DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

The ICD-10 Medicare Severity Diagnosis Related Grouper (MS-DRG), version 30.0 (FY 2013) mainframe and PC software is now available. This software is being provided to offer the public a better opportunity to review and comment on the ICD-10 MS-DRG conversion of the MS-DRGs. This software can be ordered through the National Technical Information Service (NTIS) website. A link to NTIS is also available in the Related Links section of the ICD-10 MS-DRG Conversion Project website. The final version of the ICD-10 MS-DRGs will be subject to formal rulemaking and will be implemented on October 1, 2015.

MLN Matters® Number: MM8228

Related Change Request (CR) #: CR 8228

Related CR Release Date: March 1, 2013

Effective Date: April 1, 2013

Related CR Transmittal #: R169BP and R2664CP

Implementation Date: April 1, 2013

April 2013 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), Regional Home Health Intermediaries (RHHIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for services subject to the Outpatient Prospective Payment System (OPPS) provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8228 which describes changes to the Outpatient Prospective Payment System (OPPS) to be implemented in the April 2013 OPPS update. CR8228 describes changes to and billing instructions for various payment policies implemented in the April 2013 OPPS update. The April 2013 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding

System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR 8228. Make sure that your billing staffs are aware of these changes.

Background

Change Request (CR) 8228 describes changes to and billing instructions for various payment policies implemented in the April 2013 OPPS update. The April 2013 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR 8228.

The April 2013 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming April 2013 I/OCE CR which is CR8242. Upon release of CR8242, a related MLN Matters® Article can be found at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8242.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

Key changes to and billing instructions for various payment policies implemented in the April 2013 OPPS update are as follows:

Changes to Device Edits for April 2013

The most current list of device edits can be found under "Device, Radiolabeled Product, and Procedure Edits" at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/** on the CMS website. Failure to pass these edits will result in the claim being returned to the provider.

New Services

New services listed in Table 1 below (also included in Attachment A, CR 8228) are assigned for payment under the OPPS, effective April 1, 2013.

Table 1 – New Services Payable under OPPS Effective April 1, 2013

HCPCS	Effective date	Status Indicator (SI)	APC	Short Descriptor	Long descriptor	Payment	Minimum Unadjusted Copayment
C9734	4/01/2013	S	0067	U/S trtmt, not leiomyomata	Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with or without magnetic resonance (MR) guidance	$3,300.64	$660.13

HCPCS	Effective date	Status Indicator (SI)	APC	Short Descriptor	Long descriptor	Payment	Minimum Unadjusted Copayment
C9735	4/01/2013	T	0150	Anoscopy, submucosal inj	Anoscopy; with directed submucosal injection(s), any substance	$2,365.97	$473.20

Note: HCPCS code C9735 describes the administration/injection procedure for Solesta and should only be reported with HCPCS code L8605 (Injectable bulking agent dextranomer/hyaluronic acid copolymer implant, anal canal, 1 ml, includes shipping and necessary supplies).

Payment Reduction for Single Session Cobalt-60 Based Stereotactic Radiosurgery (SRS)

Section 634 of the American Taxpayer Relief Act of 2012 (see **http://www.gpo.gov/fdsys/pkg/BILLS-112hr8enr/pdf/BILLS-112hr8enr.pdf**) requires that effective April 1, 2013, CMS reduce the payment amount for Cobalt-60 based Stereotactic Radiosurgery (SRS) described by Current Procedural Terminology (CPT) code 77371 to an amount equal to the payment amount for the linear accelerator based SRS procedure described by HCPCS code G0173. This requirement does not apply to rural hospitals, as defined in sections 1886 (d)(2)(D) and 1866(d)(5)(C), or to sole community hospitals, as defined in section 1886 (d)(5)(D)(iii) of the Social Security Act. (See **http://www.ssa.gov/OP_Home/ssact/title18/1886.htm** on the Internet.)

