CHAPTER 13
SECTION 2

BILLING AND CODING OF SERVICES UNDER APC GROUPS

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I. APPLICABILITY

This policy is mandatory for the reimbursement of services provided either by network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

II. ISSUE

The billing and coding requirements for reimbursement under the hospital outpatient prospective payment system (OPPS).

III. POLICY

A. Packaging of Services Under APC Groups.

1. The prospective payment system establishes a national payment rate, standardized for geographic wage differences, that includes operating and capital-related costs that are directly related and integral to performing a procedure or furnishing a service on an outpatient basis. These costs include, but are not limited to:

a. Use of an operating suite.

b. Procedure room or treatment room.

c. Use of the recovery room or area.

d. Use of an observation bed.

e. Anesthesia, certain drugs, biologicals, and other pharmaceuticals; medical and surgical supplies and equipment; surgical dressings; and devices used for external reduction of fractures and dislocations.

f. Supplies and equipment for administering and monitoring anesthesia or sedation.

g. Intraocular lenses (IOLs).

h. Capital-related costs.

i. Costs incurred to procure donor tissue other than corneal tissue.

j. Incidental services such as venipuncture.

k. Implantable items used in connection with diagnostic X-ray testing, diagnostic laboratory tests, and other diagnostics.

l. Implantable prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of these devices.

2. Costs associated with certain expensive procedures and services are not packaged within an APC payment rate. Instead, separate APC payment will be made for these particular items and services under the OPPS. Additional payments will be provided for certain packaged medical devices, drugs, and biologicals that are eligible for transitional pass-throughs (i.e., payments for expensive drugs or devices that are temporarily reimbursed in addition to the APC amount for the service or procedure to which they are normally associated), while strapping and casting will be paid under two new APC groupings (0058 and 0059).

a. Costs of drugs, biologicals and devices packaged into APCs to which they are normally associated.

The costs of drugs, biologicals and pharmaceuticals are generally packaged into the APC payment rate for the primary procedure or treatment with which the drugs are usually furnished. No separate payment is made under the OPPS for drugs, biologicals and pharmaceuticals whose costs are packaged into the APCs with which they are associated.

(1) For the drugs paid under the OPPS, hospitals can bill both for the drug and for the administration of the drug.

(2) The overhead cost is captured in the administration codes, along with the costs of all drugs that are not paid for separately.

(3) Each time a drug is billed with an administration code, the total payment thus includes the acquisition cost for the billed drug, the packaged cost of all other drugs and the overhead.

b. Separate payment of drugs, biologicals and devices outside the APC amounts of the services to which they are normally associated.

(1) Special transitional pass-through payments (additional payments) made for at least 2 years, but not more than 3 years for the following drugs and biologicals:

(a) Current orphan drugs, as designated under section 526 of the Federal Food, Drugs, and Cosmetic Act;

(b) Current drugs and biological agents used for treatment of cancer;

(c) Current radiopharmaceutical drugs and biological products; and

(d) New drugs and biologic agents in instances where the item was not being paid as a hospital outpatient service as of December 31, 1996, and where the cost of the item is "not insignificant" in relation to the hospital outpatient PPS payment amount.

NOTE: The process to apply for transitional pass-through payment for eligible drugs and biological agents can be found on the CMS website: http://www.cms.hhs.gov.

(2) Separate APC payment for drugs and radiopharmaceuticals for which the median cost per line exceeds $50, with the exception of injectible and oral forms of antiemetics.

(3) Separately payable radiopharmaceuticals, drugs and biologicals classified as "specified covered outpatient drugs" for which payment was made on a pass-through basis on or before December 31, 2002, and a separate APC exists.

(4) Separate payment for new drugs and biologicals that have assigned HCPCS codes, but that do not have a reference AWP, approval for pass-through payment or hospital claims data.

(5) Drugs and biologicals that have not been eligible for pass-through status but have been receiving nonpass-through payments since implementation of the Medicare OPPS.

(6) Separate payment for new drugs, biologicals and radiopharmaceuticals enabling hospitals to begin billing for drugs and biologicals that are newly approved by the FDA, and for which a HCPCS code has not yet been assigned by the National HCPCS Alpha-Numeric Workgroup.

