin inj, 5mg	**J9300**	**9004**	**Gemtuzumab ozogamicin**
C9011	9011	Caffeine Citrate, inj, 1ml	**J0706**	**9011**	**Caffeine citrate injection**
C9012	9012	Injection, arsenic trioxide	**J9017**	**9012**	**Arsenic trioxide**
C9018	9018	Botulinum tox B, per 100 u	**J0587**	**9018**	**Botulinum toxin type B**
C9104	9104	Anti-thymocyte globulin, 25mg	**J7511**	**9104**	**Antithymocyte globuln rabbit**
J7315	7315	Sodium hyaluronate injection [20 mg]	**J7316**	**7316**	**Sodium hyaluronate injection**
Q0160	931	Factor IX non-recombinant [per I.U.]	**J7193**	**931**	**Factor IX non-recombinant**
Q0161	932	Factor IX recombinant	**J7195**	**932**	**Factor IX recombinant**
Q2015	7033	Somatrem, 5 mg	**J2940**	**7052**	**Somatrem injection**
Q2016	7034	Somatropin, 1 mg	**J2941**	**7034**	**Somatropin injection**

B. Codes Not Reportable Under the Hospital OPPS

Effective April 1, 2002, the following HCPCS codes are no longer reportable under the hospital OPPS. These codes were either assigned to a status indicator of "D" or "E" in the OPPS Final Rule that was published on March 1, 2002.

HCPCS Code	APC	Short Descriptor	Additional Information
C1090	1090	IN 111 chloride, per mCi	Based on consultation with a nuclear pharmaceutical expert, it has been determined that this radiopharmaceutical agent is never administered in isolation. It is always combined with another agent. Therefore, this code will no longer be reportable under the hospital OPPS.
J1810	7047	Droperidol/fentanyl inj	Review of this specific drug indicates that it is no longer manufactured. Therefore, this code will no longer be reportable under the hospital OPPS.
J9266	843	Pegaspargase/singl dose vial	Review of this specific drug indicates that it is no longer manufactured. Therefore, this code will no longer be reportable under the hospital OPPS.

HCPCS Code	APC	Short Descriptor	Additional Information
Q2020	1616	Histrelin acetate	Review of this specific drug indicates that it is no longer manufactured. Therefore, this code will no longer be reportable under the hospital OPPS.

C. Additional Drugs Eligible for Pass-Through Payments

The following drugs were inadvertently omitted in the OPPS Final Rule dated November 30, 2001. These drugs are reflected in the March 1, 2002 final rule and payment will be made for these drugs effective April 1, 2002. Although the OCE and OPPS PRICER currently contain these codes, fiscal intermediaries must ensure that these codes are reflected in the HCPCS files in their internal claims processing systems.

HCPCS	APC	Short Descriptor	Payment Rate	Co-pay
C1774	734	Darbepoetin alfa, 1 mcg	$ 4.74	$ 0.68
C1775	1775	FDG, per dose (4-40 mCi/ml)_	$ 475.00	$68.00

D. Changes to Payment Rates and Co-Pay from the March 1, 2002 OPPS Final Rule

The information below supercedes what was published in the March 1, 2002 Final Rule, and has been updated in the latest OPPS PRICER that will be effective April 1, 2002. Only applicable changes are noted below.

HCPCS	APC	Short Descriptor	Old Payment Rate	Old Co-Pay	Corrected Payment Rate	Corrected Co-Pay
C9010	9010	Baclofen refill kit—per 4000 mcg	$ 43.08	$ 6.17	**$ 86.17**	**$ 12.34**
J1190	726	Dexrazoxane HCL injection per 250 mg	N/A	24.98	**N/A**	**27.85**
J1327	1607	Eptifibatide injection, 5 mg	N/A	1.45	**N/A**	**1.62**
J7330	1059	Cultured chondrocytes implnt	14,250.00	2040.00	**14,250.00**	**2,040.00**
J7505	7038	Monoclonal antibodies	269.06	38.52	**777.31**	**111.28**
Q3007	1624	Sodium phosphate p32	N/A	7.78	**N/A**	**11.61**

E. Additional Corrections

The information below identifies additional information or changes to the November 30, 2001 and/or March 1, 2002 Final Rule. These changes are effective April 1, 2002.

HCPCS Code	APC	SI	Short Descriptor	Additional Information
A4642	0704	G	Satumomab pendetide, per dose	Status Indicator changed to "E"
J1561	0905	G	Immune globulin 500 mg	To be used instead of HCPC J1563
Q0081	0120	T	Infusion ther other than che	Still a valid code, not discontinued

F. Additional Billing and Reporting Information Related to Pass-Through Drugs Effective April 1, 2002

Below is additional information for the HCPCS codes listed in the November 30, 2001, and/or March 1, 2002 Final Rule.

