DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Revised product from the Medicare Learning Network® (MLN)

- **"Medicare Coverage of Imaging Services" Fact Sheet, ICN 907164, downloadable**

MLN Matters® Number: MM8572	**Related Change Request (CR) #: CR 8572**
Related CR Release Date: December 27, 2013	**Effective Date: January 1, 2014**
Related CR Transmittal #: R2845CP	**Implementation Date: January 6, 2014**

January 2014 Update of the Hospital Outpatient Prospective Payment System (OPPS)

This article was revised on March 25, 2014, to add a reference to MLN Matters® article SE1412 (**http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE1412.pdf**) which contains updated requirements for changes in the OPPS being implemented in the January 2014 update. The guidance updates the operational mechanism that outpatient hospitals should use to bill Medicare beginning July 1, 2014, for outpatient clinical diagnostic laboratory tests furnished in calendar year 2014 that are eligible for separate payment under the clinical laboratory fee schedule (CLFS). All other information is unchanged.

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors A 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) 8572 which describes changes to the OPPS to be implemented in the January 2014 update. Make sure your billing staff is aware of these changes.

Background

Change Request (CR) 8572 describes changes to and billing instructions for various payment policies implemented in the January 2014 OPPS update. Most of these policies are also outlined in the Calendar Year (CY) 2014 OPPS/ASC final rule. The January 2014 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 8572.

The January 2014 revisions to I/OCE data files, instructions, and specifications are provided in CR8548. The MLN Matters® Article related to CR8548 is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8548.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

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

Changes to Device Edits for January 2014

The most current list of device edits can be found under "Device 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.

No Cost/ Full Credit and Partial Credit Devices

Effective January 1, 2014, CMS will no longer recognize in the OPPS the FB or FC modifiers to identify a device that is furnished without cost or with a full or partial credit. Also effective January 1, 2014, for claims with APCs that require implantable devices and have significant device offsets (greater than 40%), the amount of the device credit will be specified in the amount portion for value code “FD” (Credit Received from the Manufacturer for a Replaced Medical Device) and will be deducted from the APC payment for the applicable procedure. The OPPS payment deduction for the applicable APCs referenced above will be limited to the total amount of the device offset when the FD value code appears on a claim. The offset amounts for the above referenced APCs are available at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/** on the CMS website.

New Services

One new service listed in Table 1 below is assigned for payment under the OPPS, effective Jan. 1, 2014.

Table 1 – New Services Payable under OPPS Effective January 1, 2014

HCPCS	Effective date	SI	APC	Short Descriptor	Long descriptor	Payment	Minimum Unadjusted Copayment
C9737	1/01/2014	T	0174	Lap esoph augmentation	Laparoscopy, surgical, esophageal sphincter augmentation with device (e.g., magnetic band)	See Addendum B of CY 2014 final rule	See Addendum B of CY 2014 final rule

Clinic Visits

Effective January 1, 2014, CMS will recognize HCPCS code G0463 (Hospital outpatient clinic visit for assessment and management of a patient) for payment under the OPPS for outpatient hospital clinic visits. Effective January 1, 2014, CPT codes 99201-99205 and 99211-99215 will no longer be recognized for payment under the OPPS.

Extended Assessment and Management (EAM) Composite APC (8009)

Effective January 1, 2014, CMS will provide payment for all qualifying extended assessment and management encounters through newly created composite APC 8009 (Extended Assessment and Management (EAM) Composite). A clinic visit (G0463), a Level 4 (99284) or Level 5 Type A ED visit (99285), or Level 5 Type B ED visit (G0384) furnished by a hospital in conjunction with observation services of eight or more hours will qualify for payment through APC 8009. Effective January 1, 2014, CMS will no longer provide payment for extended assessment and management encounters through APCs 8002 (Level I Extended Assessment and Management Composite) and 8003 (Level I Extended Assessment and Management Composite), which have been deleted.

