

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



News Flash – Has Medicare sent you a notice to revalidate your enrollment? If you are not sure, you can find lists of providers sent notices to revalidate their Medicare enrollment by scrolling to the "Downloads" section at http://www.CMS.gov/MedicareProviderSupEnroll/11_Revalidations.asp on the Centers for Medicare & Medicaid Services (CMS) website. That site currently contains links to lists of providers sent notices from September, 2011 through January, 2012. Information on revalidation letters sent in February will be posted in late March. For ease of reference, the lists are in order by National Provider Identifier and the date the notice was sent.

MLN Matters® Number: MM7748

Related Change Request (CR) #: CR 7748

Related CR Release Date: March 2, 2012

Effective Date: April 1, 2012

Related CR Transmittal #: R2418CP

Implementation Date: April 2, 2012

April 2012 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), A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) 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) 7748 which describes changes to and billing instructions for various payment policies implemented in the April 2012 OPPS update. Be sure your billing staffs are aware of these changes.

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Background

CR7748 describes changes to and billing instructions for various payment policies implemented in the April 2012 OPSS update. The April 2012 Integrated Outpatient Code Editor (I/OCE) and OPSS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), Status Indicators (SIs), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this CR.

Note that the April 2012 revisions to I/OCE data files, instructions, and specifications are provided in CR7751, "April 2012 Integrated Outpatient Code Editor (I/OCE) Specifications Version 13.1." An MLN Matters® article for CR7751 will be available upon the release of that CR at <http://www.cms.gov/MLN MattersArticles/downloads/MM7751.pdf> on the Centers for Medicare & Medicaid Services (CMS) website. The key changes in the April update are as follows:

Changes to Device Edits for April 2012

Claims for OPSS services must pass two types of device edits to be accepted for processing: procedure-to-device edits and device-to-procedure edits. Procedure-to-device edits, which have been in place for many procedures since 2005, continue to be in place. These edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code. Procedures for which both a Device A and Device B are specified require that at least one each of a Device A and Device B be present on the claim (i.e., there must be some combination of a Device A with a Device B in order to pass the edit). Device B can be reported with any Device A for the same procedural HCPCS code.

Since January 1, 2007, CMS also has required that a claim that contains one of a specified set of device codes be returned to the provider if it fails to contain an appropriate procedure code. CMS has determined that the devices contained in this list cannot be correctly reported without one of the specified procedure codes also being reported on the same claim. Where these devices were billed without an appropriate procedure code prior to January 1, 2007, the cost of the device was being packaged into the median cost for an incorrect procedure code and therefore inflated the payment for the incorrect procedure code. In addition, hospitals billing devices without the appropriate procedure code were being incorrectly paid. The device-to-procedure edits are designed to ensure that the costs of these devices are assigned to the appropriate APC in OPSS rate setting.

The most current edits for both types of device edits can be found under "Device, Radiolabeled Product, and Procedure Edits" at <http://www.cms.gov/HospitalOutpatientPPS/> on the CMS website. Failure to pass these edits will result in the claim being returned to the provider.

Effective for services furnished on or after January 1, 2012, the American Medical Association (AMA) changed the descriptor for CPT code 33249 to read "Insertion or replacement of permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber." This has necessitated the removal of HCPCS code C1882 (Cardioverter-defibrillator, other than single or dual chamber (implantable)) from the list of those device codes required to be billed with CPT code 33249 on the procedure-to-device edit list, since this link is no longer clinically appropriate. CMS is making this change retroactive to January 1, 2012.

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New Service (Fluorescent Vascular Angiography)

The following new service is assigned for payment under the OPPS, effective April 1, 2012:

Table 1 – Fluorescent Vascular Angiography

HCPCS	Effective date	SI	APC	Short Descriptor	Long descriptor	Payment	Minimum Unadjusted Copayment
C9733	4/01/2012	Q2	0397	Non-ophthalmic FVA	Non-ophthalmic fluorescent vascular angiography	\$154.87	\$30.98

HCPCS code C9733 is assigned to APC 0397 (Vascular Imaging) and should be used to report fluorescent vascular angiography. C9733 describes SPY® Fluorescence Vascular Angiography and other types of non-ophthalmic fluorescent vascular angiography.

