DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

News Flash –When billing Medicare, Home Health Agencies (HHAs) must use the individual National Provider Identifier (NPI) of the physician who orders/refers services, not the NPI of the physician's group practice. If an HHA asks for your NPI, be sure to provide your individual NPI. Don't know your individual NPI? You may verify your NPI on the NPI Registry on the CMS website.

MLN Matters® Number: MM8031

Related Change Request (CR) #: CR 8031

Related CR Release Date: August 24, 2012

Effective Date: October 1, 2012

Related CR Transmittal #: R2531CP

Implementation Date: October 1, 2012

October 2012 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers who submit claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries and paid under the Outpatient Prospective Payment System (OPPS).

Provider Action Needed

This article is based on Change Request (CR) 8031 which describes changes to the OPPS to be implemented in the October 2012 update. Be sure your billing staffs are aware of these changes.

Background

Change Request (CR) 8031 describes changes to and billing instructions for various payment policies implemented in the October 2012 Outpatient Prospective Payment System (OPPS) update. The October 2012 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS

Modifier, Status Indicator (SI), and Revenue Code additions, changes, and deletions identified in this notification.

Note that the October 2012 revisions to I/OCE data files, instructions, and specifications are provided in CR8035, "October 2012 Integrated Outpatient Code Editor (I/OCE) Specifications Version 13.3." Upon release of CR8035, an MLN Matters® article will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8031.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

The key changes in the October 2012 update to the hospital OPPS are as follows:

Outpatient Payment for Laparoscopic Bariatric Surgery

A revision is being made in the "Medicare Claims Processing Manual" (Chapter 32, Section 150.8) to indicate that, effective January 1, 2012, laparoscopic bariatric surgery procedures described by Current Procedural Terminology (CPT) code 43770 (Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)) are payable when performed in hospital outpatient departments.

Billing for Drugs, Biologicals, and Radiopharmaceuticals

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective October 1, 2012

In the Calendar Year (CY) 2012 OPPS/Ambulatory Surgical Center (ASC) final rule with comment period (see http://www.gpo.gov/fdsys/pkg/FR-2011-11-30/pdf/2011-28612.pdf on the Internet), CMS stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the October 2012 release of the OPPS PRICER. The updated payment rates, effective October 1, 2012, will be included in the October 2012 update of the OPPS Addendum A and Addendum B, which are posted at http://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html on the CMS website.

b. Drugs and Biologicals with OPPS Pass-Through Status

Effective October 1, 2012, two drugs and biologicals have been granted OPPS pass-through status. These items, along with their descriptors and APC assignments, are identified in Table 1 below.

Table 1 – Drugs and Biologicals with OPPS Pass-Through Status Effective October 1, 2012

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 10/1/12
C9292	Injection, pertuzumab, 10 mg	9292	G
C9293	Injection, glucarpidase, 10 units	9293	G

c. Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2012, through September 30, 2012

The payment rates for three HCPCS codes were incorrect in the July 2012 OPPS PRICER. The corrected payment rates are listed in Table 2 below and have been installed in the October 2012 OPPS PRICER, effective for services furnished on July 1, 2012, through implementation of the October 2012 update. Note that your Medicare contractor will, if you request it, adjust claims for these services where the dates of service are on or after July 1, 2012, but prior to October 1, 2012, and where the incorrect payment rates were applied.

Table 2 – Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2012 through September 30, 2012

HCPCS Code	Status Indicator (SI)	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9368	G	9368	Grafix core	$160.66	$31.53
C9369	G	9369	Grafix prime	$51.84	$10.17
Q2045	K	1414	Human fibrinogen conc inj	$0.89	$0.18

CY 2012 Transitional Outpatient Payments (TOPs)

Section 5105 of the Deficit Reduction Act of 2005 (DRA) extended hold harmless transitional outpatient payments (TOPs) through December 31, 2008, for rural hospitals having 100 or fewer beds that are not sole community hospitals (SCHs). Hospitals received 95 percent of the hold harmless amount for services furnished in CY 2006, 90 percent in CY 2007, and 85 percent in CY 2008. Section 147 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) extended the hold harmless provision for small rural hospitals with 100 or fewer beds through December 31, 2009, at 85 percent of the hold harmless amount. Section 147 also provided 85 percent of the hold harmless amount from January 1, 2009 through December 31, 2009, to SCHs with 100 or fewer beds, per CR 6320, Transmittal 1657.

Section 3121 of the Affordable Care Act extended the hold harmless provision for small rural hospitals with 100 or fewer beds through December 31, 2010, at 85 percent of the hold harmless amount. Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs) are no longer limited to those with 100 or fewer beds effective January 1, 2010 through December 31, 2010, and these providers will receive TOPs payments at 85 percent of the hold harmless amount through December 31, 2010. (Note: EACHs are considered SCHs for purposes of the TOPs adjustment.) Cancer and children's hospitals are permanently held harmless under section 1833(t)(7)(D)(ii) of the Social Security Act.

Section 108 of the Medicare and Medicaid Extenders Act of 2010 (MEA) extends the Outpatient Hold Harmless provision from January 1, 2011 through December 31, 2011 for rural hospitals with 100 or fewer beds at 85 percent of the hold harmless amount, and to all SCHs and EACHs regardless of bed size at 85 percent of the hold harmless amount from January 1, 2011 through December 31, 2011.

Section 308 of the Temporary Payroll Tax Cut Continuation Act of CY 2011 as amended by section 3002 of the Middle Class Tax Relief and Jobs Creation Act, extended through December 31, 2012, the hold harmless provision for a rural hospital with 100 or fewer beds at 85 percent of the hold harmless amount. Section 308 of the Temporary Payroll Tax Cut Continuation Act of CY 2011 also extended through February 29, 2012 the hold harmless provision to SCH and EACHs, without the bed size limitation at 85 percent of the hold harmless amount. Section 3002 of the Middle Class Tax Relief and Jobs Creation Act extended through December 31, 2012 the hold harmless provision to SCHs and EACHs that have no more than 100 beds at 85 percent of the hold harmless amount.

For CY 2012, small rural hospitals with 100 or fewer beds and sole community hospitals (and essential access community hospitals) with 100 or fewer beds remain eligible for a TOPS adjustment. Cancer and children's hospitals continue to receive hold harmless TOPs permanently.

Additional Information

The official instruction, CR8031 issued to your FIs and A/B MACs regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2531CP.pdf on the CMS website.

If you have any questions, please contact your FIs and A/B MACs at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.