Billing for Stereotactic Radiosurgery (SRS) Planning and Delivery

Effective January 1, 2014, hospitals must report SRS planning and delivery services using only the CPT codes that accurately describe the service furnished. For the delivery services, hospitals must report CPT code 77371, 77372, or 77373, as described in the following table.

Table 2 – CPT Codes that are Reportable for SRS Delivery Services
Effective January 1, 2014

CPT Code	Long Descriptor
77371	Radiation treatment delivery, stereotactic radiosurgery (srs), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source cobalt 60 based
77372	Radiation treatment delivery, stereotactic radiosurgery (srs), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions

As instructed in the CY 2014 OPPS/ASC final rule, CPT code 77371 is to be used only for single session cranial SRS cases performed with a Cobalt-60 device, and CPT code 77372 is to be used only for single session cranial SRS cases performed with a linac-based device. The term "cranial" means the pathological lesion(s) that are the target of the radiation is located in the patient's cranium or head. The term "single session" means that the entire intracranial lesion(s) that comprise the patient's diagnosis are treated in their entirety during a single treatment session on a single day. CPT code 77372 is never to be used for the first fraction or any other fraction of a fractionated SRS treatment. CPT code 77372 is to be used only for single session cranial linac-based SRS treatment.

Fractionated SRS treatment is any SRS delivery service requiring more than a single session of SRS treatment for a cranial lesion, up to a total of no more than five fractions, and one to five sessions (but no more than five) for non-cranial lesions. CPT code 77373 is to be used for any fraction (including the first fraction) in any series of fractionated treatments, regardless of the anatomical location of the lesion or lesions being radiated. Fractionated cranial SRS is any cranial SRS that exceeds one treatment session. Fractionated non-cranial SRS is any non-cranial SRS, regardless of the number of fractions but never more than five. Therefore, CPT code 77373 is the exclusive code (and the use of no other SRS treatment delivery code is permitted) for any and all fractionated SRS treatment services delivered anywhere in the body, including, but not limited to, the cranium or head. 77372 is not to be used for the first fraction of a fractionated cranial SRS treatment series and must only be used in cranial SRS when there is a single treatment session to treat the patient's entire condition.

In addition, for the planning services, hospitals must report the specific CPT code that accurately describes the service provided. The planning services may include but are not limited to CPT code 77290, 77295, 77300, 77334, or 77370, listed in Table 3 below.

Table 3 – CPT Codes that are Reportable for SRS Planning Services
Effective January 1, 2014

CPT Code	Long Descriptor
77290	Therapeutic radiology simulation-aided field setting; complex
77295	Therapeutic radiology simulation-aided field setting; 3-dimensional

CPT Code	Long Descriptor
77300	Basic radiation dosimetry calculation, central axis depth dose calculation, tdf, nsd, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician
77334	Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)
77370	Special medical radiation physics consultation

CMS notes that the APC assignment, OPPS status indicators, and payment rates for these SRS planning and delivery services can be found in Addendum B of the January 2014 OPPS Update that is posted at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html** on the CMS website.

Drugs, Biologicals, and Radiopharmaceuticals

a. New CY 2014 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

For CY 2014, several new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. These new codes are listed in Table 4.

Table 4 –– New CY 2014 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2014 HCPCS Code	CY 2014 Long Descriptor	CY 2014 SI	CY 2014 APC
A9575	Injection, Gadoterate Meglumine, 0.1 mL	N	
A9586	Florbetapir f18, diagnostic, per study dose, up to 10 millicuries	N	
A9599	Radiopharmaceutical, Diagnostic, For Beta-amyloid Positron Emission Tomography (PET) Imaging, Per Study Dose	N	
C9133	Factor ix (antihemophilic factor, recombinant), Rixubis, per i.u.	G	1467
C9441	Injection, ferric carboxymaltose, 1 mg	G	9441
C9497	Lozapine, inhalation powder, 10 mg	G	9497
J0401	Injection, Aripiprazole, Extended Release, 1 mg	K	1468
J1446	Injection, TBO-Filgrastim, 5 micrograms	E	
J1602	Injection, golimumab, 1 mg, for intravenous use	K	1474
J7508	Tacrolimus, Extended Release, Oral, 0.1 mg	G	1465
J9371	Injection, Vincristine Sulfate Liposome, 1 mg	G	1466
Q4137	Amnioexcel or Biodexcel, Per Square Centimeter	N	
Q4138	BioDfence DryFlex, Per Square Centimeter	N	
Q4139	AmnioMatrix or BioDMatrix, injectable, 1 cc	N	