HCPCS Code	APC	Short Descriptor	Additional Information
A9504	1602	Technetium tc 99m apcitide [per vial]	Payment rate for this radiopharmaceutical is based on "per vial."
C1064	1064	I-131 **cap**, each add mCi	This code should be reported after the first initial 1-5 mCi. This dosage is to be used for 6 or more capsules and is used in conjunction with C1188. For example, for a patient that received 7 mCi of I-131 capsules, the following codes should be reported: C1188 initial 1-5 mCi Units of service: 1 C1064 each add'l mCi Units of service: 2
C1065	1065	I-131 **sol**, each add mCi	This code should be reported after the first initial 1-6 mCi. For example, for a patient that received 7 mCi of I-131 solution, the following codes should be reported: C1348 initial 1-6 mCi Units of service: 1 C1065 each add'l mCi Units of service: 2
C1066	1066	In 111 Satumomab pentetide	Under OPPS, A4642 will no longer be reportable effective 04/01/2002. This radiopharmaceutical has been replaced with C1066.
C1188	1188	I-131 **cap**, per 1-5 mCi	This code should be reported for only the initial 1-5 mCi dose of I-131 capsules.
C1305	1305	Apligraf	Only HCPCS code C1305 is reportable under the hospital OPPS. HCPCS J7340 should NOT be reported for Apligraf under the hospital OPPS.
C1348	1348	I-131 **sol**, per 1-6 mCi	This code should be reported for only the initial 1-6 mCi dose of I-131 solution.
C9003	9003	Palivizumab, per 50 mg	The payment rate for this drug was based on a pediatric dose.

HCPCS Code	APC	Short Descriptor	Additional Information
C9019	9019	Caspofungin acetate, 5 mg	Dosage Descriptor Alert: The dosage for this code has been changed from 50 mg to 5 mg
C9020	9020	Sirolimus solution, 1 mg	Dosage Descriptor Alert: The descriptor for this code has been changed from Sirolimus tablet, 1 mg to Sirolimus solution 1 mg.
J1565	906	RSV-ivig	The payment rate for this drug was based on a pediatric dose.
Q2008	7027	Fomepizole, 15 mg	Dosage Descriptor Alert: The dosage for this code has been changed from 1.5 mg to 15 mg.

G. Typographical Errors from the March 1, 2002 OPPS Final Rule

The dosage descriptors and short descriptors for the following HCPCS codes were incorrectly listed in Addendum A and B of the March 1, 2002 Final Rule. The information below corrects the information published in the Final Rule.

HCPCS Code	APC	March 1, 2002 Final Rule	Corrected Information
C1079	1079	Addendum A CO 57/58 0.5 mCi	**Co 57/58 0.5 uCi**
C1094	1094	Addendum A TC 99M Albumin aggr, 1.0 cmCi	**TC 99M albumin aggr, 1.0 mCi**
C9110	9110	Addendum A Alemtuzumab, per ml	**Alemtuzumab, per 10mg/ml**
J1626	764	Addendum A Granisetron hcl injection 10 mcg	**Granisetron HCL injection 100 mcg**
Q0187	1409	Addendum A and B Factor VIII recombinant, per 1.2 mg	**Factor viia recombinant**
Q3004	1621	Addendum A Xenin xe 133	**Xenon xe 133**

H. Correction to 2002 HCPCS Code Books

In reviewing the 2002 Level II HCPCS code books, the following errors in transcription for drugs, biologicals and radiopharmaceuticals were noted. Please ensure that providers are aware of these errors and that units of service on claims should reflect the **CORRECT** descriptor dosages.

NOTE: mCi or MCI is standard abbreviation for millicurie; uCi is standard abbreviation for microcurie.

For the latest 2002 Level II HCPCS short and long descriptors, refer to the 2002 HCPCS file which can be downloaded from the CMS website at www.hcfa.gov/stats/pufiles.htm#alphanu.

