

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



News Flash – The Medicare Learning Network® (MLN) has released the first in a series of podcasts designed to educate Fee-For-Service providers about how to avoid common billing errors and other improper activities when dealing with the Medicare Program. This podcast titled, "Recovery Audit Program (RAP) Demonstration High-Risk Medical Necessity Vulnerabilities for Inpatient Hospitals," is based on MLN Matters Article #SE1027 and discusses some of the 17 findings identified by the RAP in an effort to prevent future improper payment issues. To download this podcast, go to the MLN Multimedia web page at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html> and click on 'Provider Compliance' from the list of topics. Stay tuned for future podcasts from the MLN!

MLN Matters® Number: MM7342

Related Change Request (CR) #: CR 7342

Related CR Release Date: March 18, 2011

Effective Date: April 1, 2011

Related CR Transmittal #: R2174CP

Implementation Date: April 4, 2011

April 2011 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Note: This article was updated on August 20, 2012, to reflect current Web addresses. All other content remains the same.

Provider Types Affected

This article is for providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs), and/or Regional Home Health Intermediaries (RHHIs)) for outpatient services provided to Medicare beneficiaries and paid under the Outpatient Prospective Payment System (OPPS).

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2010 American Medical Association.

Provider Action Needed

This article is based on change request (CR) 7342 which describes changes to the OPPS to be implemented in the April 2011 OPPS update. Be sure your billing staffs are aware of these changes.

Background

Change Request (CR) 7342 describes changes to and billing instructions for various payment policies implemented in the April 2011 OPPS update. The April 2011 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 this notification.

Note that the April 2011 revisions to I/OCE data files, instructions, and specifications are provided in CR7344, "April 2011 Integrated Outpatient Code Editor (I/OCE) Specifications Version 12.1." An MLN Matters® article is available for that CR at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7344.pdf> on the Centers for Medicare & Medicaid Services (CMS) website. The key changes in the April update are as follows:

Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective April 1, 2011

For Calendar Year (CY) 2011, payment for non pass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of Average Sales Price (ASP) plus five percent (ASP + 5%), which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2011, a single payment of ASP plus six percent (ASP + 6%) 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. CMS notes that for the second quarter of CY 2011, payment for drugs and biologicals with pass-through status is not made at the Part B Drug Competitive Acquisition Program (CAP) rate, as the CAP program was suspended beginning January 1, 2009. Should the Part B Drug CAP program be reinstated sometime during CY 2011, CMS would again use the Part B drug CAP rate for pass-through drugs and biologicals if they are a part of the Part B drug CAP program, as required by the statute.

In the CY 2011 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 Average Sales Price (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 2011 release of the OPPS PRICER. The updated payment rates, effective April 1, 2011, will be included in the April 2011 update of the OPPS Addendum A and Addendum B, which will be posted at

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2010 American Medical Association.

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html> on the CMS website.

Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2011

Three drugs and biologicals have been granted OPPS pass-through status effective April 1, 2011. These items, along with their descriptors and APC assignments, are identified in Table 1 below.

Table 1 - Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2011

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 4/1/11
C9280	Injection, eribulin mesylate, 1 mg	9280	G
C9281	Injection, pegloticase, 1 mg	9281	G
C9282	Injection, ceftaroline fosamil, 10 mg	9282	G

New HCPCS Codes Effective for Certain Drugs and Biologicals

One new HCPCS code has been created for reporting drugs and biologicals in the hospital outpatient setting for April 1, 2011. This code is listed in Table 2 below and is effective for services furnished on or after April 1, 2011. HCPCS code Q2040 is replacing HCPCS code C9278 beginning on April 1, 2011.

Table 2 - New HCPCS Codes Effective for Certain Drugs and Biologicals Effective April 1, 2011

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 4/1/11
Q2040	Injection, incobotulinumtoxin A, 1 unit	9278	G

Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2010 through December 31, 2010

The payment rates for several HCPCS codes were incorrect in the October 2010 OPSS PRICER. The corrected payment rate is listed in Table 3 below and has been installed in the April 2011 OPSS PRICER, effective for services furnished on October 1, 2010, through implementation of the January 2011 update. Claims already processed and impacted by these updates will be adjusted, as you bring such claims to the attention of your Medicare contractor.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2010 American Medical Association.