In Addendum B of the Calendar Year (CY) 2013 OPPS/ASC final rule (see **http://www.gpo.gov/fdsys/pkg/FR-2012-11-15/pdf/2012-26902.pdf**) that was published on the CMS website on November 1, 2012, CPT code 77371 was assigned to APC 0127 (Level IV Stereotactic Radiosurgery, MRgFUS, and MEG) and HCPCS code G0173 to APC 0067 (Level III Stereotactic Radiosurgery, MRgFUS, and MEG) effective January 1, 2013. Consistent with the requirements set forth in section 634 of the American Taxpayer Relief Act of 2012, CPT code 77371 will remain in APC 0127 but the payment rate for the procedure will be reduced to equal the payment rate for APC 0067 effective April 1, 2013 (except in rural and sole community hospitals), where the payment rate will remain at the APC 0127 level). The OPPS PRICER will provide the appropriate payment rate for CPT code 77371 based on the site of service of where the procedure is performed. Table 2 below (also included in Attachment A, CR8228) shows the APC assignment and payment rate for CPT code 77371 and HCPCS code G0173 effective April 1, 2013.

Table 2 – OPPS APC and Payment Rate for 77371 and G0173

CPT/HCPCS Code	Long Descriptor	April 2013 APC	April 2013 Payment Rate	
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based	0127	Rural Hospitals and other excepted hospitals	All other Hospitals
			$7,911	$3,301
G0173	Linear accelerator based stereotactic radiosurgery, complete course of therapy in one session	0067	$3,301	

Inpatient Telehealth Pharmacologic Management (HCPCS Code G0459)

Effective January 1, 2013, CMS established HCPCS code G0459 to track remotely-delivered inpatient pharmacologic management services provided to patients with mental disorders in rural hospitals. HCPCS code G0459 is paid under the Medicare Physician Fee Schedule and assigned to OPPS status indicator "B" to indicate that the code is not recognized by OPPS when submitted on an outpatient hospital Part B bill type.

HCPCS code G0459 did not appear in Addendum B of the CY 2013 OPPS/ASC final rule that was published on the CMS website on November 1, 2012. Therefore, CMS is providing the short and long descriptors, as well as the OPPS status indicator, for this service in Table 3 below (also included in Attachment A, CR 8228).

Table 3 – New Inpatient Telehealth Pharmacologic Management HCPCS Code

HCPCS Code	Short Descriptor	Long Descriptor	SI	APC
G0459	Telehealth inpt pharm mgmt	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy	B	N/A

Billing for Drugs, Biologicals, and Radiopharmaceuticals

Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective April 1, 2013

In the CY 2013 OPPS/ASC final rule with comment period, 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 April 2013 release of the OPPS Pricer. The updated payment rates, effective April 1, 2013 will be included in the April 2013 update of the OPPS Addendum A and Addendum B, which will be posted on the CMS website.

Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2013

Five drugs and biologicals have been granted OPPS pass-through status effective April 1, 2013. These items, along with their descriptors and APC assignments, are identified in Table 4 below (also included in Attachment A, CR 8228).

Table 4 – Drugs and Biologicals with OPPS Pass-Through Status

Effective April 1, 2013

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 4/1/13
C9130*	Injection, immune globulin (Bivigam), 500 mg	9130	G
C9297*	Injection, omacetaxine mepesuccinate, 0.01 mg	9297	G
C9298*	Injection, ocriplasmin, 0.125 mg	9298	G
J7315	Mitomycin, ophthalmic, 0.2 mg	1448	G
Q4127	Talymed, per square centimeter	1449	G

Note: The HCPCS codes identified with an "*" indicate that these are new codes effective April 1, 2013.

Additional Information on HCPCS Code C9298 (Injection, Ocriplasmin, 0.125 mg):

Jetrea (ocriplasmin) is packaged in a sterile, single-use vial containing 0.5 mg ocriplasmin in a 0.2 mL solution for intravitreal injection (2.5 mg/mL). As approved by the FDA, the recommended dose for Jetrea (NDC 24856-0001-00) is 0.125 mg. Use of the contents of an entire single-use vial to obtain one recommended dose for one eye of one patient per the FDA-approved label would result in reporting 4 units of C9298 on a claim.

