

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



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Related Change Request (CR) #: CR 9601

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Effective Date: January 1, 2016

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Implementation Date: October 3, 2016

Phase 2 of Updating the Fiscal Intermediary Shared System (FISS) to Make Payment for Drugs and Biologicals Services for Outpatient Prospective Payment System (OPPS) Providers

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs and Durable Medical Equipment MACs (DME MACs) for services provided to Medicare beneficiaries and paid under the Outpatient Prospective Payment System (OPPS).

Provider Action Needed

Change Request (CR) 9601 informs MACs about the implementation of phase 2 of system changes necessary to the Fiscal Intermediary Shared System (FISS) and Integrated Outpatient Code Editor (IOCE) which are necessary to make payment for drugs and biologicals to OPPS providers. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) pays for all outpatient drugs using the Average Sales Price (ASP) methodology. The schedule for submission of all ASP pricing is statutory per Section 621(a) of the Medicare Modernization Act. Drug manufacturers are required to submit drug ASPs within 30 days of the close of their fiscal quarter. Given the complexity, volume of data, and the number of drugs affected, approximately 6 weeks are required to process, validate, and issue final ASPs for a given quarter. As a result, the ASP rates for drugs furnished on or after January 1, 2016, were not

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available until mid-December 2015. The ASP rates for drugs furnished on or after April 1, 2016, were not available until mid-March 2016. The ASP rates for drugs furnished on or after July 1, 2016, will not be available until mid-June 2016 and the ASP rates for drugs furnished on or after October 1, 2016, will not be available until mid-September 2016 respectively.

CMS supplies MACs with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis and this file is used for payment to most institutional providers by FISS. OPSS claims were an exception to this process. Payment for OPSS claims were based on tables provided to the OPSS Pricer to account for some of the special processing rules that are unique to OPSS providers (such as, pass-through status necessary and drugs provided solely in the hospital setting).

Starting on October 1, 2016, drug HCPCS on OPSS claims will no longer be priced by the Outpatient PPS Pricer. The fee schedule amount from the ASP drug file or any future drug fee schedule amount will be used by FISS to price covered outpatient drugs, and drugs and biologicals with pass-through status under the OPSS. Phase 2 includes logic for FISS to cap the coinsurance amounts for procedures (which include blood and drug services) to the inpatient deductible amount for each calendar year and to insure the rural floor is applied.

The following examples are part of CR9601 to demonstrate the capped inpatient deductible amount:

Example 1 of inpatient deductible capped amount:

Drug Line A has a fee of \$2,000.00, a payment of \$1,600.00, and coinsurance of \$400.00.

Drug Line B has a fee of \$1,000.00, a payment of \$800.00, and coinsurance of \$200.00.

Drug Line C has a fee of \$500.00, a payment of \$400.00 and coinsurance of \$100.00.

Drug Line D has a fee of \$500.00, a payment of \$400.00 and coinsurance of \$100.00.

Highest wage adjusted national coinsurance amount for a procedure line is \$888.00.

The Inpatient Part A deductible is \$1,288.00 for 2016

$\$1,288.00 - \$888.00 = \$400.00$ remaining coinsurance to be applied toward inpatient deductible cap.

Drug Lines A-D coinsurance is \$800.00.

$\$400.00$ cap remaining / $\$800.00$ drug line(s) coinsurance = 50% reduction to coinsurance due to inpatient deductible cap

Apply 50% reduction of the coinsurance amounts for each line and add the remaining 50% back into the payment amount.

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Drug Line A has a final payment of \$1,800.00, and coinsurance of \$200.00.

Drug Line B has a final payment of \$900.00, and coinsurance of \$100.00.

Drug Line C has a final payment of \$450.00, and coinsurance of \$50.00.

Drug Line D has a final payment of \$450.00, and coinsurance of \$50.00.

Example 2 of inpatient deductible capped amount:

Drug Line A has a fee of \$2,000.00, a payment of \$1,600.00, and coinsurance of \$400.00.

Drug Line B has a fee of \$1,000.00, a payment of \$800.00, and coinsurance of \$200.00.

Drug Line C has a fee of \$500.00, a payment of \$400.00 and coinsurance of \$100.00.

Drug Line D has a fee of \$500.00, a payment of \$400.00 and coinsurance of \$100.00.

Highest wage adjusted national coinsurance amount for a procedure line is \$1,588.00.

The Inpatient Part A deductible is \$1,288.00 for 2016

\$1,588.00 is greater than \$1,288.00. The OPPS Pricer will cap the coinsurance amount to be applied on the highest wage adjusted national coinsurance procedure line prior to application of the cap on the drug lines.

Drug Lines A-D coinsurance is \$800.00.

$\$0 \text{ cap remaining} / \$800.00 = 100\%$ reduction to coinsurance due to inpatient deductible cap

Drug Line A has a final payment of \$2,000.00, and no coinsurance.

Drug Line B has a final payment of \$1,000.00, and no coinsurance.

Drug Line C has a final payment of \$500.00, and no coinsurance.

Drug Line D has a final payment of \$500.00, and no coinsurance.

Additional Information

The official instruction, CR9601 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1649OTN.pdf>.

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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