

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



New product from the Medicare Learning Network® (MLN)

- [Clarification of the Use of Modifiers When Billing Wrong Surgery on a Patient](#), Podcast (ICN 909189) Downloadable

MLN Matters® Number: MM9205

Related Change Request (CR) #: CR 9205

Related CR Release Date: June 5, 2015

Effective Date: July 1, 2015

Related CR Transmittal #: R3280CP

Implementation Date: July 6, 2015

July 2015 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 Administrative Contractors (MACs) for services provided to Medicare beneficiaries and paid under the Outpatient Prospective Payment System (OPPS).

Provider Action Needed

Change Request (CR) 9205 describes changes to and billing instructions for various payment policies implemented in the July 2015 OPPS update. Make sure your billing staff are aware of these changes.

Background

Change Request (CR) 9205 describes changes to and billing instructions for various payment policies implemented in the July 2015 OPPS update. The July 2015 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding

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System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR9205. CR 9205 also revises the “Medicare Claims Processing Manual” (Chapter 4, Section 20.6.11 (Use of HCPCS Modifier – PO)) which is included as an attachment to CR9205.

The July 2015 revisions to I/OCE data files, instructions, and specifications are provided in CR9190. The MLN Matters® Article related to CR9190 is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9190.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

Key changes to and billing instructions for various payment policies implemented in the July 2015, OPSS update are as follows:

New Device Pass-Through Categories

The Social Security Act (Section 1833(t)(6)(B); see http://www.ssa.gov/OP_Home/ssact/title18/1833.htm on the Internet) requires that, under the OPSS, categories of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. Section 1833(t)(6)(B)(ii)(IV) of the Social Security Act requires that CMS create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

CMS is establishing one new device pass-through category as of July 1, 2015. Table 1 below provides a listing of new coding and payment information, including Ambulatory Payment Classification (APC) and Status Indicator (SI), concerning the new device category for transitional pass-through payment.

Table 1 – New Device Pass-Through Code

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Device Offset from Payment
C2613	07-01-15	H	2613	Lung bx plug w/del sys	Lung biopsy plug with delivery system	\$24.83

a. Device Offset from Payment: Section 1833(t)(6)(D)(ii) of the Social Security Act requires that CMS deduct from pass-through payments for devices an amount that reflects the portion of the APC payment amount. CMS has determined that a portion of the APC payment amount associated with the cost of C2613 is reflected in APC 0005. The C2613 device should always be billed with CPT Code 32405 (Biopsy, lung or mediastinum, percutaneous needle) which is assigned to APC 0005 for Calendar Year (CY) 2015. The device offset from payment represents a deduction from pass-through payments for the device in category C2613.

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b. Application of Offset to C2623: On April 1, 2015, CMS determined that an offset would apply to C2623 because APCs 0083, APC 0229, and APC 0319 already contain costs associated with the device described by C2623. The device offset is a deduction from pass-through payments for C2623. After further review, CMS has determined that the costs associated with C2623 are already reflected in APCs 0083, APC 0229, or APC 0319. Therefore, CMS is not applying an offset to C2623. This determination to not apply the device offset from payment will be retroactive to April 1, 2015. For further discussion about the device offset policy, see 68 FR 63438-9 at <http://www.gpo.gov/fdsys/pkg/FR-2003-11-07/pdf/03-27791.pdf> on the Internet. Providers with previously-processed claims with C2623 and with dates of service on or after April 1, 2015, through July 1, 2015, may bring those claims to the attention of their MAC for adjustment.

Category III CPT Codes

The American Medical Association (AMA) releases Category III Current Procedural Terminology (CPT) codes twice per year: in January, for implementation beginning the following July, and in July, for implementation beginning the following January. For the July 2015 update, CMS is implementing in the OPSS two Category III CPT codes that the AMA released in January 2015 for implementation on July 1, 2015. Both Category III CPT codes are separately payable under the hospital OPSS. The status indicators (SIs) and APCs for these codes are shown in Table 2, below. Payment rates for these services are in Addendum B of the July 2015 OPSS 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.

Table 2 -- Category III CPT Codes Implemented as of July 1, 2015

CY 2015 CPT Code	CY 2015 Long Descriptor	July 2015 OPSS Status Indicator	July 2015 OPSS APC
0392T	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band)	T	0174
0393T	Removal of esophageal sphincter augmentation device	Q2	0130

LINX Reflux Management System

In January 2014, CMS established HCPCS code C9737 to describe the laparoscopic implantation of a magnetic esophageal ring for the treatment of gastroesophageal reflux disease (GERD), which is the procedure associated with the LINX Reflux Management

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System. For the July 2015 update, the CPT Editorial Panel established CPT code 0392T to describe the LINX Reflux Management System. With the establishment of the CPT code, CMS is deleting HCPCS code C9737 effective June 30, 2015. Therefore, effective July 1, 2015, Hospital Outpatient Departments (HOPDs) must report CPT code 0392T to report the implantation of a magnetic esophageal ring associated with the LINX Reflux Management System procedure.

