DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Want to stay connected about the latest new and revised Medicare Learning Network® (MLN) products and services? Subscribe to the MLN Educational Products electronic mailing list! For more information about the MLN and how to register for this service, visit **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//MLNProducts_listserv.pdf** and start receiving updates immediately!

MLN Matters® Number: MM8776 **Related Change Request (CR) #: CR 8776**

Related CR Release Date: May 23, 2014 **Effective Date: July 1, 2014**

Related CR Transmittal #: R2971CP **Implementation Date: July 7, 2014**

July 2014 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 Administrative Contractors (MACs), including Home Health and Hospices MACs for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8776 which describes changes to and billing instructions for various payment policies implemented in the July 2014 Outpatient Prospective Payment System (OPPS) update. Make sure your billing staffs are aware of these changes.

Background

Change Request (CR) 8776 describes changes to and billing instructions for various payment policies implemented in the July 2014 OPPS update. The July 2014 Integrated

Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, Status Indicator (SI), and Revenue Code additions, changes, and deletions identified in CR 8776.

The July 2014 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming CR8764. The MLN Matters® Article related to CR8764 is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8764.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

Key changes to and billing instructions for various payment policies implemented in the July 2014 OPPS update are as follows:

Changes to Device Edits for July 2014

The most current list of device edits is available under "Device 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 Brachytherapy Source Payment

The Social Security Act (Section 1833(t)(2)(H); see **http://www.socialsecurity.gov/OP_Home/ssact/title18/1833.htm**) mandates the creation of additional groups of covered outpatient department (OPD) services that classify devices of brachytherapy consisting of a seed or seeds (or radioactive source) ("brachytherapy sources") separately from other services or groups of services. The additional groups must reflect the number, isotope, and radioactive intensity of the brachytherapy sources furnished. Cesium-131 chloride solution is a new brachytherapy source.

The HCPCS code assigned to this source as well as payment rate under OPPS are listed in Table 1 below.

Table 1—New Brachytherapy Source Code Effective July 1, 2014

HCPCS	Effective date	SI	APC	Short Descriptor	Long descriptor	Payment	Minimum Unadjusted Copayment
C2644	7/01/2014	U	2644	Brachytx cesium-131 chloride	Brachytherapy source, cesium-131 chloride solution, per millicurie	$18.97	$3.80

Category III Current Procedural Terminology (CPT) Codes

The American Medical Association (AMA) releases Category III CPT codes twice per year: 1.) in January, for implementation beginning the following July, and 2.) in July, for implementation beginning the following January.

For the July 2014 update, CMS is implementing in the OPPS 27 Category III CPT codes that the AMA released in January 2014 for implementation on July 1, 2014. Of the 27 Category III CPT codes shown in Table 2 below, 17 of the Category III CPT codes are separately payable under the hospital OPPS. The SIs and APCs for these codes are shown in Table 2 below. Payment rates for these services can be found in Addendum B of the July 2014 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 2 – 27 Category III CPT Codes Implemented as of July 1, 2014

CY 2014 CPT Code	CY 2014 Long Descriptor	July 2014 OPPS Status Indicator	July 2014 OPPS APC
0347T	Placement of interstitial device(s) in bone for radiostereometric analysis (RSA)	Q2	0420
0348T	Radiologic examination, radiostereometric analysis (RSA); spine, (includes, cervical, thoracic and lumbosacral, when performed)	X	0261
0349T	Radiologic examination, radiostereometric analysis (RSA); upper extremity(ies), (includes shoulder, elbow and wrist, when performed)	X	0261
0350T	Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies), (includes hip, proximal femur, knee and ankle, when performed)	X	0261
0351T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; real time intraoperative	N	N/A
0352T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; interpretation and report, real time or referred	B	N/A
0353T	Optical coherence tomography of breast, surgical cavity; real time intraoperative	N	N/A
0354T	Optical coherence tomography of breast, surgical cavity; interpretation and report, real time or referred	B	N/A
0355T	Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), colon, with interpretation and report	T	0142
0356T	Insertion of drug-eluting implant (including punctal dilation and implant removal when performed) into	S	0698