Code	Name	Publication Dose	Correct Dose
A9503	Technetium TC 99m medronate	up to 30 microcurie	**up to 30 MCI**
A9504	Technetium TC 99m apcitide	none noted	**per vial**
A9505	Thallous chloride TL-201/mci	per microcurie	**per MCI**
A9508	Iobenguane sulfate I-131 per 0.5 mci	per 0.5 microcurie	**per 0.5 MCI**
A9511	Technetium Tc 99m depreotide	per microcurie	**per MCI**
A9600	Strontium-89 chloride per mCi	per microcurie	**per MCI**
A9605	Samarium sm 153 lexidronanim 50 mCi	per 50 microcurie	**per 50 MCI**
C1064	I-131 cap, each add mCi	each additional microcurie	**each additional MCI (6+ MCI)**
C1065	I-131 sol, each add mCi	each additional microcurie	**each additional MCI (7+ MCI)**
C1188	I-131 cap, per 1-5 mCi	per initial 1-5 microcurie	**per initial 1-5 MCI**
C1348	I-131 sol, per 1-6 mCi	per initial 1-6 microcurie	**per initial 1-6 MCI**
C9000	Na chromatecr51, per 0.25mCi	per 0.25 microcurie	**per 0.25 MCI**
C9013	Co 57 cobaltous chloride	no dose	**per 10 uCi**
C9100	Iodinated I-131 Albumin	per microcurie	**per MCI**
C9102	51 Na Chromate, 50mCi	per 50 microcurie	**per 50 MCI**
Q2008	Fomepizole, 15mg	1.5 mg	**15 mg**
Q3002	Gallium ga 67, per mCi	per microcurie	**per MCI**
Q3004	Xenon xe 133	per 10 microcuries	**per 10 MCI**
Q3005	Technetium tc 99m mertiotide	per microcurie	**per MCI**
Q3006	Technetium tc 99m glucepatate	per 5 microcurie	**per 5 MCI**
Q3007	Sodium phosphate P32	per microcurie	**per MCI**
Q3008	Indium 111-in pentetreotide	per 3 microcurie	**per 3 MCI**
Q3009	Technetium tc99m oxidronate	per microcurie	**per MCI**
Q3010	Technetium tc99mlabeledrbcs	per microcurie	**per MCI**
Q3011	Chromic phosphate p32	per microcurie	**per MCI**
Q3012	Co 57, 0.5 Mci	per 0.5 microcurie	**per 0.5 MCI**

X. Pro-rata Reduction in Drug and Device Pass-through Payments

The final rule published in the **Federal Register** on March 1, 2002, announced a uniform reduction of 63.6 percent to be applied to each of the transitional pass-through payments for drug and devices furnished on or after April 1, 2002. See the **Federal Registers** published on November 1, 2001, November 30, 2001, and March 1, 2002 for a full discussion of these reductions. The reductions will be implemented in the OPPS PRICER program for drugs and devices furnished on or after April 1, 2002.

Table 1, as published in the March 1, 2002 **Federal Register**, lists the device offset amounts attributable to APCs. These amounts are used in calculating device payments that reflect the pro-rata reduction as illustrated in the example that follows.

Table 1 – Offsets to Be Applied for Each APC That Contains Device Costs

1	2	3	4	5
APC	Description	Device Costs (Before Fold-in) Reflected in APC Rate	Additional Device Costs Folded into APC Rate	Total Offset for Device Costs
0032	Insertion of Central Venous/Arterial Catheter	$73.79	$279.97	$353.76
0046	Open/Percutaneous Treatment Fracture or Dislocation	NA	$100.29	$100.29
0048	Arthroplasty with Prosthesis	NA	$514.64	$514.64
0057	Bunion Procedures	NA	$162.89	$162.89
0070	Thoracentesis/Lavage Procedures	NA	$26.47	$26.47
0080	Diagnostic Cardiac Catheterization	$164.27	$134.39	$298.66
0081	Non-Coronary Angioplasty or Atherectomy	$307.06	$362.95	$670.01
0082	Coronary Atherectomy	$242.95	$1,214.06	$1,457.01
0083	Coronary Angioplasty	$528.64	$383.31	$911.95
0085	Level II Electrophysiologic Evaluation	NA	$1,578.03	$1,578.03
0086	Ablate Heart Dysrhythm Focus	NA	$1,320.96	$1,320.96
0087	Cardiac Electrophysiologic Recording/Mapping	NA	$1,980.16	$1,980.16
0088	Thrombectomy	$162.72	$261.14	$423.86
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	$3,175.70	$3,286.36	$6462.06
0090	Insertion/Replacement of Pacemaker Pulse Generator	$2,921.06	$2,123.20	$5,044.26
0094	Resuscitation and Cardioversion	NA	$19.34	$19.34
0103	Miscellaneous Vascular Procedures	NA	$207.18	$207.18
0104	Transcatheter Placement of Intracoronary Stents	$428.16	$1,256.31	$1,684.47
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	$657.59	$1,049.13	$1,706.72
0107	Insertion of Cardioverter-Defibrillator	$6,803.85	$11,099.62	$17,903.47