Table 3, below, lists the long descriptors for HCPCS C9737 and CPT code 0392T. To view the July 2015 OPSS payment rate for CPT code 0392T, refer to the July 2015 OPSS Addendum B (which is available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html> on the CMS website).

Table 3 – Long Descriptors for HCPCS C9737 and CPT Code 0392T

CPT / HCPCS Code	Long Descriptor	Add Date	Termination Date	July 2015 OPSS SI	July 2015 OPSS APC
C9737	Laparoscopy, surgical, esophageal sphincter augmentation with device (eg, magnetic band)	1/1/2014	6/30/2015	T	0174
0392T	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band)	7/1/2015		T	0174

Use of HCPCS Modifier - PO

Effective January 1, 2015, the definition of modifier ‘PO’ is “**Services, procedures, and/or surgeries furnished at off-campus provider-based outpatient departments.**” This modifier is to be reported with every HCPCS code for all outpatient hospital items and services furnished in an off-campus provider-based department of a hospital. See 42 CFR 413.65(a)(2) at http://www.ecfr.gov/cgi-bin/text-idx?SID=867b6f12ebf5c84c0469ca86a7bbe88a&mc=true&node=pt42.2.413&rgn=div5#se42.2.413_165 for a definition of “campus”.

This modifier should not be reported for remote locations of a hospital (defined at 42 CFR 413.65(a)(2)), satellite facilities of a hospital (defined at 42 CFR 412.22(h); see http://www.ecfr.gov/cgi-bin/text-idx?SID=867b6f12ebf5c84c0469ca86a7bbe88a&mc=true&node=pt42.2.412&rgn=div5#se42.2.412_122), or for services furnished in an emergency department.

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Reporting of this modifier is voluntary for CY 2015; reporting of this modifier is required beginning January 1, 2016.

Drugs, Biologicals, and Radiopharmaceuticals

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective July 1, 2015

For CY 2015, payment for nonpass-through drugs, biologicals, and therapeutic radiopharmaceuticals is made at a single rate of ASP+6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological, or therapeutic radiopharmaceutical. In CY 2015, 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. Updated payment rates effective July 1, 2015 and drug price restatements can be found in the July 2015 update of the OPSS 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.

b. Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates

Some drugs and biologicals paid based on the ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the first date of the quarter at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html> on the CMS website. Providers may resubmit claims that were impacted by adjustments to previous quarter’s payment files.

c. Drugs and Biologicals with OPSS Pass-Through Status Effective July 1, 2015

Three drugs and biologicals have been granted OPSS pass-through status effective July 1, 2015. These items, along with their descriptors and APC assignments, are identified in Table 4 as follows.

Table 4 – Drugs and Biologicals with OPSS Pass-Through Status Effective July 1, 2015

HCPCS Code	Long Descriptor	Status Indicator	APC
C9453	Injection, nivolumab, 1 mg	G	9453
C9454	Injection, pasireotide long acting, 1 mg	G	9454
C9455	Injection, siltuximab, 10 mg	G	9455

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d. New HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Biosimilar Biological Products

Effective July 1, 2015 two 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 5, below.

Table 5 – New HCPCS Codes Effective July 1, 2015, for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2015 HCPCS Code	CY 2015 Long Descriptor	CY 2015 SI
Q9976	Injection, Ferric Pyrophosphate Citrate Solution, 0.01 mg of iron	E
Q9977	Compounded Drug, Not Otherwise Classified	N

The first biosimilar, Zarxio®, listed in Table 6 below, was approved by the FDA on March 6, 2015. -. As the biosimilar is currently not being marketed, pricing information is not available for Zarxio for the July OPPS quarterly release. Once Zarxio is marketed, CMS will make pricing information available at the soonest possible date on the OPPS payment files and payment for Zarxio will be retroactive to the date the product is first marketed.

Table 6 – New HCPCS Code Effective March 6, 2015, for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2015 HCPCS Code	CY 2015 Long Descriptor	CY 2015 SI
Q5101	Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram	E

e. Revised Descriptor for HCPCS Code C9349

Effective July 1, 2015, the descriptor for HCPCS code C9349 will change from FortaDerm, and FortaDerm Antimicrobial, any type, per square centimeter to PuraPly, and PuraPly Antimicrobial, any type, per square centimeter. See Table 7 below.