(7) Special APC groups that have been created to accommodate payment for new technologies. The drugs, biologicals and pharmaceuticals that are incorporated into these new technology APCs are paid separately from, and in addition to, the procedure or treatment with which they are associated yet are not eligible for transitional pass-through payment.

(8) New drugs, biologicals and devices which qualify for separate payment under OPPS, but have not yet been assigned to a transitional APC (i.e., assigned to a temporary APC for separate payment of an expensive drug or device) will be reimbursed under TRICARE standard allowable charge methodology. This allowable charge payment will continue until a transitional APC has been assigned (i.e., until CMS has had the opportunity to assign the new drug, biological or device to a temporary APC for separate payment).

NOTE: The contractors will not be held accountable for the development of transitional APC payments for new drugs, biologicals or devices.

c. Corneal tissue acquisition costs.

(1) Corneal tissue acquisition costs not packaged into the payment rate for corneal transplant surgical procedures.

(2) Separate payment will be made based on the hospital's reasonable costs incurred to acquire corneal tissue.

(3) Corneal acquisition costs must be submitted using HCPCS code V2785 (Processing, Preserving and Transporting Corneal Tissue), indicating the acquisition cost rather than the hospital's charge on the bill.

d. Costs for other procedures or services not packaged in the APC payment.

(1) Blood and blood products, including anti-hemophilic agents.

(2) Casting, splinting and strapping services.

(3) Immunosuppressive drugs for patients following organ transplant.

(4) Certain other high cost drugs that are infrequently administered.

NOTE: New APC groups have been created for these items and services, which allows separate payment.

e. Reporting Requirements for Device Dependent Procedures.

Hospitals are required to bill all device-dependent procedures using the appropriate C-codes for the devices. Following are provisions related to the required use of C-codes:

(1) Hospitals are required to report device category codes on claims when such devices are used in conjunction with procedure(s) billed and paid for under the OPPS in order to improve the claims data used annually to update the OPPS payment rates.

(2) The OCE will include edits to ensure that certain procedure codes are accompanied by an associated device category code:

(a) These edits will be applied at the HCPCS I and II code levels rather than at the APC level.

(b) They will not apply when a procedure code is reported with a modifier -73 or -74 to designate an incomplete procedure.

B. Treatment of Clinic and Emergency Departments

1. Payment groups for medical visits were constructed using level I and II HCPCS procedure codes.

2. 31 HCPCS Level I and II codes were collapsed into six groups, three each for the clinics and the emergency department. The final APC groups for clinic and emergency visits are as follows:

a. APC 0600 – Low-Level Clinic Visits

b. APC 0601 - Mid-Level Clinic Visits

c. APC 0602 – High-Level Clinic Visits

d. APC 0603 - Interdisciplinary Team Conference

e. APC 0610 – Low-Level Emergency Visits

f. APC 0611 - Mid-Level Emergency Visits

g. APC 0612 – High-Level Emergency Visits

h. APC 0620- Critical Care

(1) HCPCS code 99291 is required to report outpatient encounters in which critical care services are furnished.

(2) HCPCS code 99291 is used in place of, but not in addition to, a code for medical visit for an emergency department service.

3. It is important that each facility accurately assess the intensity, resource use, and charges for evaluation and management (E/M) services. There is interest in developing and implementing a standardized coding process for facility reporting of E/M services. This process could include the use of current HCPCS codes or the establishment of new HCPCS codes in conjunction with guidelines for facility coding.

a. Current coding used in reporting evaluation and management (E/M) services:

(1) Under OPPS, 31 codes are used to indicate visits with payment differentials for more or less intense services.

(2) The following E/M coding should be used in differentiating the level and intensity of services provided in a hospital outpatient setting (i.e., coding used in differentiating clinic and emergency visit services): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99271, 99272, 99273, 99274, 99275, 99281, 99282, 99283, 99284, 99285, and G0175.

(3) Because HCPCS Level I coding is more descriptive of practitioner than of facility services, hospitals should use HCPCS Level I coding guidelines when applicable, or crosswalk hospital coding structures to HCPCS. For example, a hospital that has 8 levels of

emergency and trauma care, depending on nursing ratios, should walk those 8 levels to the HCPCS Level I codes for emergency care.

