

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



Revised product from the Medicare Learning Network® (MLN)

- [ICD-10-CM/PCS Billing and Payment Frequently Asked Questions](#), Fact Sheet (ICN 908974)

MLN Matters® Number: MM9298 **Revised**      Related Change Request (CR) #: CR 9298

Related CR Release Date: September 15, 2015      Effective Date: October 1, 2015

Related CR Transmittal #: R3352CP      Implementation Date: October 5, 2015

## October 2015 Update of the Hospital Outpatient Prospective Payment System (OPPS)

**Note: This article was revised on September 17, 2015, to reflect the revised CR9298, issued on September 15. In the article, information on HCPCS Code Q5101 has been added via subsection g. and Table 6 on pages 5-6. Also, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.**

### Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs), including Home Health and Hospice (HH&H) MACs for services provided to Medicare beneficiaries.

### Provider Action Needed

Change Request (CR) 9298 describes changes to and billing instructions for various payment policies implemented in the October 2015 OPPS update. Make sure that your billing staffs are aware of these changes.

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## Background

The October 2015 Integrated Outpatient Code Editor (I/OCE) and OPSS 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 CR9298.

The October 2015 revisions to I/OCE data files, instructions, and specifications are provided in the October 2015 I/OCE CR9290. A related MLN Matters® Article, MM9290 is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9290.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

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

### *New Separately Payable Procedure Code*

Effective October 1, 2015, a new HCPCS code C9743 has been created. See Table 1 below which provides the short and long descriptors and the APC placement for this new code.

**Table 1 – New Separately Payable Procedure Code Effective October 1, 2015**

HCPCS Code	Short Descriptor	Long Descriptor	OPSS SI	OPSS APC	Effective Date
C9743	Bulking/spacer material impl	Injection/implantation of bulking or spacer material (any type) with or without image guidance (not to be used if a more specific code applies)	S	0310	10/01/2015

### *Compounded Drugs*

Effective June 30, 2015, modifier JF (Compounded drug) was discontinued and replaced with HCPCS code Q9977 (Compounded Drug, Not Otherwise Classified) effective July 1, 2015. HCPCS code Q9977 should be used to report compounded drug combinations.

### *Revised Coding Guidance for Intraocular or Periocular Injections of Combinations of Anti-Inflammatory Drugs and Antibiotics*

Intraocular or periocular injections of combinations of anti-inflammatory drugs and antibiotics are being used with increased frequency in ocular surgery (primarily cataract surgery). One example of combined or compounded drugs includes triamcinolone and moxifloxacin with or without vancomycin. Such combinations may be administered as separate injections or as a single combined injection. Because such injections may obviate the need for post-operative anti-inflammatory and antibiotic eye drops, some have referred to cataract surgery with such injections as “dropless cataract surgery.”

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As stated in the Calendar Year (CY) 2015 National Correct Coding Initiative (NCCI) Policy Manual (Chapter VIII, section D, item 20; see <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/>), injection of a drug during a cataract extraction procedure or other ophthalmic procedure is not separately reportable. Specifically, no separate procedure code may be reported for any type of injection during surgery or in the perioperative period. Injections are a part of the ocular surgery and are included as a part of the ocular surgery and the HCPCS code used to report the surgical procedure.

According to the “Medicare Claims Processing Manual (Chapter 17, Section 90.2; see <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf>), the compounded drug combinations described above and similar drug combinations should be reported with HCPCS code Q9977, regardless of the site of service of the surgery, and are packaged as surgical supplies in both the Hospital Outpatient Department (HOPD) and the Ambulatory Surgical Center (ASC). Although these drugs are a covered part of the ocular surgery, no separate payment will be made. In addition, these drugs and drug combinations may not be reported with HCPCS code C9399.

According to the “Medicare Claims Processing Manual” (Chapter 30, Section 40.3.6; see <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf>), physicians or facilities should not give Advance Beneficiary Notices (ABNs) to beneficiaries for either these drugs or for injection of these drugs because they are fully covered by Medicare. Physicians or facilities are not permitted to charge the patient an extra amount (beyond the standard copayment for the surgical procedure) for these injections or the drugs used in these injections because they are a covered part of the surgical procedure. Also, physicians or facilities cannot circumvent packaged payment in the HOPD or ASC for these drugs by instructing beneficiaries to purchase and bring these drugs to the facility for administration.

### *Drugs, Biologicals, and Radiopharmaceuticals*

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

For CY 2015, payment for non-pass-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 October 1, 2015 and drug price restatements can be found in the October 2015 update of the

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OPPS Addendum A and Addendum B at <http://www.cms.gov/HospitalOutpatientPPS/> on the CMS website.

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

Some drugs and biologicals based on 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 October 1, 2015**

Two drugs and biologicals have been granted OPSS pass-through status effective October 1, 2015. These items, along with their descriptors and APC assignments, are identified in Table 2 below.

**Table 2 – Drugs and Biologicals with OPSS Pass-Through Status Effective October 1, 2015**

HCPCS Code	Long Descriptor	APC	Status Indicator
<b>C9456</b>	Injection, isavuconazonium sulfate, 1 mg	9456	G
<b>C9457</b>	Injection, sulfur hexafluoride lipid microsphere, per ml	9457	G

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

Effective October 1, 2015 a new HCPCS code has been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. This new code is listed in Table 3 below.

**Table 3 – New HCPCS Code Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals**

CY 2015 HCPCS Code	CY 2015 Long Descriptor	CY 2015 SI	CY 2015 APC
<b>Q9979</b>	Injection, alemtuzumab, 1 mg	K	1809

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**e. Corrected Dosage Descriptor for HCPCS Code Q9976**

The correct dosage descriptor for Q9976 is 0.1 mg of iron. The short and long descriptor are included in Table 4 below.

**Table 4 – Corrected Dosage Descriptor for HCPCS Code Q9976**

<b>HCPCS Code</b>	<b>Revised Short Descriptor</b>	<b>Revised Long Descriptor</b>
<b>9976</b>	Inj Ferric Pyrophosphate Cit	Injection, Ferric Pyrophosphate Citrate Solution, 0.1 mg of iron

**f. Reassignment of Skin Substitute Products from the Low Cost Group to the High Cost Group**

One existing skin substitute product has been reassigned from the low cost skin substitute group to the high cost skin substitute group based on updated pricing information. This product is listed in Table 5 below.

**Table 5 – Updated Skin Substitute Product Assignment to High Cost Status Effective October 1, 2015**

<b>HCPCS Code</b>	<b>Short Descriptor</b>	<b>Status Indicator</b>	<b>Low/High Cost Status</b>
<b>Q4151</b>	AmnioBand, guardian 1 sq cm	N	High

**g. Revised Status Indicator for HCPCS Code Q5101**

Effective September 3, 2015, the status indicator for HCPCS code Q5101 (Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram) will change from SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=K (Paid under OPSS; separate APC payment). APC 1822 is assigned to Q5101 as shown in Table 6 below. If you had claims for Q5101 for dates of service on or after September 3, 2015, that were processed prior to the installation of the October 2015 OPSS Pricer, your MAC will adjust those claims if you bring them to the attention of your MAC.

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**Table 6 – Drug and Biological with Revised Status Indicator  
Effective September 3, 2015**

<b>HCPCS Code</b>	<b>Long Descriptor</b>	<b>APC</b>	<b>Status Indicator</b>
<b>Q5101</b>	Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram	1822	K

### *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. 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**

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The official instruction, CR9298, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3352CP.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.

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