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Table 7 – Revised Descriptor for HCPCS Code C9349

HCPCS Code	Previous 2015 Short Descriptor	Previous 2015 Long Descriptor	Revised July 2015 Short Descriptor	Revised July 2015 Long Descriptor
C9349	FortaDerm, FortaDerm Antimic	FortaDerm , and FortaDerm Antimicrobial, any type, per square centimeter	PuraPly, PuraPly Antimic	PuraPly, and PuraPly Antimicrobial, any type, per square centimeter

f. Revised Status Indicators for HCPCS Codes J0365, 90620, and 90621

Effective April 1, 2015, the status indicator for HCPCS code J0365 (Injection, aprotonin, 10,000 kiu) will change from SI=K (Paid under OPPS; separate APC payment) to SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)).

Effective February 1, 2015, the status indicators for HCPCS codes 90620 (Menb pr w/omv vaccine im) and 90621 (Menb rlp vaccine im) will change from SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=K (Paid under OPPS; separate APC payment). These codes are listed in Table 8, below, along with the effective date for the revised status indicator.

Table 8 – Drug and Biological with Revised Status Indicator

HCPCS Code	Long Descriptor	APC	Status Indicator	Effective Date
J0365	Injection, aprotonin, 10,000 kiu		E	4/1/2015
90620	Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B, 2 dose schedule, for intramuscular use	1807	K	2/1/2015
90621	Meningococcal recombinant lipoprotein vaccine, serogroup B, 3 dose schedule, for intramuscular use	1808	K	2/1/2015

g. Other Changes to CY 2015 HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals

Effective July 1, 2015, HCPCS code Q9978 Netupitant Palonosetron oral will replace HCPCS code C9448 Netupitant Palonosetron oral. The status indicator will remain G,

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“Pass-Through Drugs and Biologicals”. Table 9, below, describes this HCPCS code change and effective date.

Table 9 – Other Changes to CY 2015 HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals

HCPCS Code	Short Descriptor	Long Descriptor	Status Indicator	APC	Added Date	Termination Date
C9448	Netupitant Palonosetron oral	Netupitant 300 mg and Palonosetron 0.5 mg, oral	G	9448	04/01/2015	06/30/2015
Q9978	Netupitant Palonosetron oral	Netupitant 300 mg and Palonosetron 0.5 mg, oral	G	9448	07/01/2015	

Hyperbaric Oxygen Therapy

Effective January 1, 2015, HCPCS code C1300, Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval has been discontinued. Hospitals providing hyperbaric oxygen (HBO) therapy should report this service using HCPCS code G0277, Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval that is effective January 1, 2015. The following may be included in calculating the total number of 30-minute intervals billable under G0277:

- 1) Time spent by the patient under 100% oxygen;
- 2) Time for descent;
- 3) Time for air breaks; and
- 4) Time for ascent.

NOTE: A physician order for a 90-minute HBO treatment typically means that the physician desires that the patient be placed under 100% oxygen for 90 minutes. In order to safely achieve 100% oxygen for 90 minutes, additional time may be needed to provide for the descent, air breaks, and ascent. Therefore, the total number of billable 30-minute intervals would not be based solely on the amount of time noted on the physician order.

In calculating how many 30-minute intervals to report, hospitals should take into consideration the time spent under pressure during descent, air breaks, and ascent. Additional units may be billed for sessions requiring at least 16 minutes of the next 30-minute interval.

For example, 2 units of HCPCS code G0277 should be billed for a session in duration of between 46 and 75 minutes, while 3 units should be billed for a session in duration of between

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76 and 105 minutes. Furthermore, 4 units of HCPCS code G0277 should be billed for a session in duration of between 106 and 135 minutes. HBO is typically prescribed for an average of 90 minutes, which hospitals should report using appropriate units of HCPCS code G0277 in order to properly bill for full body HBO therapy. In general, CMS does not expect that a physician order for 90 minutes of HBO therapy would exceed 4 billed units of HCPCS code G0277.

EXAMPLE:

Physician orders and patient receives 90 minutes of therapeutic HBO;

- Patient requires and receives 10 minutes of descent time;
- Patient requires and receives 10 minutes of air breaks; and
- Patient requires and receives 10 minutes of ascent time.

The above example would be billed correctly by

- Reporting 4 units of HCPCS code G0277,
- Reflecting the sum of:
 - 90 minutes of therapeutic HBO,
 - 10 minutes for descent,
 - 10 minutes for air breaks, and
 - 10 minutes for ascent.

Coverage Determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPSS 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. Medicare Administrative Contractors (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 9205, issued to your MAC regarding these changes is available at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3280CP.pdf> on the CMS website.

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

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