**Table 3 - Updated Payment Rates for Certain HCPCS Codes
Effective October 1, 2010, through December 31, 2010**

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J0833	K	0835	Cosyntropin injection NOS	\$51.32	\$10.26
J1451	K	1689	Fomepizole, 15 mg	\$7.14	\$1.43
J3030	K	3030	Sumatriptan succinate / 6 MG	\$45.71	\$9.14
J7502	K	1292	Cyclosporine oral 100 mg	\$3.04	\$0.61
J7507	K	0891	Tacrolimus oral per 1 MG	\$3.18	\$0.64
J9185	K	0842	Fludarabine phosphate inj	\$162.67	\$32.53
J9206	K	0830	Irinotecan injection	\$7.45	\$1.49
J9218	K	0861	Leuprolide acetate injection	\$4.50	\$0.90
J9263	K	1738	Oxaliplatin	\$4.52	\$0.90

Updated Payment Rate for HCPCS Code Q4118 Effective January 1, 2011, through March 31, 2011

The payment rate for HCPCS code Q4118 was incorrect in the January 2011 OPPTS PRICER. The corrected payment rate is listed in Table 4 below and has been installed in the April 2011 OPPTS PRICER, effective for services furnished on January 1, 2011, through implementation of the April 2011 update. Claims already processed and impacted by these updates will be adjusted, as you bring such claims to the attention of your Medicare contractor.

**Table 4 - Updated Payment Rates for HCPCS Code
Q4118 Effective January 1, 2011, through March 31, 2011**

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
4118 ^Q	K	1342	Matristem micromatrix	\$3.19	\$0.64

***Adjustment to Status Indicator for HCPCS code Q4119
Effective January 1, 2011***

In the CY 2011 OPPTS/ASC Final Rule with comment period, CMS assigned HCPCS code Q4119, Matristem wound matrix, per square centimeter, a status indicator of "E" for services billed on or after January 1, 2011, indicating that the service is not paid by Medicare when

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2010 American Medical Association.

submitted on outpatient claims. For services furnished on or after January 1, 2011, CMS is changing the status indicator for HCPCS code Q4119 to "K" to indicate that separate payment may be made for this product. HCPCS code Q4119 is assigned to APC 1351 (Matristem wound matrix, per square centimeter) with a payment rate of \$5.62 and a minimum unadjusted copayment rate of \$1.12 for the first quarter of CY 2011. The January 2011 price for HCPCS code Q4119 will be incorporated into the April 2011 OPPS Pricer. Claims already processed and impacted by these updates will be adjusted, as you bring such claims to the attention of your Medicare contractor.

Category I H1N1 Vaccine Codes

As stated in the July 2010 update of the hospital OPPS that was published in CR6996, CMS assigned status indicator "E" to Current Procedural Terminology (CPT) codes 90663 and 90470. (A related MLN Matters® article for CR6996 is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6996.pdf> on the CMS website) As of December 31, 2011, the American Medical Association discontinued the use of these codes. Therefore, effective January 1, 2011, CPT codes 90663 and 90470 are being assigned a status indicator of "D" under the OPPS, to indicate that these codes are discontinued and are no longer paid under the OPPS or any other Medicare payment system.

Correct Reporting of Units for Drugs

Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full Healthcare Common Procedure Coding System HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor. For example, if the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be 1. As another example, if the description for the drug code is 50 mg, but 200 mg of the drug was administered to the patient, the units billed should be 4. Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient; hospitals should bill 10 units, even though only 1 vial was administered. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

As discussed in the "Medicare Claims Processing Manual" (Pub.100-04, Chapter 17, Section 40; see <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf> on the CMS website), CMS encourages hospitals to use drugs efficiently and in a clinically appropriate manner. However, CMS also recognizes that hospitals may discard some drug and biological product when administering from a single use vial or package. In that circumstance, Medicare pays for the amount of drug or biological discarded *as well as* the *dose* administered, up to the amount of

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2010 American Medical Association.

the drug or biological as indicated on the vial or package label. Multi-use vials are not subject to payment for discarded amounts of drug or biological.

Reporting of Outpatient Diagnostic Nuclear Medicine Procedures

With the specific exception of HCPCS code C9898 (Radiolabeled product provided during a hospital inpatient stay), to be reported by hospitals on outpatient claims for nuclear medicine procedures to indicate that a radiolabeled product that provides the radioactivity necessary for the reported diagnostic nuclear medicine procedure was provided during a hospital inpatient stay, hospitals should only report HCPCS codes for products they provide in the hospital outpatient department and should not report a HCPCS code and charge for a radiolabeled product on the nuclear medicine procedure-to-radiolabeled product edit list solely for the purpose of bypassing those edits present in the Integrated Outpatient Code Editor (I/OCE.)

