DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Revised products from the Medicare Learning Network® (MLN)

- "Discharge Planning," Booklet, ICN 908184, Hard Copy only.

MLN Matters® Number: MM8338

Related Change Request (CR) #: CR 8338

Related CR Release Date: June 7, 2013

Effective Date: July 1, 2013

Related CR Transmittal #: R2718CP

Implementation Date: July 1, 2013

July 2013 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 OPPS.

Provider Action Needed

This article is based on Change Request (CR) 8338 which describes changes and billing instructions for various payment policies implemented in the July 2013 Outpatient Prospective Payment System (OPPS) update. The July 2013 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), Status Indicator (SI), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR8338. CR8338 also updates the "Medicare Claims Processing Manual," Chapter 4, Sections 61.4.1 (Billing for Brachytherapy Sources) and 61.4.5 (Payment for New Brachytherapy

Sources) which is included as an attachment.

The July 2013 revisions to I/OCE data files, instructions, and specifications are provided in CR8317. A related MLN Matters® article is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8317.pdf on the Centers for Medicare & Medicaid Services (CMS) website. Be sure that your billing staff is aware of these changes.

Background

The key changes in the July 2013 OPPS update are as follows:

Changes to Device Edits for July 2013

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

New Service

The new service, listed in Table 1 below, is assigned for payment under the OPPS, effective July 1, 2013.

Table 1 – New Service Payable Under OPPS Effective July 1, 2013

HCPCS Code	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Payment	Minimum Unadjusted Copayment
C9736	7/1/2013	T	0131	Lap ablate uteri fibroid rf	Laparoscopy, surgical, radiofrequency ablation of uterine fibroid(s), including intraoperative guidance and monitoring, when performed	$3,487.15	$1,001.89

New Long Descriptor for C9734

Table 2, shown below, reflects a new long descriptor for HCPCS code C9734, effective July 1, 2013. HCPCS code C9734 must be performed with Magnetic Resonance (MR) guidance.

Table 2 – New Long Descriptor for C9734 Effective July 1, 2013

HCPCS Code	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Payment	Minimum Unadjusted Copayment
C9734	4/01/2013	S	0067	U/S trtmt, not leiomyomata	Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with magnetic resonance (MR) guidance	$3,300.64	$660.13

Deletion of HCPCS Code C1879 and Use of A4648

Consistent with the CMS general policy of using permanent HCPCS codes rather than using temporary HCPCS codes under the OPPS in order to streamline coding, CMS is deleting HCPCS code C1879 (Tissue marker, implantable) on June 30, 2013, because it is described by HCPCS code A4648 (Tissue marker, implantable, any type). Therefore, effective July 1, 2013, when using implantable tissue markers with any services provided in the OPPS, providers should report the use and cost of the implantable tissue marker with HCPCS code A4648 only.

Category III CPT Codes

The American Medical Association (AMA) releases Category III 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 2013 update, CMS is implementing in the OPPS six Category III CPT Codes that the AMA released in January 2013 for implementation on July 1, 2013. Of the six, four Category III CPT codes are separately payable under the hospital OPPS. The status indicators and APCs for these codes are shown in Table 3, below. Payment rates for these services can be found in Addendum B of the "July 2013 OPPS 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 3 -- Category III CPT Codes Implemented as of July 1, 2013

CPT Code	Long Descriptor	SI	APC
0329T	Monitoring of intraocular pressure for 24 hours or longer, unilateral or bilateral, with interpretation and report	E	N/A
0330T	Tear film imaging, unilateral or bilateral, with interpretation and report	S	0230
0331T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment;	S	0398
0332T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT	S	0398

CPT Code	Long Descriptor	SI	APC
0333T	Visual evoked potential, screening of visual acuity, automated	E	N/A
0334T	Sacroiliac joint stabilization for arthrodesis, percutaneous or minimally invasive (indirect visualization), includes obtaining and applying autograft or allograft (structural or morselized), when performed, includes image guidance when performed (e.g., CT or fluoroscopic)	T	0208

Billing for Drugs, Biologicals, and Radiopharmaceuticals

1. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective July 1, 2013

   In the Calendar Year (CY) 2013 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 July 2013 release of the OPPS Pricer. The updated payment rates, effective July 1, 2013 will be included in the July 2013 update of the OPPS Addendum A and Addendum B, which will be posted at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html on the CMS website.

2. Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2013

   Two drugs and biologicals have been granted OPPS pass-through status effective July 1, 2013. These items, along with their descriptors and APC assignments, are identified in Table 4, below.

Table 4 – Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2013

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 7/1/13
C9131*	Injection, ado-trastuzumab emtansine, 1 mg	9131	G
Q4122	Dermacell, per square centimeter	1419	G

Note: The HCPCS codes identified with an "*" indicate that these are new codes effective July 1, 2013.

3. Flublok (Influenza virus vaccine)

   Flublok (influenza virus vaccine) was approved by the FDA on January 16, 2013. For the July 2013 update, the HCPCS Workgroup established HCPCS code Q2033 to describe Flublok. CMS is assigning the OPPS status indicator "L" (Influenza Vaccine; Pneumococcal Pneumonia Vaccine) to HCPCS code Q2033 effective July 1, 2013. Prior to July 1, 2013, the appropriate code to report for Flublok would be an unlisted CPT/HCPCS vaccine code. Table 5, below, provides the descriptors and OPPS status indicator for HCPCS code Q2033.

Table 5– Flublok Influenza Vaccine OPPS Status Indicator

HCPCS Code	Short Descriptor	Long Descriptor	APC	Status Indicator Effective 07/01/13
Q2033	Influenza Vaccine, (Flublok)	Influenza Vaccine, Recombinant Himagglutinin Antigens, for Intramuscular Use (Flublok)	N/A	L

4. Fluarix Quadrivalent (Influenza Virus Vaccine)

Fluarix Quadrivalent (Influenza virus vaccine) was approved by the FDA on December 14, 2012, and is described by CPT code 90686. Because of the timing of the FDA approval, CMS was unable to assign CPT code 90686 to a separately payable status. For the July 2013 update, CMS is revising the OPPS status indicator for CPT code 90686 from "E" (Not Covered by Medicare) to "L" (Influenza Vaccine; Pneumococcal Pneumonia Vaccine) effective January 1, 2013. Prior to January 1, 2013, the appropriate code to report for Fluarix Quadrivalent would be an unlisted CPT/HCPCS vaccine code. Table 6, below, provides the descriptors and OPPS status indicator for CPT code 90686.

Table 6– Fluarix Quadrivalent (Influenza Virus Vaccine) Effective January 1, 2013

HCPCS Code	Short Descriptor	Long Descriptor	APC	Status Indicator Effective 01/01/13
90686	Flu vac no prsv 4 val 3 yrs+	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use	N/A	L

5. New HCPCS Codes Effective July 1, 2013 for Certain Drugs and Biologicals

Two new HCPCS codes have been created for reporting certain drugs and biologicals (other than new pass-through drugs and biological listed in Table 4 above) in the hospital outpatient setting for July 1, 2013. These codes are listed in Table 7, below, and are effective for services furnished on or after July 1, 2013.

Table 7 – New HCPCS Codes for Certain Drugs and Biologicals Effective July 1, 2013

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 7/1/13
Q2050*	Injection, Doxorubicin Hydrochloride, Liposomal, Not Otherwise Specified, 10 mg	7046	K
Q2051**	Injection, Zoledronic Acid, Not Otherwise Specified, 1 mg	1356	K

**HCPCS code J9002 (Injection, Doxorubicin Hydrochloride, Liposomal, Doxil, 10 mg) will be replaced with HCPCS code Q2050 effective July 1, 2013. The status indicator for HCPCS code J9002 will change to E, "Not Payable by Medicare," effective July 1, 2013.*

*** HCPCS code J3487 (Injection, Zoledronic Acid (Zometa), 1 mg) and HCPCS code J3488 (Injection, Zoledronic Acid (Reclast), 1 mg) will be replaced with HCPCS code Q2051 effective July 1, 2013. The status indicators for HCPCS codes J3487 and J3488 will change to E, "Not Payable by Medicare," effective July 1, 2013.*

6. Revised Status Indicator for HCPCS Codes Q4126 and Q4134 Effective July 1, 2013

Effective July 1, 2013, the status indicators for HCPCS code Q4126 (Memoderm, dermaspan, tranzgraft or integuply, per square centimeter) and HCPCS code Q4134 (Hmatrix, per square centimeter) 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). For the remainder of CY 2013, HCPCS code Q4126 and HCPCS code Q4134 will be separately paid and the prices for these codes will be updated on a quarterly basis. These codes are listed in Table 8, below, and are effective for services furnished on or after July 1, 2013.