1	2	3	4	5
APC	Description	Device Costs (Before Fold-in) Reflected in APC Rate	Additional Device Costs Folded into APC Rate	Total Offset for Device Costs
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	$6,940.27	$19,607.20	$26,547.47
0111	Blood Product Exchange	NA	$209.72	$209.72
0115	Cannula/Access Device Procedures	NA	$127.26	$127.26
0117	Chemotherapy Administration by Infusion Only	NA	$30.03	$30.03
0118	Chemotherapy Administration by Both Infusion and Other Technique	NA	$28.50	$28.50
0119	Implantation of Devices	NA	$3,348.98	$3,348.98
0120	Infusion Therapy Except Chemotherapy	NA	$35.12	$35.12
0121	Level I Tube Changes and Repositioning	NA	$6.10	$6.10
0122	Level II Tube Changes and Repositioning	$72.55	$214.82	$287.37
0124	Revision of Implanted Infusion Pump	NA	$3,308.76	$3,308.76
0144	Diagnostic Anoscopy	NA	$128.28	$128.28
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	$60.92	$0.00	$60.92
0152	Percutaneous Biliary Endoscopic Procedures	$107.61	$0.00	$107.61
0153	Peritoneal and Abdominal Procedures	NA	$41.23	$41.23
0154	Hernia/Hydrocele Procedures	$108.11	$378.73	$486.84
0161	Level II Cystourethroscopy and other Genitourinary Procedures	NA	$11.20	$11.20
0162	Level III Cystourethroscopy and other Genitourinary Procedures	NA	$319.68	$319.68
0163	Level IV Cystourethroscopy and other Genitourinary Procedures	NA	$901.51	$901.51
0179	Urinary Incontinence Procedures	NA	$3,400.90	$3,400.90
0182	Insertion of Penile Prosthesis	$2,238.90	$569.11	$2,808.14
0202	Level VIII Female Reproductive Proc	$505.32	$1,233.41	$1,738.73
0203	Level V Nerve Injections	NA	$420.98	$420.98
0207	Level IV Nerve Injections	NA	$63.63	$63.63

1	2	3	4	5
APC	Description	Device Costs (Before Fold-in) Reflected in APC Rate	Additional Device Costs Folded into APC Rate	Total Offset for Device Costs
0222	Implantation of Neurological Device	$4,458.57	$9,599.99	$14,058.56
0223	Implantation of Pain Management Device	$421.33	$3,330.14	$3,751.47
0225	Implantation of Neurostimulator Electrodes	$1,182.00	$11,941.06	$13,123.06
0226	Implantation of Drug Infusion Reservoir	NA	$3,363.74	$3,363.74
0227	Implantation of Drug Infusion Device	$3,810.46	$2,395.55	$6,206.01
0229	Transcatherter Placement of Intravascular Shunts	$1,074.41	$842.97	$1,917.38
0246	Cataract Procedures with IOL Insert	$146.82	$0.00	$146.82
0259	Level VI ENT Procedures	$12,407.52	$3,836.13	$16,243.65
0264	Level II Miscellaneous Radiology Procedures	NA	$61.59	$61.59
0312	Radioelement Applications	NA	$5,897.22	$5,897.22
0313	Brachytherapy	NA	$998.23	$998.23
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	NA	$210.75	$210.75
0686	Level V Skin Repair	NA	$465.77	$465.77
0687	Revision/Removal of Neurostimulator Electrodes	NA	$1,444.65	$1,444.65
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver	NA	$6,238.79	$6,238.79
0692	Electronic Analysis of Neurostimulator Pulse Generators	NA	$644.44	$644.44

The following examples illustrate how transitional pass-through payments are calculated for devices and for drugs, taking into account the pro-rata reductions.

A. Example of how a transitional pass-through payment would be calculated for a pass-through device furnished on or after April 1, 2002 :

Device: C1776 Joint device (implantable)
Device cost = Hospital charge converted to cost = $960

Associated procedure: CPT 25446 Wrist replacement (APC 48)
Payment rate = $2211.27
National unadjusted copayment amount = $725.94

Total offset amount to be applied for each APC that contains device costs = $514.64
[**Note:** the total offset amount (from Table 1 above)is wage and discount factor adjusted before it is subtracted from the device cost.]

Device cost adjusted by total offset amount:
$960-$514.64 = $445.36

Device cost after adjustment for pro rata reduction:
$445.36 x .364 = $162.11

Medicare program payment (before wage index adjustment) for APC 48:
$2211.27 - 725.94 = $1485.33

Medicare program payment for pass-through device C1776
$162.11

Beneficiary copayment liability:
$725.94

Total amount received by provider for APC 48 and pass-through device C1776:
$1485.33 (Medicare program payment for CPT code 25446)
725.94 (Beneficiary unadjusted copayment amount for CPT code 25446)
162.11 (Transitional pass-through payment for device)
$2373.38

B. Example of how a transitional pass-through payment is calculated for a pass-through drug furnished on or after April 1, 2002:

APC 1613 Trastuzumab, 10 mg

Unadjusted Copayment Amount = $7.56
Payment rate = $52.83
Non-pass-through portion = (5 x copay) = 5 x 7.56 = $37.80
Pass-through portion = $52.83 - $37.80 = $15.03

Pass-through portion after adjustment for 63.6 percent pro rata reduction
$15.03 x .364 = $5.47