CY 2014 HCPCS Code	CY 2014 Long Descriptor	CY 2014 SI	CY 2014 APC
Q4140	Biodfence, Per Square Centimeter	N	
Q4141	Alloskin AC, Per Square Centimeter	N	
Q4142	XCM Biologic Tissue Matrix, Per Square Centimeter	N	
Q4143	Repriza, Per Square Centimeter	N	
Q4145	Epifix, Injectable, 1mg	N	
Q4146	Tensix, Per Square Centimeter	N	
Q4147	Architect Extracellular Matrix, Per Square Centimeter	N	
Q4148	Neox 1k, Per Square Centimeter	N	
Q4149	Excellagen, 0.1 cc	N	

b. Other Changes to CY 2014 HCPCS and CPT Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals

Many HCPCS and CPT codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS and CPT code descriptors that will be effective in CY 2014. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2013 and replaced with permanent HCPCS codes in CY 2014. Hospitals should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the active CY 2014 HCPCS and CPT codes.

Table 5 shown below, notes those drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS/CPT code, their long descriptor, or both. Each product's CY 2013 HCPCS/CPT code and long descriptor are noted in the two left hand columns and the CY 2014 HCPCS/CPT code and long descriptor are noted in the adjacent right hand columns.

Table 5 –– Other CY 2014 HCPCS and CPT Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2013 HCPCS/ CPT code	CY 2013 Long Descriptor	CY 2014 HCPCS/ CPT Code	CY 2014 Long Descriptor
C1204	Technetium Tc 99m tilmanocept, diagnostic, up to 0.5 millicuries	A9520	Technetium Tc 99m tilmanocept, diagnostic, up to 0.5 millicuries
J0152	Injection, adenosine for diagnostic use, 30 mg (not to be used to report any adenosine phosphate compounds)	J0151	Injection, Adenosine For Diagnostic Use, 1 mg (not to be used to report any Adenosine Phosphate Compounds, Instead use A9270)
J0718	Injection, certolizumab pegol, 1 mg	J0717	Injection, certolizumab pegol , 1 mg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)

CY 2013 HCPCS/ CPT code	CY 2013 Long Descriptor	CY 2014 HCPCS/ CPT Code	CY 2014 Long Descriptor
J1440	Injection, filgrastim (g-csf), 300 mcg	J1442	Injection, Filgrastim (G-CSF), 1 microgram
J1441	Injection, filgrastim (g-csf), 480 mcg	J1442	Injection, Filgrastim (G-CSF), 1 microgram
C9130	Injection, immune globulin (Bivigam), 500 mg	J1556	Injection, immune globulin (Bivigam), 500 mg
C9294	Injection, taliglucerase alfa, 10 units	J3060	Injection, taliglucerase alfa, 10 units
Q2051*	Injection, Zoledronic Acid, Not Otherwise Specified, 1 mg	J3489	Injection, Zoledronic Acid, 1mg
C9298	Injection, ocriplasmin, 0.125 mg	J7316	Injection, Ocriplasmin, 0.125mg
C9295	Injection, carfilzomib, 1 mg	J9047	Injection, carfilzomib, 1 mg
C9297	Injection, omacetaxine mepesuccinate, 0.1 mg	J9262	Injection, omacetaxine mepesuccinate, 0.01 mg
C9292	Injection, pertuzumab, 10 mg	J9306	Injection, pertuzumab, 1 mg
C9131	Injection, ado-trastuzumab emtansine, 1 mg	J9354	Injection, ado-trastuzumab emtansine, 1 mg
C9296	Injection, ziv-aflibercept, 1 mg	J9400	Injection, Ziv-Aflibercept, 1 mg
Q0171	Chlorpromazine hydrochloride, 10 mg, oral, fda approved prescription	Q0161	Chlorpromazine hydrochloride, 5 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen
Q0172	Chlorpromazine hydrochloride, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotheapy treatment, not to exceed a 48-hour dosage regimen	Q0161	Chlorpromazine hydrochloride, 5 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen
Q2027	Injection, Sculptra, 0.1 ml	Q2028	Injection, Sculptra, 0.1 ml
Q3025	Injection, interferon beta-1a, 11 mcg for intramuscular use	Q3027	Injection, Interferon Beta-1a, 1 mcg For Intramuscular Use

c. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective January 1, 2014

In CY 2014, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and

pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Effective January 1, 2014, payment rates for many drugs and biologicals have changed from the values published in the CY 2014 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2013. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2014 release of the OPPS Pricer. CMS is not publishing the updated payment rates in this Change Request implementing the January 2014 update of the OPPS. However, the updated payment rates effective January 1, 2014 can be found in the January 2014 update of the OPPS Addendum A and Addendum B at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html** on the CMS website.

d. Updated Payment Rate for C1204 Effective October 1, 2013 through December 31, 2013

The payment rate for C1204 was incorrect in the October 2013 OPPS Pricer. The corrected payment rate is listed in Table 6, and has been installed in the January 2014 OPPS Pricer, effective for services furnished on October 1, 2013, through December 31, 2013. If you have claims that were incorrectly processed, you may ask your MAC to adjust those claims using the corrected payment rate.

Table 6 – Updated payment Rates for Certain HCPCS Codes
Effective October 1, 2013 through December 31, 2013

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
A9520	G	1463	Tc 99m tilmanocept	$223.15	$0.00

e. Elimination of Nuclear Medicine Procedure-to-Radiolabeled Product Edits

Beginning January 1, 2008, CMS implemented OPPS edits that require hospitals to include a HCPCS code for a radiolabeled product when a separately payable nuclear medicine procedure is present on a claim. Effective January 1, 2014, the nuclear medicine procedure-to-radiolabeled product edits are no longer required. Hospitals are still expected to adhere to the guidelines of correct coding and append the correct radiolabeled product code to the claim when applicable. Claims will no longer be returned to providers when HCPCS codes for radiolabeled products do not appear on claims with nuclear medicine procedures.

f. Skin Substitute Procedure Edits

Effective January 1, 2014, the payment for skin substitute products that do not qualify for pass-through status will be packaged into the payment for the associated skin substitute application procedure. The skin substitute products are divided into two groups:

1) high cost skin substitute products and

2) low cost skin substitute products for packaging purposes.

Table 7 lists the skin substitute products and their assignment as either a high cost or a low cost skin substitute product, when applicable.

Table 7 – Skin Substitute Product Assignment to High Cost/Low Cost Status for CY 2014

CY 2014 HCPCS Code	CY 2014 Short Descriptor	CY 2014 SI	Low/High Cost Skin Substitute
C9358	SurgiMend, fetal	N	Low
C9360	SurgiMend, neonatal	N	Low
C9363	Integra Meshed Bil Wound Mat	N	Low
Q4100	Skin substitute, NOS	N	Low
Q4101	Apligraf	N	High
Q4102	Oasis wound matrix	N	Low
Q4103	Oasis burn matrix	N	Low
Q4104	Integra BMWD	N	Low
Q4105	Integra DRT	N	Low
Q4106	Dermagraft	N	High
Q4107	Graftjacket	N	High
Q4108	Integra matrix	N	Low
Q4110	Primatrix	N	High
Q4111	Gammagraft	N	Low
Q4115	Alloskin	N	Low
Q4116	Alloderm	N	High
Q4117	Hyalomatrix	N	Low
Q4119	Matristem wound matrix	N	Low
Q4120	Matristem burn matrix	N	Low
Q4121	Theraskin	N	Low
Q4122	Dermacell	G	n/a
Q4123	Alloskin	N	Low
Q4124	Oasis tri-layer wound matrix	N	Low
Q4125	Arthroflex	N	High
Q4126	Memoderm/derma/tranz/integup	N	High