C. Additional payments under the outpatient PPS

1. Clinical diagnostic testing (labwork)

2. Administration of infused drugs

3. Therapeutic procedures including resuscitation that are furnished during the course of an emergency visit.

4. Certain high-cost drugs, such as the expensive "clotbuster" drugs that must be given within a short period of time following a heart attack or stroke.

5. Cases that fall far outside the normal range of costs. These cases will be eligible for an outlier adjustment.

D. Payment for patients who die in the emergency department.

1. If the patient dies in the emergency department, and the patient's status is outpatient, the hospital should bill for payment under the OPPS for the services furnished.

2. If the emergency department or other physician orders the patient to the operating room for a surgical procedure, and the patient dies in surgery, payment will be made based on the status of the patient.

a. If the patient had been admitted as an inpatient, pay under the hospital DRG-based payment system.

b. If the patient was not admitted as an inpatient, pay under the outpatient PPS (an APC-based payment) for the services that were furnished.

c. If the patient was not admitted as an inpatient and the procedure designated as an inpatient-only procedure (by OPPS payment status indicator "C") is performed, the hospital should bill for payment under the OPPS for the services that were furnished on that date and should include modifier –CA on the line with the HCPCS code for the inpatient procedure. Payment for all services other than the inpatient procedure designated under OPPS by the status indicator C, furnished on the same date, is bundled into a single payment under APC 0375.

3. Billing and Payment Rules for Using New Modifier –CA-*Procedure payable only in the inpatient setting when performed emergently on an outpatient who dies prior to admission*.

a. All the following conditions must be met in order to receive payment for services billed with modifier –CA:

(1) The status of the patient is outpatient;

(2) The patient has an emergent, life-threatening condition;

(3) A procedure on the inpatient list (designated by payment status indicator C) is performed on an emergency basis to resuscitate or stabilize the patient; and

(4) The patient dies without being admitted as an inpatient.

b. If all of the conditions for payment are met, the claim should be submitted using a 13X bill type for all services that were furnished, including the inpatient procedure (e.g., a procedure designated by OPPS payment status indicator C). The hospital should include modifier –CA on the line with the HCPCS code for the inpatient procedure.

c. Payment for all services on a claim that have the same date of service as the HCPCS billed with modifier – CA is made under APC 0375. Separate payment is not allowed for other services furnished on the same date.

d. Deny claims submitted with modifier—CA appended to a HCPCS code that has a status indicator "C" if billed with other services furnished on the same date of service, providing a summary notice. Following is some suggested language for this notice: "TRICARE does not pay for this service separately since payment for it is included in our allowance for other services you received on the same day".

E. Medical Screening Examinations

1. Appropriate emergency department codes will be used for medical screening examinations including ancillary services routinely available to the emergency department in determining whether or not an emergency condition exists.

2. If no treatment is furnished, medical screening examinations would be billed with a low-level emergency department code.

F. HCPCS/Revenue Coding Required Under OPPS. Hospital outpatient departments should use the UB-92 Editor as a guide for reporting HCPCS and revenue codes under the OPPS.

G. Treatment of Partial Hospitalization Services.

1. Partial hospitalization is an intensive outpatient program of psychiatric services provided to patients in lieu of inpatient psychiatric care in a hospital outpatient department.

2. Services of physicians, clinical psychologists, clinical nurse specialists (CNSs), nurse practitioners (NPs), and physician assistants (PAs) furnished to partial hospitalization patients will continue to be billed separately as professional services and are not considered to be partial hospitalization services.

3. Payment for partial hospitalization services represents the provider's overhead costs, support staff, and the services of clinical social workers (CSWs) and occupational therapists (OTs), whose professional services are considered to be partial hospitalization services for which payment is made to the provider.

a. Hospitals will not bill the contractor for the professional services furnished by CSWs.

b. Rather, the hospital's costs associated with the services of CSWs will continue to be billed to the contractor and paid through the PHP per diem amount.