Total payment to provider for APC 1613 after pro rata reduction:
$5.47 (pass-through portion adjusted for pro rata reduction)
37.80 (non-pass-through portion)
$43.27 (total payment to provider)
- 7.56 (beneficiary copayment)
$35.71 (total Medicare program payment)

XI. Payment for Observation Services

Since the beginning of OPPS, observation services have been packaged services. No separate payment was made for observation services, as the payment for observation was included in the APC payment for the procedure or visit with which it was furnished. Although observation services will continue to be packaged in most situations, the final rule for 2002 provides a separate APC payment for observation that is provided under certain specific conditions. The APC for observation services is effective for services furnished on or after April 1, 2002. The instructions contained in PM A-01-91 dated July 31, 2001, remain in effect for all observation services provided prior to April 1, 2002, and continue to be in effect for observation services that do not qualify for separate APC payment on or after April 1, 2002. A hospital may receive a separate APC payment for observation services

for patients having diagnoses of chest pain, asthma, or congestive heart failure, when certain additional criteria are met. More than one non-overlapping observation meeting the observation criteria is allowed on a single claim and each observation is paid separately. Hospitals must use the new code G0244 for observation services that meet the criteria for separate payment and must submit the claim using bill type13X. Observation is not separately paid if a surgical procedure or any service that has a status indicator of "T" under the OPPS occurs on the day before or the day that the patient is admitted to observation.

A. Required Diagnoses for Separate Observation APC Payment

One of the following ICD-9-CM diagnoses must be present on the bill as the principal or secondary diagnosis:

NOTE: Admitting Diagnosis is not a required field for Medicare outpatient claims. Admitting diagnosis will not be taken into account to determine that a patient has a qualifying diagnosis for purposes of paying an APC for observation.

1. For Chest Pain:

411.0 Postmyocardial infarction syndrome
411.1 Intermediate coronary syndrome
411.81 Coronary occlusion without myocardial infarction
411.89 Other acute ischemic heart disease
413.0 Angina decubitus
413.1 Prinzmetal angina
413.9 Other and unspecified angina pectoris
786.05 Shortness of breath
786.50 Chest pain, unspecified
786.51 Precordial pain
786.52 Painful respiration
786.59 Other chest pain

2. For Asthma:

493.01 Extrinsic asthma with status asthmaticus
493.02 Extrinsic asthma with acute exacerbation
493.11 Intrinsic asthma with status asthmaticus
493.12 Intrinsic asthma with acute exacerbation
493.21 Chronic obstructive asthma with status asthmaticus
493.22 Chronic obstructive asthma with acute exacerbation
493.91 Asthma, unspecified with status asthmaticus
493.92 Asthma, unspecified with acute exacerbation

3. For Congestive Heart Failure:

391.8 Other acute rheumatic heart disease
398.91 Rheumatic heart failure (congestive)
402.01 Malignant hypertensive heart disease with congestive heart failure
402.11 Benign hypertensive heart disease with congestive heart failure
402.91 Unspecified hypertensive heart disease with congestive heart failure
404.01 Malignant hypertensive heart and renal disease with congestive heart failure
404.03 Malignant hypertensive heart and renal disease with congestive heart and renal failure
404.11 Benign hypertensive heart and renal disease with congestive heart failure
404.13 Benign hypertensive heart and renal disease with congestive heart and renal failure
404.91 Unspecified hypertensive heart and renal disease with congestive heart failure

404.93 Unspecified hypertensive heart and renal disease with congestive heart and renal failure
428.0 Congestive heart failure
428.1 Left heart failure
428.9 Heart failure, unspecified

B. Additional Requirements for Separate Observation APC Payment:

In addition to having one of the above diagnoses on the bill the following requirements must also be met in order to receive a separate APC payment for observation services:

1. An emergency department visit (APC 0610, 0611, or 0612), a clinic visit (APC 0600, 0601,or 0602) or critical care (APC 620) is billed in conjunction with each bill for observation services. An Emergency Management (E/M) code for the emergency room, clinic visit or critical care is required to be billed on the day before or the day that the patient is admitted to observation. Both the associated E/M code and the observation are paid separately if the observation criteria are met. Observation services are packaged into the E/M visit if all observation criteria are not met. More than one period of observation is allowed to be billed on a single claim however each observation period must be paired with a separate E/M visit. The E/M code associated with observation must be billed on the same claim as the observation service.

NOTE: An E/M visit must be billed with a modifier –25 if it has the same date of service as the observation code G0244.