Billing for Drugs, Biologicals, and Radiopharmaceuticals

Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective April 1, 2012

For Calendar Year (CY) 2012, payment for non-pass-through drugs, biologicals, and therapeutic radiopharmaceuticals is made at a single rate of ASP + 4 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2012, 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.

In the CY 2012 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 2012 release of the OPPS Pricer. The updated payment rates, effective April 1, 2012 will be included in the April 2012 update of the OPPS Addendum A and Addendum B, which will be posted at <http://www.cms.gov/HospitalOutpatientPPS/AU/> on the CMS website.

Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2012

Four drugs and biologicals have been granted OPPS pass-through status effective April 1, 2012. These items, along with their descriptors and APC assignments, are identified in Table 2 below.

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Table 2 – Drugs and Biologicals with OPSS Pass-Through Status Effective April 1, 2012

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 4/1/12
C9288	Injection, centruroides (scorpion) immune f(ab)2 (equine), 1 vial	9288	G
C9289	Injection, asparaginase erwinia chrysanthemi, 1,000 international units (I.U.)	9289	G
C9290	Injection, bupivacaine liposome, 1 mg	9290	G
C9291	Injection, aflibercept, 2 mg vial	9291	G

Additional Information on HCPCS Code C9291 (Injection, aflibercept, 2 mg vial)

Eylea (aflibercept) is packaged in a sterile, 3 mL single use vial containing a 0.278 mL fill of 40 mg/mL Eylea (NDC 61755-0005-02). As approved by the Food and Drug Administration (FDA), the recommended dose for Eylea is 2 mg every 4 weeks, followed by 2 mg every 8 weeks. Payment for HCPCS code C9291 is for the entire contents of the single-use vial, which is labeled as providing a 2 mg dose of aflibercept. As indicated in 42 CFR § 414.904, CMS calculates an 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.

a. Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2011 through September 30, 2011

The payment rates for several HCPCS codes were incorrect in the July 2011 OPSS Pricer. The corrected payment rates are listed in Table 3 below and have been installed in the April 2012 OPSS Pricer, effective for services furnished on July 1, 2011, through implementation of the October 2011 update. If you have claims that were incorrectly processed based on the incorrect prices, make your contractor aware and they will adjust the claims.

Table 3 – Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2011 through September 30, 2011

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J0735	K	0935	Clonidine hydrochloride	\$35.67	\$7.13

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HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J1212	K	1221	Dimethyl sulfoxide 50% 50 ML	\$84.55	\$16.91
J1756	K	9046	Iron sucrose injection	\$0.34	\$0.07
J9245	K	0840	Inj melphalan hydrochl 50 MG	\$1,308.97	\$261.79

b. Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2011 through December 31, 2011

The payment rates for several HCPCS codes were incorrect in the October 2011 OPSS Pricer. The corrected payment rates are listed in Table 4 below and have been installed in the April 2012 OPSS Pricer, effective for services furnished on October 1, 2011, through implementation of the January 2012 update. If you have claims that were incorrectly processed based on the incorrect prices, make your contractor aware and they will adjust the claims.

Table 4 – Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2011 through December 31, 2011

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J0735	K	0935	Clonidine hydrochloride	\$30.54	\$6.11
J1212	K	1221	Dimethyl sulfoxide 50% 50 ML	\$84.86	\$16.97
J1742	K	9044	Ibutilide fumarate injection	\$126.92	\$25.38
J9245	K	0840	Inj melphalan hydrochl 50 MG	\$1,280.08	\$256.02

c. Correct Reporting of Biologicals When Used As Implantable Devices

When billing for products that are used as either a surgically implanted or inserted biological, or as a skin substitute, hospitals should report the appropriate HCPCS code for the product. Implantable biologicals with pass-through status receive separate payment, but for those that do not have pass-through status, the OPSS payment for the implanted biological is packaged into the payment for the associated procedure. Products that can be used as either a skin substitute or as an implantable biological will only be separately paid when billed with a skin substitute application procedure (see below for further details on payment for skin substitutes). Units should be reported in multiples of the units included in the HCPCS descriptor. Providers and hospitals should not bill the units based on the way the implantable biological is packaged, stored, or stocked, if different from the HCPCS descriptor.

