



INDUSTRY INSIGHT

Industry Insight No. 201

January 2003

ADDITIONAL APC PAYMENT SYSTEM UPDATES FOR CY 2003

In the November 1, 2002 *Federal Register* (pages 66718 – 67046), the Centers for Medicare and Medicaid Services (CMS) published final changes to the APC-based outpatient prospective payment system (OPPS) for services provided on or after January 1, 2003. These changes are summarized in HSS *Industry Insight No. 195, APC Payment System Updates for CY 2003: Final Rule*. On January 3, 2003, CMS published Program Memorandum (PM) A-02-129 (2003 Update of the Hospital Outpatient Prospective Payment System), which provides additional information regarding the 2003 OPPS update. Details not previously discussed in *Industry Insight No. 195* are summarized below. Be sure to use this *Industry Insight*, in conjunction with *Insight No. 195*, for a complete synopsis of the calendar year (CY) 2003 OPPS changes.

1. **DRUG-ELUTING STENTS:** CMS has created two temporary HCPCS codes for the insertion of coronary artery drug-eluting stents:

- G0290, *transcatheter placement of a drug-eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel.*
- G0291, *transcatheter placement of a drug-eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; additional vessel.*

These codes are assigned to new APC 0656 (Transcatheter Placement of Drug Eluting Coronary Stents). However, payment under APC 0656 will not be implemented before April 1, 2003 and is contingent upon FDA approval. If FDA approval is received prior to April, these codes will be paid under APC 0104 (Transcatheter Placement of Intracoronary Stents). If FDA approval is not received by April 1, 2003, CMS will announce through Program Memorandum a new effective date for HCPCS codes G0290 and G0291 and for APC 0656.

2. **CODES FOR OUTPATIENT SERVICES UNDER NATIONAL CLINICAL TRIALS:** CMS has created three new codes for reporting services furnished in hospital outpatient departments under qualifying national clinical trials:

- G0292, *administration(s) of experimental drug(s) only in a Medicare qualifying clinical trial (includes administration for chemotherapy and other types of therapy via infusion and/or other than infusion), per day.*
- G0293, *noncovered surgical procedure(s) using conscious sedation, regional, general or spinal anesthesia in a Medicare qualifying clinical trial, per day.*
- G0294, *noncovered surgical procedure(s) using either no anesthesia or local anesthesia only, in a Medicare qualifying clinical trial, per day.*

Although experimental interventions are not covered, Medicare will pay for the routine costs of items and services required because of the intervention. The interim APC assignments for codes G0292, G0293 and G0294 are APC 0708 (New Technology – Level III), APC 0710 (New Technology – Level V) and APC 0707 (New Technology – Level II). In order to use these codes, hospitals must report ICD-9-CM diagnosis code V70.7 (examination for clinical research) on the claim as a “diagnosis other than the principal”.