2. The hospital must furnish certain other diagnostic services along with observation services to ensure that separate payment is made only for those beneficiaries truly requiring observation care. We believe that these tests are typically performed on beneficiaries requiring observation care for the three specified conditions. The tests are medically necessary to determine whether a beneficiary will benefit from being admitted to observation care and the appropriate disposition of a patient in observation care. The specified diagnostic services must be performed within the dates of the E/M visit plus the first 24 hours of observation and must be billed on the same claim as the observation services to which they are related. The diagnostic tests are as follows:

- For chest pain, at least two sets of cardiac enzymes two CPK (82550, 82552, or 82553) or two troponin (84484 or 84512)] and two sequential electrocardiograms (93005);
- For asthma, a peak expiratory flow rate (94010) or pulse oximetry (94760 or 94761),
- For congestive heart failure, a chest x-ray (71010, 71020 or 71030) and an electrocardiogram (93005) and pulse oximetry (94760 or 94761).

NOTE: Pulse oximetry codes 94760 and 94761 are treated as packaged services under the OPPS. Although as packaged codes no separate payment is made for these codes, hospitals must separately report the HCPCS code and a charge for pulse oximetry in order to establish that observation services for congestive heart failure and asthma diagnoses meet the criteria for separate APC payment.

Multiple observation periods on a claim may be paid separately if the required criteria are met for each observation. If there are multiple observation periods for the same diagnoses, each of the required tests must be performed multiple times, that is, the tests must be rerun for each period of observation. Therefore, if a claim contains 2 separate periods of observation related to chest pain, 4 EKGs and 4 cardiac enzyme tests must be performed. If multiple observations are for different diagnoses, the re-use of tests will be permitted. For example, if there are 2 periods of observation on a claim, one for chest pain and one for congestive heart failure, 2 EKGs, not 3, are needed. The EKGs that are performed to meet the diagnostic test requirements for observation related to chest pain may also be used for the observation related to congestive heart failure.

3. Observation services must be billed hourly for a minimum of 8 hours up to a maximum of 48 hours. In billing for observation services, the units of services represent the number of hours the patient spends in observation. We will not pay separately for any hours a beneficiary spends in observation over 24 hours, but all costs beyond 24 hours will be included in the APC payment for observation services. Observation services of less than 8 hours do not qualify for an APC payment. If a period of observation spans more than one 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 the patient is admitted to observation.

- ? Observation time begins at the clock time appearing on the nurse's observation admission note. (We note that this coincides with the initiation of observation care or with the time of the patient's arrival in the observation unit.)

- ? Observation time ends at the clock time documented in the physician's discharge orders, or, in the absence of such a documented time, the clock time when the nurse or other appropriate person signs off on the physician's discharge order. (This time coincides with the end of the patient's period of monitoring or treatment in observation.)

- ? The beneficiary must be under the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes, timed, written, and signed by the physician.

- ? The medical record must include documentation that the physician used risk stratification criteria to determine that the beneficiary would benefit from observation care.

(These criteria may be either published generally accepted medical standards or established hospital-specific standards.)

4. Only observation services that are billed on a 13X bill type maybe considered for a separate APC payment.

5. To receive an APC payment for observation services that qualify for separate payment a hospital must bill using HCPCS code G0244. HCPCS code G0244 is to be used only when billing for observation services that meet the requirements for separate APC payment as outlined above. If the observation services furnished by a hospital do not meet the requirements for separate APC payment, the hospital must bill observation services using revenue code 762 only or using revenue code 762 with one of the HCPCS codes for packaged observation services i.e., 99218 – 99220 or 99234 – 99236**.**

6. Note that because the status indicator on HCPCS G0244 is an "S", any claim with an E/M visit on the same day as the observation will be subject to OPPS OCE edit 21 (medical visit on same day as type T or S procedure without modifier -25). Therefore, the E/M code for the visit must be billed with modifier –25 in order for the observation to be paid. Please be sure to make this clear in your program instructions.

XII. Modifier Issues Under the Hospital OPPS

Below is a listing of all the modifiers that are reported under the OPPS as of April 1, 2002:

Level I (CPT)	Level II (HCPCS)
-25 -74	-E1 -F5 -RT -T6
-27 -76	-E2 -F6 -QM-T7
-50 -77	-E3 -F7 -QN -T8
-52 -78	-E4 -F8 -TA -T9
-58 -79	-FA -F9 -T1
	-GG -GH
-59 -91	-F1 -LC -T2
-73	-F2 -LD -T3
	-F3 -LT -T4
	-F4 -RC -T5

As we indicated in §Section 442.9 of the Hospital Manual as well as in Transmittal A-00-73 dated October 5, 2000, modifier -50 should be used to report bilateral procedures that are performed at the same operative session as a single line item. Do **not** use modifiers RT and LT when modifier -50 applies. Do not submit two line items to report a bilateral procedure using modifier -50. Modifier -50 applies to any bilateral procedure performed on both sides at the same session.