4. Per diem is the unit of payment since it defines the structure and scheduling of partial hospitalization services. The established per diem represents the median hospital cost of furnishing a day of partial hospitalization. The following are billing instructions for submission of partial hospitalization claims/services:

a. Hospitals are required to use HCPCS codes and report line item dates for their partial hospitalization services.

b. Newly established HCPCS codes for occupational therapy and training and education services have been furnished as a component of a partial hospitalization treatment program.

c. The following is a complete listing of the revenue codes and HCPCS codes that may be billed as partial hospitalization services:

FIGURE 13-2-1 REVENUE AND HCPCS LEVEL I AND II CODES USED IN BILLING FOR PARTIAL HOSPITALIZATION SERVICES FOR CY 2003

REVENUE CODE	DESCRIPTION	HCPCS LEVEL I[1] AND II CODES
250	Pharmacy	HCPCS code not required
43X	Occupational Therapy	G0129
904	Activity Therapy	G0176
905	Intensive Outpatient Services - Psychiatric	90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90845 - 90853, 90857, 90862, 90865, 90870 - 90880, and 90899
906	Intensive Outpatient Services - Chemical Dependency	
911	Psychiatric General Services	90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90845 - 90853, 90857, 90862, 90865, 90870 - 90880, and 90899
912	Partial Hospitalization Program - Less Intensive (Half-day PHP)	H0035
913	Partial Hospitalization Program - Intensive (Full-day PHP)	H0037
914	Individual Psychotherapy	90816- 90819, 90821- 90824, 90826-90829
915	Group Therapy	90849, 90853, 90857

[1] **HCPCS Level I/CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.**

FIGURE 13-2-1 REVENUE AND HCPCS LEVEL I AND II CODES USED IN BILLING FOR PARTIAL HOSPITALIZATION SERVICES FOR CY 2003 (CONTINUED)

REVENUE CODE	DESCRIPTION	HCPCS LEVEL I[1] AND II CODES
916	Family Psychotherapy	90846, 90847, 90849
918	Psychiatric Testing	96100, 96115, 96117
942	Education/Training	G0177

[1] **HCPCS Level I/CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.**

d. To bill for partial hospitalization services under the hospital outpatient PPS, hospitals are to use the above HCPCS and revenue codes and are to report partial hospitalization services under bill type 13X, along with condition code 41 on the HCFA-1450 claim form.

e. The claim must include a mental health diagnosis and an authorization on file for each day of service, along with a designated H-code (i.e., either H0035 for half-day PHP or H0037 for full-day PHP) and its accompanying revenue code, prior to assigning a full- or half-day partial hospitalization APC. Claims that do not meet the above criteria (e.g., claims filed without condition code 41 and/or appropriate H-coding - H0035 or H0037) will undergo further prepayment review to ensure that outpatient department mental health procedures do not exceed the full-day partial hospitalization per diem amount; i.e., the sum of the individual mental health APC amounts on any particular day does not exceed the full-day partial hospitalization per diem amount. The following are basic reporting requirements for assigning full- and half-day partial hospitalization APCs:

Reporting Requirements for PHP:

- Bill Type 13x
- Mental Health (MH) Diagnosis
- Condition code 41 (yes/no)
  - ***Yes***
    - Authorization on File
      - Yes
        - H0035/RC 912 - APC xxxx (half-day PHP)
        - H0037/RC 913 - APC 0033 (full-day PHP)
      - ***No*** - deny claim
  - ***No*** (Bill Type 12x, 13x, 14x without condition code 41)
    - Sum of Mental Health APCs >PHP APC 0033 payment amount on a given day (yes/no)
      - ***Yes***
        - Assign daily MH service payment APC 0034
        - Package all other MH services

➢ Apply standard APC payment rule to non-MH services

➢ ***No*** - Apply standard APC payment rules

(1) Each day of service will be assigned to a partial hospitalization APC, and the partial hospitalization per diem amount will be paid.

(2) Specific therapy codes (e.g., coding for family, group and individual psychotherapy) will be reported in addition to designated partial hospitalization codes H0035 and H0037 (refer to Figure 13-2-1 above for specific therapy coding). Specific mental health (MH) services will be packaged into a single PHP code for the same date of service with the exception of electroconvulsive therapy (ECT).

(3) Only one PHP APC will be paid per day.

(a) If multiples of the same H-code (either H0035 or H0037 but not both) appear on the claim for the same date of service, the first H-code will be designated for APC assignment and all other specific therapy codes will be packaged into the H-code line for remittance reporting.