3. **LIMITATIONS ON BENEFICIARY COPAYMENTS:** For CY 2003, the national unadjusted copayment for a single service cannot exceed 55% of the APC rate for that service. In addition, wage-adjusted copayments for a single service cannot exceed the 2003 inpatient hospital deductible, which is \$840.
4. **TRANSITIONAL PASS-THROUGHS – DEVICES:** 95 device categories expired and may no longer be billed effective January 1, 2003. Even though a device may no longer be eligible for pass-through payment and may no longer have a reportable HCPCS code, it is important that providers submit device charges in the appropriate revenue center so that hold harmless, transitional corridor and outlier payments can be correctly calculated. In addition, it is important that packaged device costs be included in the data used for calculating future APC updates.
5. **TRANSITIONAL PASS-THROUGHS – DRUGS AND BIOLOGICALS:** For CY 2003, CMS is making the following changes relative to the payment of transitional pass-through drugs and biologicals, in addition to those published in the November 1, 2002 OPSS Final Rule.
 - **Additional Pass-Through or High Cost Drugs:** The following drugs were not included in the November Final Rule:
 - ✓ J3315, *triptorelin pamoate, 3.75 mg*, was recently approved as a pass-through drug and has been assigned a payment status indicator of “G”. It is assigned to APC 9122, which has a payment rate of \$415.24, and a copayment of \$62.07.
 - ✓ Q3000, *rubidium RB-82*, was not previously payable as a pass-through drug or otherwise separately payable drug. This code has a payment status indicator of “K” and is assigned to APC 9025 (payment rate of \$133.41; copayment of \$26.68).
 - **Orphan Drugs:** The following four orphan drugs: J1785 (*injection imiglucerase/unit*), J0205 (*alglucerase injection*), J0256 (*alpha 1 proteinase inhibitor*) and J9300 (*gemtuzumab ozogamicin*) are excluded from the OPSS and now paid on a reasonable cost basis. They are assigned a payment status indicator of “F”.
 - **Vaccines Covered Under a Benefit Other Than OPSS:** Hospital outpatient departments administer many vaccines for flu, pneumonia and Hepatitis B. As of January 1, 2003, these vaccines are paid on a reasonable cost basis. Because CMS will not be able to appropriately process these claims until July 2003, claims containing these codes will be held for processing. Hospitals may remove the vaccine and administration charge from the claim to receive payment for the remaining services. An adjustment bill would then be submitted in July. The applicable HCPCS codes are 90657, 90658, 90659, 90732, G0008 and G0009. All have been assigned the new payment status of “L”, indicating that they are paid based on reasonable cost and are exempt from coinsurance and deductibles.
6. **CHANGES IN BILLING AND PAYMENT REQUIREMENTS FOR DIRECT ADMISSIONS TO OBSERVATION:**
 - **Background:** As previously described in *Industry Insight No. 195*, CMS has modified the criteria and coding for patients who are “direct admissions” to observation for services furnished on or after January 1, 2003. Two new procedure codes are being added to

categorize patients directly admitted from a physician's office to observation, bypassing the clinic or emergency department (ED). Code G0263 is for patients with a diagnosis of congestive heart failure, chest pain or asthma who meet criteria for separate observation payment, and G0264 is for patients with any other diagnosis or who don't otherwise meet the separate observation payment criteria. G0263 will have a payment status of "N", indicating that the service is packaged. G0264 will be assigned to APC 0600, Low Level Clinic Visit. Hospitals should bill direct observations using these new codes rather than a low-level visit code, as previously instructed. Note that the payment for G0264 is intended to reimburse facilities for the costs associated with a baseline nursing assessment, creation of a medical record, recording and initiation of telephone orders, etc.

- **ADDITIONAL BILLING REQUIREMENTS:**

- ✓ Code G0263 (*direct admission of patient with diagnosis of congestive heart failure, chest pain or asthma for observation services that meet all criteria for separate payment*) must be billed with code G0244 (*observation care provided by a facility to a patient with CHF, chest pain, or asthma, minimum eight hours, maximum forty-eight hours*). Although code G0263 is packaged and will not generate a separate OPPS payment, it is recognized as taking the place of a visit or critical care code in meeting APC 0339 assignment criteria and separate payment eligibility. Code G0263 must be billed with a modifier -25 in order to receive payment for G0244. Although no separate payment is made for G0263, charges billed with G0263 are considered in determining the costs associated with APC 0339.
- ✓ G0264 (*initial nursing assessment of patient directly admitted to observation with diagnosis other than congestive heart failure, chest pain, or asthma or patient directly admitted to observation with diagnosis of congestive heart failure, chest pain or asthma when observation stay does not qualify for separate payment*) should not be billed with G0244.
- ✓ Hospitals should bill codes G0263 and G0264 with revenue code 762.