XIII. Wage Index Changes

We adjust payments to hospitals for geographic wage differences, as required by the statute, using the FY 2002 hospital inpatient PPS wage index. We are using the same annual rates as the Inpatient PPS, based on their final regulations published August 2001 and as revised in PM A-01-144, issued on December 20, 2001. Please refer to the CMS website www.hcfa.gov/medicare/hopsmain.htm for more detailed information.

XIV. Applications for APC Payments for New Technologies, Additional Device Categories, and Pass-through Payments for Drugs and Biologicals

The most recent information concerning applications and requirements for APC payments for new technologies, additional device categories and pass-through payments for drugs and biologicals is located on the CMS website at www.hcfa.gov/medlearn/refopps.htm.

XV. Changes to PRICER Logic

The following list contains a description of all OPPS PRICER logic changes that are effective beginning April 1, 2002.

A. New OPPS wage indexes will be effective April 1, 2002. These are the same wage indexes that were implemented on October 1, 2001 for inpatient hospitals. Some corrections have been made since the publication of the inpatient rule and we are using the corrected wage indexes where applicable.

B. Inpatient hospitals considered reclassified on October 1, 2001, will be considered reclassified for OPPS on April 1, 2002.

C. Section 401 designations and floor MSA designations will be considered effective for OPPS on April 1, 2002.

D. New payment rates and coinsurance amounts will be effective for OPPS on April 1, 2002, except those 55 APCs with coinsurance amounts limited to 55 percent of the payment rate, these will stay effective January 1, 2002, and the coinsurance limit equal to the inpatient deductible of $812 will stay effective January 1, 2002.

E. APC 339, for Observation, will be priced at 1 unit no matter how many units are submitted.

F. If a claim has more than 1 service with a status indicator (SI) of S or T and any lines with SI of S or T have less than $1.01 as charges, charges for all S and/or T lines will be summed and the charges will then be divided up proportionately to the payment rate for each S or T line. The new charge amount will be used in place of the submitted charge amount in the line item outlier calculation.

E.g., SI	Charges	Payment Rate	New Charges Amount
S	$19,999	$6,000	$12,000
T	$1	$3,000	$6,000
S	$0	$1,000	$2,000
	$20,000	$10,000	$20,000

Because total charges here are $20,000 and the first SI of S gets 6,000 of 10,000 total payment, the new charge for that line is 6,000/10,000 * $20,000 = $12,000.

G. All charges on lines with a SI of N (bundled services) on the claim will be summed and the charges will then be divided up proportionately to the payment rate for each S, T, V or X line. This proportional amount will be added to the new charges amount from item F above or, if that doesn't apply, they will be added to the actual submitted charges for each S, T, V or X before making a line item outlier calculation.

H. Outliers will be calculated at a line item level. No outlier payment will be calculated for SIs of G, N or H, although charges for packaged services (SI=N) will be used in calculating outlier payments for other services as described in G. above. We will use submitted charges as modified by items F and G above. We will change the factor multiplied times the total claim payments from 2.5 to 3.5 and factor used to multiply the difference between claim payments and costs from .75 to .50. We will keep the cost to charge ratio adjustment factor at .981956. We will sum all line item outlier amounts and output them as a single total claim outlier amount, just as we output the outlier amount now to go in value code 17.

I. Any claim with one or more APCs that match those listed in Table 1 of the March 1, 2002 **Federal Register** will have all applicable APC offset amounts summed and wage adjusted. The total wage adjusted offset amount will be subtracted proportionately from the charges reduced to costs for any SI H devices that have a HCPCS code beginning with a C, i.e., C1713 through C2631.

J. A pro rata reduction of 63.6percent applies to all SI G and/or H payments. For H, devices, the offset (or reduction) is applied to the final payment amount after all device offset amounts (see item I above) have been taken. For SI G, pass thru drugs, we will determine the pass through amount (PTA) by subtracting 5 times the minimum coinsurance from the Medicare payment amount. We will multiply .364 times the PTA and add that amount to 5 times the minimum coinsurance to get the new Medicare payment amount.

K. The provider specific file for SNFs and HHAs that may be reimbursed for splints, casts and/or antigens under OPPS should have a cost to charge ratio of 0.000 (or 0.001 if your system will not allow 0.000). We will not pay outliers for these services.

L. PRICER Drug Co-Payment Changes

APC	**Drug Name**	**Corrected Co-Payment**
726	Dexrazoxane	$27.85
1607	Eptifibatide	$1.62

XVI. Routing of Claims

Standard system maintainers should reroute the following types of bills (TOBs) that contain dates of service on or after April 1, 2002, back to the OPPS 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 a Part A (POT)
34X- HHA visits not under a POT
71X- Rural Health Clinic
72X- Hospital Based or Independent Renal Dialysis Center
73X- Federally Qualified Health Center
74X- Other Rehabilitation Facilities
75X- Comprehensive Outpatient Rehabilitation Facility (CORF)
81X- Hospice (non-hospital based)
82X- Hospice (hospital based)

Intermediaries should advise their providers that claims containing the above TOBs, other than 32X and 33X, with services that span beyond April 1, 2001, must be split prior to their submittal. For example, if a claim contains services prior to and after April 1, 2002, the provider must submit two separate claims. One for the services prior to April 1, 2002, which will be routed to the non-OPPS OCE and another claim for the services April and later which will be routed to the OPPS OCE. In the event you receive a claim containing pre and post April 1, 2002 dates of service, return it to the provider requesting that the claim be split as indicated above.