(b) If both H-codes (H0035 and H0037) appear on the claim for the same date of service, payment will default to the less intensive treatment modality (half-day PHP); i.e., H0035 will be recognized for payment. Other therapy codes reported on the same date of service will be packaged into the less intensive H-code for remittance reporting.

(4) Non-mental health services submitted on the same day will be processed and paid separately.

(5) Revenue codes 912 and 913 must be accompanied by an appropriately designated HCPCS code (refer to Figure 13-2-1 for designated PHP coding). If revenue codes 912 and 913 are submitted without a HCPCS, assign status indicator E and edit 48 ("revenue center requires HCPCS) which will result in claim denial.

(6) Claims that include days that do not meet the above requirements for assignment to a partial hospitalization APC will be identified for further review.

(7) The total amount payable for psychiatric services furnished in a hospital outpatient department (not under the partial hospitalization program) for an individual for one day will be limited to the APC per diem payment amount for full-day partial hospitalization.

(8) Half-day PHP per diem will be priced at 75 percent of the full-day PHP rate.

5. Freestanding psychiatric partial hospitalization services will continue to be reimbursed under all-inclusive per diem rates established under Chapter 7, Section 2 of this manual.

H. Billing and Payment Requirements for Observation Services.

1. General Billing Requirements

Under the OPPS, hospitals are required to bill for observation services in one of two ways:

a. As packaged services, or

b. As a separately payable APC when certain conditions are met for patients having diagnoses of chest pain, asthma, congestive heart failure or maternity, for which observation services are furnished. (Refer to Chapter 2, Section 3.3 of the TRICARE Policy Manual for additional information on observation stays).

2. Observation Stays with Diagnoses of Chest Pain, Asthma or Congestive Heart Failure.

a. Hospital billing requirements to receive separate payment for observation services furnished with diagnosis of asthma, chest pain, or congestive heart failure (CHF):

(1) To bill for separate payment, hospitals should report HCPCS code G0244, *Observation care provided by a facility with CHF, chest pain, or asthma, minimum eight hours*.

(2) Admission requirements to bill for separate observation payments – Hospitals must bill: 1) an emergency department visit; 2) a clinic visit; or 3) a critical care visit; or 4) 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, with each bill for separate observation payment using HCPCS G0244*.

(a) To receive separate payment for G0244, hospitals must bill an Evaluation/Management (E/M) code for an emergency room visit, a clinic visit or critical care on the day before or the day that the patient is admitted to observation.

1 If hospitals bill for more than one period of observation on a single claim, each observation period must be paired with a separate E/M visit.

2 Hospitals must bill the E/M code associated with observation on the same claim as the observation service.

3 Hospitals must use modifier -25 with the E/M code in order to receive payment for G0244.

(3) When billing for separate payment for observation services using HCPCS code G0244, hospitals must include at least one of the ICD-9-CM diagnoses listed in Figure 13-2-2 through Figure 13-2-4 on the bill as the admitting, primary, or secondary diagnosis:

FIGURE 13-2-2 REQUIRED DIAGNOSES FOR CHEST PAIN

ICD-9-CM	DESCRIPTION
411.0	Postmyocardila 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	Pinzmetal 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

FIGURE 13-2-3 REQUIRED DIAGNOSES FOR ASTHMA

ICD-9-CM	DESCRIPTION
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

FIGURE 13-2-4 REQUIRED DIAGNOSES FOR CONGESTIVE HEART FAILURE

ICD-9-CM	DESCRIPTION
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

FIGURE 13-2-4 REQUIRED DIAGNOSES FOR CONGESTIVE HEART FAILURE (CONTINUED)

ICD-9-CM	DESCRIPTION
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
428.20	Unspecified systolic heart failure
428.21	Acute systolic heart failure
428.22	Chronic systolic heart failure
428.23	Acute or chronic systolic heart failure
428.30	Unspecified diastolic heart failure
428.31	Acute diastolic heart failure
428.32	Chronic diastolic heart failure
428.33	Acute or chronic diastolic heart failure
428.40	Unspecified combined systolic and diastolic heart failure
428.41	Acute combined systolic and diastolic heart failure
428.42	Chronic combined systolic and diastolic heart failure
428.43	Acute or chronic combined systolic and diastolic heart failure
428.9	Heart failure, unspecified

(4) Additional billing requirements.