Table 8 – Drugs and Biologicals with Revised Status Indicators Effective July 1, 2013

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 7/1/13
Q4126	Memoderm, dermaspan, tranzgraft or integuply, per square centimeter	1452	K
Q4134	Hmatrix, per square centimeter	1453	K

7. Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2013, Through June 30, 2013

The payment rates for two HCPCS codes were incorrect in the April 2013 OPPS Pricer. The corrected payment rates are listed in Table 9, below, and have been installed in the July 2013 OPPS Pricer, effective for services furnished on April 1, 2013, through June 30, 2013.

Table 9 – Updated Payment Rates for Certain HCPCS Codes
Effective April 1, 2013, Through June 30, 2013

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9297	G	9297	Omacetaxine mepesuccinate	$2.53	$0.51
C9298	G	9298	Injection, ocriplasmin	$1,046.75	$209.35

8. Updated Guidance: Billing and Payment for New Drugs, Biologicals, or Radiopharmaceuticals Approved by the FDA But Before Assignment of a Product-Specific HCPCS Code

   Hospital outpatient departments are allowed to bill for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which pass-through status has not been approved and a C-code and APC payment have not been assigned using the "unclassified" drug/biological HCPCS code C9399 (Unclassified drugs or biological). Drugs that are assigned to HCPCS code C9399 are contractor priced at 95 percent of AWP.

   Diagnostic radiopharmaceuticals and contrast agents are policy packaged under the OPPS unless they have been granted pass-through status. Therefore, new diagnostic radiopharmaceuticals and contrast agents are an exception to the above policy and should not be billed with C9399 prior to the approval of pass-through status but, instead, should be billed with the appropriate "A" NOC code as follows:

   a. Diagnostic Radiopharmaceuticals – All new diagnostic radiopharmaceuticals are assigned HCPCS code A4641 (Radiopharmaceutical, diagnostic, not otherwise classified). HCPCS code A4641 should be used to bill a new diagnostic radiopharmaceutical until the new diagnostic radiopharmaceutical has been granted pass-through status and a C-code has been assigned. HCPCS code A4641 is assigned status indicator "N" and, therefore, the payment for a diagnostic radiopharmaceutical assigned to HCPCS code A4641 is packaged into the payment for the associated service.

   b. Contrast Agents – All new contrast agents are assigned HCPCS code A9698 (Non-radioactive contrast imaging material, not otherwise classified, per study) or A9700 (Supply of injectable contrast material for use in echocardiography, per study). HCPCS code A9698 or A9700 should be used to bill a new contrast agent until the new contrast agent has been granted pass-through status and a C-code has been assigned. HCPCS code A9698 is assigned status indicator "N" and, therefore, the payment for a drug assigned to HCPCS code A9698 is packaged into the payment for the associated service. The status indicator for A9700 will change from SI=B (Not paid under OPPS) to SI=N (Payment is packaged into payment for other services) and, therefore, the payment for a drug assigned to HCPCS code A9700 is packaged into the payment for the associated service.

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. 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.

Revisions to the "Medicare Claims Processing Manual," Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS))

CR8338 updates the "Medicare Claims Processing Manual" (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)) by revising the Table of Contents and Section 61; 4.1 (Billing for Brachytherapy Sources), and by adding new Section 61.4.5 (Payment for New Brachytherapy Sources). The updated Chapter 4 is included as an attachment to CR8338, and the new Section 61.4.5 (Payment for New Brachytherapy Sources) is as follows:

61.4.5-Payment for New Brachytherapy Sources

"Not otherwise specified (NOS) Brachytherapy source codes are available for payment of new Brachytherapy sources for which source codes have not yet been established: C2698 (Brachytherapy source, stranded, not otherwise specified, per source), and C2699 (Brachytherapy source, non-stranded, not otherwise specified, per source). The payment rates for these NOS codes are based on a rate equal to the lowest stranded or non-stranded payment rate for such sources, respectively, on a per source basis (as opposed, for example, to per mCi). Once CMS establishes a new HCPCS code for a new source, the new code will be assigned to its own APC, with the payment rate set based on consideration of external data and other relevant information, until claims data are available for the standard OPPS rate making methodology."

Additional Information

The official instruction, CR8338 issued to your FIs, RHHIs, and A/B MACs regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2718CP.pdf on the CMS website.

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