CY 2014 HCPCS Code	CY 2014 Short Descriptor	CY 2014 SI	Low/High Cost Skin Substitute
Q4127	Talymed	G	n/a
Q4128	Flexhd/Allopatchhd/matrixhd	N	Low
Q4129	Unite biomatrix	N	Low
Q4131	Epifix	G	n/a
Q4132	Grafix core	G	n/a
Q4133	Grafix prime	G	n/a
Q4134	hMatrix	N	High
Q4135	Mediskin	N	Low
Q4136	EZderm	N	Low
Q4137	Amnioexcel or biodexcel, 1cm	N	Low
Q4138	BioDfence DryFlex, 1cm	N	Low
Q4140	Biodfence 1cm	N	Low
Q4141	Alloskin ac, 1 cm	N	Low
Q4142	Xcm biologic tiss matrix 1cm	N	Low
Q4143	Repriza, 1cm	N	Low
Q4146	Tensix, 1cm	N	Low
Q4147	Architect ecm, 1cm	N	Low
Q4148	Neox 1k, 1cm	N	Low

Beginning January 1, 2014, CMS will implement an OPPS edit that requires hospitals to report all high cost skin substitute products in combination with one of the skin application procedures described by CPT codes 15271-15278 and to report all low cost skin substitute products in combination with one of the skin application procedures described by HCPCS code C5271-C5278. All pass-through skin substitute products are to be reported in combination with one of the skin application procedures described by CPT code 15271-15278.

g. Offset from Payment for Pass-Through Skin Substitute Products

The Social Security Act (Section 1833(t)(6)(D)(i); see **http://www.ssa.gov/OP_Home/ssact/title18/1833.htm** on the Internet) requires that CMS deduct from pass-through payments for drugs or biologicals an amount that reflects the portion of the APC payment amount that CMS determines is associated with the cost of the drug or biological. Effective January 1, 2014, there will be five skin substitute products receiving pass-through payment. All pass-through skin substitute products are to be reported in combination with one of the skin application procedures described by CPT code 15271-15278. These skin application procedure codes are assigned to either APC 0328 (Level III Skin Repair) or APC 0329 (Level IV Skin Repair). CMS has determined that it is able to

identify a portion of the APC payment amount associated with the cost of skin substitute products in APC 0328 and APC 0329. This portion of the APC payment represents the required deduction from pass-through payments for skin substitute products when they are billed with a skin substitute application procedure code in APC 0328 or APC 0329. The offset amount for APC 0328 and APC 0329, along with the offsets for other APCs, is available under "Annual Policy Files" at **http://www.cms.gov/HospitalOutpatientPPS/** on the CMS OPPS website.

Billing for "Sometimes Therapy" Services that May be Paid as Non-Therapy Services for Hospital Outpatients

Effective January 1, 2014, CMS is updating one of the services on the manual list of "sometimes therapy" services with a newly assigned HCPCS code. HCPCS code 0183T (Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day) is being replaced with HCPCS code 97610 (Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day). The code descriptor is not changed. The limited set of sometimes therapy services listed in the manual are paid under the OPPS when they are not furnished as therapy, meaning are not furnished under a certified therapy plan of care. When a hospital furnishes these services to a hospital outpatient as non-therapy, the hospital may submit a claim for facility payment for the services to the OPPS.