(a) In order to receive payment for G0244, hospitals must bill observation services for a minimum of 8 hours. In billing for observation services, hospitals should enter as units of service for G0244 the number of hours the patient spends in observation.

1 Hospitals should not use G0244 to bill for observation services of less than 8 hours. Observation services of less than 8 hours should be billed as packaged services using revenue code 762, as explained above.

2 If a period of observation spans more than one calendar day, hospitals should include all of the hours for the entire period of observation on a single line and enter as the date of service for that line the date the patient is admitted to observation.

3 Observation time begins at the clock time appearing on the nurse's observation admission note, which should coincide with the initiation of observation care or with the time of the patient's arrival in the observation unit.

4 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 should coincide with the end of the patient's period of monitoring or treatment in observation.

(b) The medical record must document that the beneficiary was under the care of a physician during the period of observation, as indicated by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.

(c) Requirements Affecting Separate Payment for Observation Services Furnished to Patients with Diagnosis of Asthma, Chest Pain, or Congestive Heart Failure

1 Allow separate payment for observation services that meet the required conditions only when billed on a 13X bill type.

2 Pay separately for any service that is separately payable under the OPPS; that is, procedures with status indicators S, X, K, G, V, or H, when billed with G0244.

3 Payment for G0244 is not allowed if a surgical procedure, or any service that has a status indicator of "T" (with the exception of Q0081) occurs on the day before or the day that the patient is admitted to observation.

4 If there are multiple observation stays on the same day without condition code G0 to indicate that the visits were distinct and independent of each other, pay for the first listed observation stay and deny the rest; i.e., line item denial for all subsequent observation stays listed on that particular day.

5 Do not allow separate payment for any hours a beneficiary spends in observation over 24 hours; all costs beyond 24 hours will be included in the APC payment for observation services.

6 If all criteria for G0244 are not met, the claim will be denied and returned to the provider. The hospital should resubmit the claim reporting the observation services under revenue code 762 alone, or with codes 99217 through 99220 or 99234 through 99236.

(d) The previous requirement for specific diagnostic testing for coverage/reimbursement of observation stays was removed. Instead clinical judgment, in combination with an internal and external quality review process, will be relied upon to ensure that appropriate diagnostic testing (which is expected to include some of the previously required diagnostic tests) is provided for patients receiving high quality medically necessary observation care.

b. Direct Admissions to Observation

(1) Hospitals may bill for patients who are "direct admissions" to observation. A "direct admission" occurs when a physician in the community refers a patient to the hospital for observation, bypassing the clinic or emergency department (ED). Hospitals may bill for a patient directly admitted for observation services using one of the following HCPCS codes:

(a) G0263 – Direct admission of patient with diagnosis of congestive heart failure, chest pain or asthma for observation services that meet all criteria for G0244.

(b) 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 the diagnosis of congestive heart failure, chest pain or asthma when the observation stay does not meet all criteria for G0244.

(2) The determination of whether use of G0263 is appropriate will be made after reviewing all diagnoses submitted on the claim (e.g., admission, principal, and secondary diagnoses).

(3) Code G0263 must be billed with G0244. Although code G0263 is treated as a packaged service and will not generate a payment under OPPS, the code will be recognized as taking the place of a visit or critical care code in meeting the observation criteria for patients directly admitted to observation and its charges will be packaged. Modifier -25 must be used with G0263 in order to receive payment for G0244.

(4) Code G0264 should not be billed with G0244. G0264 is paid the same amount as a low-level clinic visit. This code provides a way to recognize and pay for the initial nursing assessment and any packaged observation services attributable to patients that are directly admitted to observation but whose observation services do not meet the criteria necessary to qualify for a separate observation payment.

(5) Hospitals should bill G0263 and G0264 with revenue code 762.

3. Observation Stays with Maternity Diagnosis.

a. To bill for maternity observation stays, hospitals are to use Level I HCPCS[1] codes available for hospital observation services (99218 – 99220). The observation coding will be reported with revenue code 762 on the HCFA-1450 (UB-92) using bill type 13x.