As CMS stated in the October 2009 OPPS update, in the rare instance when a diagnostic radiopharmaceutical may be administered to a beneficiary in a given calendar year prior to a hospital furnishing an associated nuclear medicine procedure in the subsequent calendar year, hospitals are instructed to report the date the radiolabeled product is furnished to the beneficiary as the same date that the nuclear medicine procedure is performed. CMS believes that this situation is extremely rare and expects that the majority of hospitals will not encounter this situation.

Where a hospital or a nonhospital location administers a diagnostic radiopharmaceutical product for a different hospital providing the nuclear medicine scan, hospitals should comply with the OPPS policy that requires that radiolabeled products be reported and billed with the nuclear medicine scan. In these cases, the first hospital or nonhospital location may enter into an arrangement under Section 1861(w)(1) of the Social Security Act and as discussed in 42 CFR 410.28(a)(1) and defined in 42 CFR 409.3 where the second hospital that administers the nuclear medicine scan both bills Medicare for the administration of the nuclear medicine scan with diagnostic radiopharmaceutical and pays the first hospital or nonhospital location that administers the diagnostic radiopharmaceutical some amount for administration of the diagnostic radiopharmaceutical. CMS notes that it considers the radiolabeled product and the nuclear medicine scan to be part of one procedure and would expect both services to be performed together.

Use of HCPCS Code C9399

As stated in the "Medicare Claims Processing Manual" (Pub. 100-04, Chapter 17, Section 90.3; see <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf> on the CMS website), hospitals are to report HCPCS code C9399, unclassified drug or biological, solely for new outpatient drugs or biologicals that are approved by the FDA on or after January 1, 2004, and that are furnished as part of covered outpatient department services for which a product-specific HCPCS code has not been assigned. It is not appropriate to report HCPCS code C9399 for drugs and biologicals that are defined as usually self-administered drugs by the patient as defined in the "Medicare Benefit Policy Manual" (Chapter 15, Section 50.2; see

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2010 American Medical Association.

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf> on the CMS website).

New Service

The following new service is assigned for payment under the OPPS:

Table 5 - New Service Assigned for Payment Under the OPPS

HCPCS	Short Descriptor	Long Descriptor	SI	APC	Payment Rate	Minimum Unadjusted Copayment	Effective Date
C9729	Percut lumbar lami	Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with ligamentous resection, discectomy, facetectomy and/or foraminotomy, when performed) any method under indirect image guidance, with the use of an endoscope when performed, single or multiple levels, unilateral or bilateral; lumbar	T	0208	\$3,535.92	\$707.19	4/1/2011

Adjustment to Status Indicator for HCPCS Code G0010 Effective January 1, 2011

HCPCS code G0010 (Administration of hepatitis B vaccine) was erroneously assigned status indicator "B" effective January 1, 2011, in the January 2011 update issued in CR7271. (An MLN Matters® article related to CR7271 is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7271.pdf> on the CMS website). Therefore, retroactively effective January 1, 2011, the status indicator for HCPCS code G0010 will change from status indicator "B" (Codes that are not recognized by OPSS when submitted on an outpatient hospital Part B bill type (12x and 13x)) to status indicator "S" (Significant Procedure, Not Discounted When Multiple). Beginning January 1, 2011, HCPCS code G0100 will be assigned to APC 0436.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2010 American Medical Association.

In order to ensure correct waiver of coinsurance and deductible for the administration of hepatitis B vaccines, providers should report HCPCS G0010 for billing under the OPPS rather than CPT code 90471 (Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)) or CPT code 90472 (Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure)) for services performed beginning January 1, 2011.

HCPCS Code Q1003 Deleted Effective April 1, 2011

HCPCS code Q1003 (New technology intraocular lens category 3) is currently packaged under the OPPS and is being deleted for dates of service effective April 1, 2011. For more information on the deletion of this HCPCS code, refer to the MLN Matters® article related to CR7271, which is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7271.pdf> on the CMS website.

Additional Information

The official instruction, CR7342, issued to your FIs, A/B MACs, and RHHIs regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2174CP.pdf> on the CMS website.

If you have any questions, please contact your FIs, A/B MACs, or RHHIs 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.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2010 American Medical Association.