Claims containing the above TOBs with dates of service January 1, 2002 through March 31, 2002, should continue to be routed through the non-OPPS OCE.

NOTE: TOBs (12X, 13X, 14X and 85X) from Critical Access Hospitals, Maryland Hospitals, Indian Health Service Hospitals, U.S.Virgin Island Hospitals, and those hospitals located in the Pacific (American Samoa, Guam, and Saipan) do not have to be rerouted since they are sent through the non-OPPS OCE.

XVII. Changes in Transitional Outpatient Payment (TOP) for 2002

Beginning January 1, 2002, TOPs are reduced for all providers except those hospitals that receive hold harmless TOPs (cancer hospitals, children's hospitals, and rural hospitals having 100 or fewer beds). To avoid TOP overpayments, as soon as possible, but no later than July 1, 2002, revise the monthly interim TOP calculations to reflect the new calculation.

A. Revised TOP Calculation for Calendar Year 2002:

The calculation of monthly interim TOPs payments described in PM A-00-36, issued June 2000, is revised as follows for calendar year 2002:

Step 1 Find the total charges for covered services for all OPPS services on claims paid during the month [and] reduce the total charges to cost by multiplying them by the outpatient cost-to-charge ratio, and multiply this amount by the provider-specific payment-to-cost ratio (PSPCR).

Step 2 Find the total Medicare program payments, unreduced coinsurance and deductible applied for all APCs as well as all outlier payments and transitional pass-through payments for drugs, biologicals and/or devices for those same claims paid during the month under OPPS. If the result is greater than the result of step 1, go to step 8. No transitional payment is due this month.

Step 3 If the hospital is a children's hospital, a small rural hospital with not more than 100 beds or a cancer hospital, go to step 4. If any other type of hospital, divide the result of step 2 by the result of step 1, skip step 4 and perform step 5, 6, or 7, as appropriate.

Step 4 If the hospital is a children's hospital, a small rural hospital with not more than 100 beds or a cancer hospital subtract the result of step 2 from the result of step 1 and pay .85 times this amount. Do not perform steps 5-7.

Step 5 If the result of step 3 is greater than or equal to .9 and less than 1.0, subtract the result of step 2 from the result of step 1, [and] multiply the difference by .7, and pay .85 times this amount.

Step 6 If the result of step 3 is greater than or equal to .8 and less than .9, subtract .6 times the result of step 2 from .61 times the result of step 1, and pay .85 times this amount.

Step 7 If the result of step 3 is less than .8, multiply the result of step 1 by .13 and pay .85 times this amount.

Step 8 When the result of step 2 is greater than the result of step 1 for the final month of a provider's cost report period, do nothing more. When the result of step 2 is greater than the result of step 1 for any other month, store all step 1 and step 2 totals and include these totals with the totals for the next month's TOP calculation.

B. TOP Overpayments

Because the revised TOP calculation will be implemented in the system sometime after the January 1, 2002 effective date of the TOP reduction, overpayments to providers are expected. Once the system change is completed, you must determine whether overpayments have been made by comparing TOP amounts you have already paid for OPPS charges attributable to services furnished in calendar year 2002 to what TOP amounts would be using the revised calculation. Because interim TOPs are based on charges billed during the previous month rather than on actual dates of service, in determining whether an overpayment exists, apply the new calculation to monthly TOP amounts paid for OPPS charges billed beginning in February 2002.

If you determine that an overpayment exists and take action to recoup the overpayments by withholding future monthly interim TOPs until the overpayment is recouped.

XVIII. 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 listserv that are used to communicate with your provider community, post this message to your providers using that facility.

XIX. Medical Nutrition Therapy Services

Bill for these service the same way you bill for services of practitioners such as nurse practitioners or physicians. Hospitals should submit claims for the following HCPCS codes to their local carriers: 97802, 97803, and 97804. See PM B-01-48, issued August 7, 2001 and PM B-02-10, issued February 8, 2002 for more details.

The *effective date* for this PM is April 1, 2002.

The *implementation date* for this PM is April 8, 2002, unless otherwise noted.

These instructions should be implemented within your current operating budget.

This PM may be discarded after April 1, 2003.

If you have any questions contact your Regional Office.