[1] HCPCS Level I/CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

b. The new maternity observation APC will be assigned to the Level I HCPCS[2] observation code (99218 – 99220) if the stay is for a minimum of 4 hours and accompanied with one of the required maternity diagnoses in Figure 13-2-5. The observation stay will be reimbursed at the new maternity observation APC rate adjusted for geographical wage differences.

FIGURE 13-2-5 REQUIRED DIAGNOSES FOR MATERNITY

ICD-9-CM	DESCRIPTION
V22.0	Supervision of normal first pregnancy
V22.1	Supervision of other normal pregnancy
V22.2	Pregnant state, incidental
V23.0	Pregnancy with history of infertility
V23.1	Pregnancy with history of trophoblastic disease
V23.2	Pregnancy with history of abortion
V23.3	Grand multiparty
V23.41	Pregnancy with history of pre-term labor
V23.49	Pregnancy with other poor obstetric history
V23.5	Pregnancy with other poor reproductive history
V23.7	Insufficient prenatal care
V23.81	Elderly primigravida
V23.82	Elderly multigravida
V23.83	Young primigravida
V23.84	Young multigravida
V23.89	Other high-risk pregnancy
V23.9	Unspecified high-risk pregnancy
630	Hydatidiform mole
631	Other abnormal production of conception
632	Missed abortion
633.00	Abdominal pregnancy without intrauterine pregnancy
633.01	Abdominal pregnancy with intrauterine pregnancy
633.10	Tubal pregnancy without intrauterine pregnancy
633.11	Tubal pregnancy with intrauterine pregnancy
633.20	Ovarian pregnancy without intrauterine pregnancy
633.21	Ovarian pregnancy with intrauterine pregnancy

[2] HCPCS Level I/CPT codes, descriptions and other data only are copyright 2005 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

FIGURE 13-2-5 REQUIRED DIAGNOSES FOR MATERNITY (CONTINUED)

ICD-9-CM	DESCRIPTION
633.80	Other ectopic pregnancy without intrauterine pregnancy
633.81	Other ectopic pregnancy with intrauterine pregnancy
633.90	Unspecified ectopic pregnancy without intrauterine pregnancy
633.91	Unspecified ectopic pregnancy with intrauterine pregnancy
640.0	Threatened abortion
640.8	Other specified hemorrhage in early pregnancy
640.9	Unspecified hemorrhage in early pregnancy
641.0	Placenta previa without hemorrhage
641.1	Hemorrhage from placenta previa
641.2	Premature separation of placenta
641.3	Antepartum hemorrhage associated with coagulation defects
641.8	Other antepartum hemorrhage
641.9	Unspecified antepartum hemorrhage
642.0	Benign essential hypertension complicating pregnancy, childbirth and the puerperium
642.1	Hypertension secondary to renal disease, complicating pregnancy, childbirth and the puerperium
642.2	Other pre-existing hypertension complicating pregnancy, childbirth and the puerperium
642.3	Transient hypertension of pregnancy
642.4	Mild or unspecified pre-eclampsia
642.5	Severe pre-eclampsia
642.6	Eclampsia
642.7	Pre-eclampsia or eclampsia superimposed on pre-existing hypertension
642.9	Unspecified hypertension complicating pregnancy, childbirth or the puerperium
643.0	Mild hyperemesis gravidarum
643.1	Hyperemesis gravidarum with metabolic disturbance
643.2	Late vomiting of pregnancy
643.8	Other vomiting complication pregnancy
643.9	Unspecified vomiting of pregnancy
644.0	Threatened premature labor
644.1	Other threatened labor

FIGURE 13-2-5 REQUIRED DIAGNOSES FOR MATERNITY (CONTINUED)

ICD-9-CM	DESCRIPTION
644.2	Early onset of delivery
645.1	Post-term pregnancy
645.2	Prolonged pregnancy
646.0	Papyraceous fetus
646.1	Edema or excessive weight gain in pregnancy, without mention of hypertension
646.2	Unspecified renal disease in pregnancy, without mention of hypertension
646.3	Habitual aborter
646.4	Peripheral neuritis in pregnancy
646.5	Asymptomatic bacteriuria in pregnancy
646.6	Infections of genitourinary tract in pregnancy
646.7	Liver disorders in pregnancy
646.8	Other specified complications of pregnancy
646.9	Specified complication of pregnancy
647.0	Syphilis
647.1	Gonorrhea
647.2	Other venereal diseases
647.3	Tuberculosis
647.4	Malaria
647.5	Rubella
647.6	Other viral diseases
647.8	Other specified infectious and parasitic diseases
648.0	Diabetes mellitus
648.1	Thyroid dysfunction
648.2	Anemia
648.3	Drug dependence
648.4	Mental disorders
648.5	Congenital cardiovascular disorder
648.6	Other cardiovascular diseases
648.7	Bone and joint disorders of back, pelvis, and lower limbs
648.8	Abnormal glucose tolerance
649.9	Other current conditions classifiable elsewhere