In addition, as indicated in 42 CFR 414.904 (See **http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=769ce9ced61112db9a3240a3f403e23c&rgn=div8&view=text&node=42:3.0.1.1.1.11.1.3&idno=42**), CMS calculates an average sales price (ASP) payment limit based on the amount of product included in a vial or other container as reflected on the FDA-approved label, and any additional product contained in the vial or other container does not represent a cost to providers and is not incorporated into the ASP payment limit. In addition, no payment is made for amounts of product in excess of that reflected on the FDA-approved label.

Additional Information Related to HCPCS Code J7315 (Mitomycin, ophthalmic, 0.2 mg):

HCPCS Code J7315 should only be used for Mitosol and should not be used for compounded mitomycin or other forms of mitomycin.

Flucelvax (Influenza virus vaccine)

Flucelvax (Influenza virus vaccine) was approved by the FDA on November 20, 2012. Although this vaccine recently received FDA approval, CPT code 90661, which was established by the CPT Editorial Panel effective January 1, 2008, describes Flucelvax. Since January 1, 2008, CPT code 90661 has been assigned to OPPS status indicator "E" (Not Covered by Medicare) because the product associated with this code had not received FDA approval until recently. CMS is revising the OPPS status indicator for CPT code 90661 from "E" to "L" (Influenza Vaccine; Pneumococcal Pneumonia Vaccine) effective November 20, 2012. This change will be reflected in the April 2013 I/OCE. Table 5 below (also included in Attachment A, CR 8228), provides the descriptors and OPPS status indicator for CPT code 90661.

Table 5 – Flucelvax Flu Vaccine OPPS Status Indicator

HCPCS Code	Short Descriptor	Long Descriptor	APC	SI Effective 11/20/12
90661	Flu vacc cell cult prsv free	Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use	N/A	L

Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2013, through March 31, 2013

The payment rates for two HCPCS codes: J9263 and Q4106 were incorrect in the January 2013 OPPS Pricer. The corrected payment rates are listed in Table 6 below (also included in Attachment A, CR 8228), and they have been installed in the April 2013 OPPS Pricer, effective for services furnished on January 1, 2013, through March 31, 2013. Your contractor will adjust any claims previously processed with the incorrect rates if you bring such claims to the attention of your contractor.

Table 6 – Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2013 through March 31, 2013

HCPCS Code	SI	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J9263	K	1738	Oxaliplatin	$3.95	$0.79
Q4106	K	1245	Dermagraft	$42.55	$8.51

Changes to OPPS Pricer logic

Effective April 1, 2013, the OPPS Pricer will respond to hospital billed lines that contain the stereotactic radiosurgery services reimbursed under APC 0127 and reduce the reimbursement to APC 0067, unless the hospital is exempted by statute. OPPS Pricer will apply the reduction of reimbursement to line item payment before applying coinsurance logic so that coinsurance is based on the payment amount remaining after the reduction.

Coverage Determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Fiscal Intermediaries (FIs)/Medicare Administrative Contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, FIs/MACs determine if it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Update to the Medicare Benefit Policy Manual

CR8228 updates the reference link in the "Medicare Benefit Policy Manual," Chapter 6, Sections 20.5.2 and 20.7, to the list of hospital outpatient therapeutic services that may be furnished under general supervision or are defined as non-surgical extended duration therapeutic services (NSEDTS). The updated link is **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html** on the CMS website. The revised list of services reflects changes in the required supervision level for certain services in 2012 and 2013, based upon the recommendations of the Hospital Outpatient Payment Panel.

Additional Information

The official instruction, CR 8228 issued to your FIs, RHHIs, and A/B MACs regarding this change via two transmittals. The first updates the "Medicare Benefit Policy Manual" and it is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R169BP.pdf** on the CMS website. The second updates the "Medicare Claims Processing Manual" and it is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2664CP.pdf** on the CMS website

If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.