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The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the implantable biological. Therefore, before submitting Medicare claims for biologicals that are used as implantable devices, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

d. I/OCE Logic Changes for Skin Substitutes

Hospitals are reminded that HCPCS codes describing products that can be used as skin substitutes, as listed in Table 5 below, will be separately paid only when used with one of the CPT codes describing the application of a skin substitute (15271-15278). Effective April 1, 2012, CMS is implementing logic changes to the I/OCE to ensure that separate payment is made for skin substitutes only when they are billed with a skin substitute application procedure.

Table 5 – Payable Skin Substitute HCPCS Codes for CY 2012

HCPCS Code	APC	Short Descriptor	Status Indicator
C9358	9358	SurgiMend, fetal	K
C9360	9360	SurgiMend, neonatal	K
C9363	9363	Integra Meshed Bil Wound Mat	K
C9366	9366	EpiFix wound cover	G
C9367	9367	Endoform Dermal Template	G
Q4100	N/A	Skin substitute, NOS	N
Q4101	1240	Apligraf	K
Q4102	1241	Oasis wound matrix	K
Q4103	1242	Oasis burn matrix	K
Q4104	1243	Integra BMWD	K
Q4105	1244	Integra DRT	K
Q4106	1245	Dermagraft	K
Q4107	1246	Graftjacket	K
Q4108	1247	Integra matrix	K
Q4110	1248	Primatrix	K
Q4111	1252	Gammagraft	K
Q4112	1249	Cymetra injectable	K
Q4113	1250	Graftjacket xpress	K

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HCPCS Code	APC	Short Descriptor	Status Indicator
Q4114	1251	Integra flowable wound matri	K
Q4115	1287	Alloskin	K
Q4116	1270	Alloderm	K
Q4118	1342	Matristem micromatrix	K
Q4119	1351	Matristem wound matrix	K
Q4121	1345	Theraskin	K
Q4122	1419	Dermacell	K
Q4124	9365	Oasis Ultra Tri-Layer Matrix	G
Q4130	N/A	Strattice TM	N

Update to Section 308 of the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA)

CR7748 revises the "Medicare Claims Processing Manual" (Chapter 4, Section 70.7) to include Section 308 of the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA) which extends the Outpatient Hold-Harmless provision, effective for dates of service on or after January 1, 2012, through February 29, 2012, to rural hospitals with 100 or fewer beds and to all Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs) regardless of bed size. The revised Section 70.7 is included as attachment to CR7748, and the revised paragraph is as follows:

"Section 308 of the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA) extends the Outpatient Hold-Harmless provision, effective for dates of service on or after January 1, 2012, through February 29, 2012, to rural hospitals with 100 or fewer beds and to all SCHs and EACHs regardless of bed size."

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. FIs/MACs determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, FIs/MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

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Additional Information

The official instruction, CR7748, issued to your FIs, A/B MACs, and RHHs regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2418CP.pdf> on the CMS website.

If you have any questions, please contact your FIs, A/B MACs, or RHHs at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

News Flash - It's Not too Late to Give and Get the Flu Vaccine. Take advantage of each office visit and protect your patients against the seasonal flu. Medicare will continue to pay for the seasonal flu vaccine and its administration for all Medicare beneficiaries through the entire flu season. The Centers for Disease Control and Prevention (CDC) also recommends that patients, healthcare workers and caregivers be vaccinated against the seasonal flu. **Protect your patients. Protect your family. Protect yourself. Get the Flu Vaccine—Not the Flu. Remember: The flu vaccine plus its administration are covered Part B benefits. The flu vaccine is NOT a Part D-covered drug.** For more information on coverage and billing of the flu vaccine and its administration, and related provider resources, visit [2011-2012 Provider Seasonal Flu Resources](#) and [Immunizations](#). For the 2011-2012 seasonal flu vaccine payment limits, visit http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp on the Centers for Medicare & Medicaid Services (CMS) website.

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