7. **BILLING INTRAVENOUS INFUSION WITH OBSERVATION:** CMS confirms that for services furnished on or after January 1, 2003, hospitals should utilize code Q0081 for infusion therapy provided during a separately payable observation stay and should discontinue use of HCPCS code G0258. Q0081 may be reported for infusions started in the emergency department, clinic or observation area, so long as the infusion continues during the observation stay. The outpatient code editor (OCE) has been modified to allow payment, effective for services furnished on or after April 1, 2002, for HCPCS code G0244 when billed with Q0081, subject to all other conditions for payment having been met. Hospitals may resubmit claims that were denied for services furnished on or after April 1, 2002 through December 31, 2002 because G0244 is billed with Q0081.

8. **USE OF ADMISSION DIAGNOSIS IN EVALUATING ELIGIBILITY FOR SEPARATE OBSERVATION PAYMENT (ASSIGNMENT TO APC 339):** Admitting diagnosis (UB-92 field locator 76) will be captured for use in outpatient claims processing as of January 1, 2003. In addition, admitting diagnosis will be taken into account in determining eligibility for separate observation payment for services furnished on or after April 1, 2002, when the bill is submitted or resubmitted, or when an adjustment bill is submitted after January 1, 2003. Prior to January 1, 2003, only the principal and other/secondary diagnoses on the claim (UB-92 field locators 67-75) were considered during evaluation of separate observation payment eligibility.

9. **INPATIENT ONLY PROCEDURES PERFORMED ON AN EMERGENCY BASIS:** CMS is changing its payment policies for “inpatient only” procedures performed on an emergency basis when (1) the patient dies during or after the procedure, before being admitted, or (2) the patient survives the procedure and is transferred following the procedure.

- **Billing for Patients that Expire:** Beginning January 2003, CMS will reimburse hospitals under the OPPTS for those rare and unusual cases where an “inpatient only” procedure is performed to resuscitate or stabilize a patient who dies before being admitted as an inpatient. To receive payment, the “inpatient only” service (designated by a payment status indicator of “C”) must be billed with a modifier of “-CA” (*procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission*). Payment for all services on the claim with the same date of service as the HCPCS code billed with modifier “-CA” will be bundled into a single payment under APC 0977 (New Technology – Level VIII). Separate payment will not be allowed for these services.
- **Billing for Patients that are Transferred:** For eligible cases where the patient survives the emergency procedure and is immediately transferred to another acute care facility, the transferring facility can bill for the procedure as an inpatient service and will be reimbursed based on a per-diem DRG rate.
- **Required Documentation:** For a hospital to receive payment for either of the above situations, the patient’s medical record must contain all of the following information.
 - ✓ Documentation that the surgical procedure with a payment status indicator of “C” was actually performed and was medically necessary.
 - ✓ If the patient was admitted as an inpatient and subsequently transferred, written orders to admit and transfer the patient, as well as documentation that the transfer was medically necessary.

10. **OUTPATIENT BILLING FOR DIALYSIS:** CMS will allow payment under specific circumstances for unscheduled or emergency dialysis treatments furnished to End-Stage Renal Disease (ESRD) patients in the outpatient department of a hospital that does not have a certified ESRD facility. Services will be paid if (1) dialysis is performed following or in connection with a vascular access procedure, (2) dialysis is performed following treatment for an unrelated medical emergency, or (3) dialysis is performed on an emergency basis. Dialysis services meeting these criteria must be billed with new procedure code G0257 (*unscheduled or emergency treatment for dialysis for ESRD patient in the outpatient department of a hospital that does not have a certified ESRD facility*). These cases are assigned to APC 0170 (Dialysis), which has a payment status indicator of “S” (non-discounted procedure) and a payment rate approximately equivalent to the reimbursement rate for acute dialysis. The new procedure code G0257 should not be used in the case of acute renal failure. CMS will be issuing further instructions on the use of code G0257. System edits to monitor code usage and to prevent potential fraud and abuse will also be developed.

Be sure to check the HSS web site (www.hssweb.com) for up-to-date information on upcoming changes to Medicare’s OPPTS. **Hssweb** is updated on a regular basis with new and timely **Industry Insights**, as well as access to source documents, such as PM A-02-129.