FIGURE 13-2-5 REQUIRED DIAGNOSES FOR MATERNITY (CONTINUED)

ICD-9-CM	DESCRIPTION
651.0	Twin pregnancy
651.1	Triplet pregnancy
651.2	Quadruplet pregnancy
651.3	Twin pregnancy with fetal loss and retention of one fetus
651.4	Triplet pregnancy with fetal loss and retention of one or more fetus(es)
651.5	Quadruplet pregnancy with fetal loss and retention of one or more fetus(es)
651.6	Other multiple pregnancy with fetal loss and retention of one or more fetus(es)
651.8	Other unspecified multiple gestation
651.9	Unspecified multiple gestation
655.0	Central nervous system malformation in fetus
655.1	Chromosomal abnormality in fetus
655.2	Hereditary disease in family possibly affecting fetus
655.3	Suspected damage to fetus from viral disease in the mother
655.4	Suspected damage to fetus from other disease in the mother
655.5	Suspected damage to fetus from drugs
655.6	Suspected damage to fetus from radiation
655.7	Decrease fetal movement
655.8	Other known or suspected fetal abnormality, not elsewhere classified
655.9	Unspecified
656.0	Fetal-maternal hemorrhage
656.1	Rhesus isoimmunization
656.2	Isoimmunization from other and unspecified blood-group incompatibility
656.3	Fetal distress
656.4	Intrauterine death
656.5	Poor fetal growth
656.6	Excessive fetal growth
656.7	Other placental conditions
656.8	Other specified fetal and placental problems
656.9	Unspecified fetal and placental problem
657	Polyhydramnios
658.0	Oligohydraminos

FIGURE 13-2-5 REQUIRED DIAGNOSES FOR MATERNITY (CONTINUED)

ICD-9-CM	DESCRIPTION
658.1	Premature rupture of membranes
658.2	Delayed delivery after artificial rupture of membranes
658.3	Delayed delivery after artificial rupture of membranes
658.4	Infection of amniotic cavity
658.8	Other
658.9	Unspecified

c. If an observation stay is less than 4 hours its services will not be paid separately.

d. If there are multiple observation stays on the same day without condition code G0 to indicate that the visits were distinct and independent of each other, pay for the first listed observation stay and deny the rest; i.e., line item denial for all subsequent observation stays listed on that particular day.

e. Medical review is no longer required for observation stays longer than 24 hours.

4. All other observation stays will be packaged under the primary procedure.

l. Inpatient Only Procedures

1. Under the hospital outpatient PPS, payment will not be made for procedures that are designated as "inpatient only" (list of "inpatient only" procedures found in Addendum D).

2. The list will be updated in response to comments as often as quarterly to reflect current advances in medical practice.

3. On rare occasions, a procedure on the inpatient list must be performed to resuscitate or stabilize a patient with an emergent, life-threatening condition whose status is that of an outpatient and the patient dies before being admitted as an inpatient.

a. Hospitals are instructed to submit an outpatient claim for all services furnished, including the procedure code with status indicator "C" to which a newly designated modifier (-CA) is attached.

b. Such patients would typically receive services such as those provided during a high-level emergency visit, appropriate diagnostic testing (X-ray, CT scan, EKG, and so forth) and administration of intravenous fluids and medication prior to the surgical procedure.

c. Because these combined services constitute an episode of care, claims will be paid with a procedure code on the inpatient list that is billed with the new modifier under new technology APC 0375. Separate payment will not be allowed for other services furnished on the same date.

d. The –CA modifier is not to be used to bill for a procedure with status indicator "C" that is performed on an elective basis or scheduled to be performed on a patient whose status is that of an outpatient.

- END -