2014 Hospital Outpatient Clinical Diagnostic Laboratory Test Payment and Billing

Since the inception of the OPPS, OPPS hospitals were paid separately for clinical diagnostic laboratory tests or services (laboratory tests) provided in the hospital outpatient setting at Clinical Laboratory Fee Schedule (CLFS) rates. Beginning in CY 2014, payment for most laboratory tests (except for molecular pathology tests) will be packaged under the OPPS. The general rule for OPPS hospitals is laboratory tests should be reported on a 13X bill type. There are limited circumstances described below in which hospitals can separately bill for laboratory tests. For these specific situations CMS is expanding the use of the 14x bill type to allow separate billing and payment at CLFS rates for hospital outpatient laboratory tests.

Laboratory tests may be (or must be for a non-patient specimen) billed on a 14X claim in the following circumstances:

(1) Non-patient laboratory specimen tests; non-patient continues to be defined as a beneficiary that is neither an inpatient nor an outpatient of a hospital, but that has a specimen that is submitted for analysis to a hospital and the beneficiary is not physically present at the hospital;

(2) Beginning in 2014, when the hospital only provides laboratory tests to the patient (directly or under arrangement) and the patient does not also receive other hospital outpatient services during that same encounter; and

(3) Beginning in 2014, when the hospital provides a laboratory test (directly or under arrangement) during the same encounter as other hospital outpatient services that is clinically unrelated to the other hospital outpatient services, and the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services provided in the hospital outpatient setting. In this case the lab test would be billed on a 14X claim and the other hospital outpatient services would be billed on a 13X claim.

It will be the hospital's responsibility to determine when laboratory tests may be separately billed on the 14X claim under these limited exceptions. In addition, laboratory tests for molecular pathology tests described by CPT codes in the ranges of 81200 through 81383, 81400 through 81408, and 81479 are not packaged in the OPPS and should be billed on a 13X type of bill.

CY 2014 OPPS Payment Adjustment for Certain Cancer Hospitals

Consistent with the Affordable Care Act (Section 3138; see **http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf**), CMS adopted a policy beginning in CY 2012 to provide additional payments to each of the 11 cancer hospitals so that each cancer hospital's final payment to cost ratio (PCR) for services provided in a given calendar year is equal to the weighted average PCR (which CMS refers to as the "target PCR") for other hospitals paid under the OPPS. The target PCR is set in advance of the calendar year and is calculated using the most recent submitted or settled cost report data that are available at the time of final rulemaking for the calendar year. CMS is updating the Medicare Claims Processing Manual (Pub. 100-04, Chapter 4) by adding Section 10.6.3.2, to reflect that the target PCR for CY 2014, for purposes of the cancer hospital payment adjustment, is 0.89 for outpatient services furnished on or after January 1, 2014 through December 31, 2014, and the revised section is included as an attachment to CR 8572.

Changes to OPPS Pricer Logic

a. Rural sole community hospitals and essential access community hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in CY 2014. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with the Social Security Act (section 1833(t)(13)(B)), as added by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA; Section 411; see **http://www.gpo.gov/fdsys/pkg/PLAW-108publ173/pdf/PLAW-108publ173.pdf** on the Internet).

b. New OPPS payment rates and copayment amounts will be effective January 1, 2014. All copayment amounts will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the CY 2014 inpatient deductible.

c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2014. This threshold of 1.75 is multiplied by the total line-item APC

payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount. The payment formula is (cost-(APC payment x 1.75))/2.

d. The fixed-dollar threshold increase in CY 2014 relative to CY 2013. The estimated cost of a service must be greater than the APC payment amount plus $2,900 in order to qualify for outlier payments.

e. For outliers for Community Mental Health Centers (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2014. This threshold of 3.4 is multiplied by the total line-item APC payment for APC 0173 to determine eligibility for outlier payments. This multiple amount is also used to determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment formula is (cost-(APC 0173 payment x 3.4))/2.

f. Effective October 1, 2013, and continuing for CY 2014, 1 device is eligible for pass-through payment in the OPPS Pricer logic. Category C1841 (Retinal prosthesis, includes all internal and external components), has an offset amount of $0, because CMS is not able to identify portions of the APC payment amounts associated with the cost of the device in APC 0672, Level III, Posterior segment eye procedures. For outlier purposes, when C1841 is billed with CPT code 0100T, assigned to APC 0672, it will be eligible for outlier calculation and payment.

g. Effective January 1, 2014, the OPPS Pricer will apply a reduced update ratio of 0.980 to the payment and copayment for hospitals that fail to meet their hospital outpatient quality data reporting requirements or that fail to meet CMS validation edits. The reduced payment amount will be used to calculate outlier payments.

h. Effective January 1, 2014, there will be one diagnostic radiopharmaceutical receiving pass-through payment in the OPPS Pricer logic. For APCs containing nuclear medicine procedures, Pricer will reduce the amount of the pass-through diagnostic radiopharmaceutical payment by the wage-adjusted offset for the APC with the highest offset amount when the radiopharmaceutical with pass-through appears on a claim with a nuclear procedure. The offset will cease to apply when the diagnostic radiopharmaceutical expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals are the “policy-packaged” portions of the CY 2014 APC payments for nuclear medicine procedures and may be found on the CMS website.

i. Effective January 1, 2014, there will be five skin substitute products receiving pass-through payment in the OPPS Pricer logic. For skin substitute application procedure codes that are assigned to APC 0328 (Level III Skin Repair) or APC 0329 (Level IV Skin Repair), Pricer will reduce the payment amount for the pass-through skin substitute product by the wage-adjusted offset for the APC when the pass-through skin substitute product appears on a claim with a skin substitute application procedure that maps to APC 0328 or APC 0329. The offset amounts for skin substitute products are the “policy-packaged” portions of the CY 2014 payments for APC 0328 and APC 0329.

j. Pricer will update the payment rates for drugs, biologicals, therapeutic radiopharmaceuticals, and diagnostic radiopharmaceuticals with pass-through status when those payment rates are based on ASP on a quarterly basis.

k. Effective January 1, 2014, CMS is adopting the FY 2014 IPPS post-reclassification wage index values with application of out-commuting adjustment authorized by Section 505 of the MMA to non-IPPS hospitals discussed below.

l. Effective January 1, 2014, for claims with APCs, which require implantable devices and have significant device offsets (greater than 40%), a device offset cap will be applied based on the credit amount listed in the "FD" (Credit Received from the Manufacturer for a Replaced Medical Device) value code. The credit amount in value code "FD" which reduces the APC payment for the applicable procedure, will be capped by the device offset amount for that APC. The offset amounts for the above referenced APCs are available on the CMS website.

Update the Outpatient Provider Specific File (OPSF)

a.) Updating the OPSF for Expiration of Transitional Outpatient Payments (TOPs)

Cancer and children's hospitals are permanently held harmless under the Social Security Act (Section 1833(t)(7)(D)(ii)) and continue to receive hold harmless TOPs permanently. For CY 2014, cancer hospitals will continue to receive an additional payment adjustment.

b.) Updating the OPSF for the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) Requirements

Effective for OPPS services furnished on or after January 1, 2009, Subsection (d) hospitals that have failed to submit timely hospital outpatient quality data as required in the Social Security Act (Section 1833(t)(17)(A)) will receive payment under the OPPS that reflects a two percentage point deduction from the annual OPPS update for failure to meet the HOP QDRP requirements. This reduction will not apply to hospitals not required to submit quality data or hospitals that are not paid under the OPPS.

c.) Updating the OPSF for the Outpatient Cost to Charge Ratio (CCR)

As stated in the "Medicare Claims Processing Manual" (Chapter 4, Section 50.1) MACs must maintain the accuracy of the data and update the OPSF as changes occur in data element values, including changes to provider cost–to-charge ratios. The file of OPPS hospital upper limit CCRs and the file of Statewide CCRs are located at **http://www.cms.gov/HospitalOutpatientPPS/** on the CMS website in the left column under "*Annual Policy Files*."

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. MACs determine whether a drug, device, procedure, or other service meets all program

requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Additional Information

The official instruction, CR 8572 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2845CP.pdf** on the CMS website.

If you have any questions, please contact your MAC 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.