CY 2014 CPT Code	CY 2014 Long Descriptor	July 2014 OPPS Status Indicator	July 2014 OPPS APC
	lacrimal canaliculus, each		
0358T	Bioelectrical impedance analysis whole body composition assessment, supine position, with interpretation and report	Q1	0340
0359T	Behavior identification assessment, by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report	V	0632
0360T	Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; first 30 minutes of technician time, face-to-face with the patient	V	0632
0361T	Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; each additional 30 minutes of technician time, face-to-face with the patient (List separately in addition to code for primary service)	N	N/A
0362T	Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; first 30 minutes of technician(s) time, face-to-face with the patient	V	0632
0363T	Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; each additional 30 minutes of technician(s) time, face-to-face with the patient (List separately in addition to code for primary procedure)	N	N/A
0364T	Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; first 30 minutes of technician time	S	0322
0365T	Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; each	N	N/A

CY 2014 CPT Code	CY 2014 Long Descriptor	July 2014 OPPS Status Indicator	July 2014 OPPS APC
	additional 30 minutes of technician time (List separately in addition to code for primary procedure)		
0366T	Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; first 30 minutes of technician time	S	0325
0367T	Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; each additional 30 minutes of technician time (List separately in addition to code for primary procedure)	N	N/A
0368T	Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; first 30 minutes of patient face-to-face time	S	0322
0369T	Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; each additional 30 minutes of patient face-to-face time (List separately in addition to code for primary procedure)	N	N/A
0370T	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)	S	0324
0371T	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)	S	0324
0372T	Adaptive behavior treatment social skills group, administered by physician or other qualified health care professional face-to-face with multiple patients	S	0325
0373T	Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technicians' time, face-to-face with patient	S	0323
0374T	Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); each additional 30 minutes of technicians' time face-to-face with patient (List separately in addition to code for primary procedure)	N	N/A

Billing for Drugs, Biologicals, and Radiopharmaceuticals

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective July 1, 2014

In the CY 2014 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 2014 release of the OPPS Pricer. The updated payment rates, effective July 1, 2014, will be included in the July 2014 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.

b. Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2014

Three drugs and biologicals have been granted OPPS pass-through status effective July 1, 2014. These items, along with their descriptors and APC assignments, are identified below in Table 3.

Table 3 – Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2014

HCPCS Code	Long Descriptor	APC	Status Indicator
C9022*	Injection, elosulfase alfa, 1mg	1480	G
C9134*	Factor XIII (antihemophilic factor, recombinant), Tretten, per 10 i.u.	1481	G
J1446	Injection, tbo-filgrastim, 5 micrograms	1447	G

Note: The HCPCS codes identified with an "*" indicate that these are new codes effective July 1, 2014.

c. New HCPCS Codes Effective July 1, 2014, 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) in the hospital outpatient setting for July 1, 2014. These codes are listed below in Table 4, and they are effective for services furnished on or after July 1, 2014.

Table 4 – New HCPCS Codes for Certain Drugs and Biologicals Effective July 1, 2014

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 7/1/14
Q9970*	Injection, ferric carboxymaltose, 1 mg	9441	G
Q9974**	Injection, Morphine Sulfate, Preservative-Free For Epidural Or Intrathecal Use, 10 mg	N/A	N

***HCPCS code** C9441 (Injection, ferric carboxymaltose, 1 mg) will be deleted and replaced with HCPCS code Q9970 effective July 1, 2014.

****HCPCS code** J2275 (Injection, morphine sulfate (preservative-free sterile solution), per 10 mg) and will be replaced with HCPCS code Q9974 effective July 1, 2014. The SI for HCPCS code J2275 will change to E, "Not Payable by Medicare," effective July 1, 2014.

d. Revised SIs for HCPCS Codes J2271 and Q2052

Effective July 1, 2014, the SI for HCPCS code J2271 (Injection, morphine sulfate, 100mg) will change:

1) From SI=N (Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.),
2) To SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)).

Effective April 1, 2014, the SI for HCPCS code Q2052 (Services, supplies, and accessories used in the home under the Medicare intravenous immune globulin (IVIG) demonstration) will change:

1) From SI=N (Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.)
2) To SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)).

e. Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2013, through December 31, 2013

The payment rate for one HCPCS code was incorrect in the October 2013 OPPS Pricer. The corrected payment rate is listed in Table 5 below, and it has been installed in the July 2014 OPPS Pricer, effective for services furnished on October 1, 2013, through December 31, 2013. Your MAC will adjust any claims incorrectly processed if you bring those claims to the attention of your MAC.

Table 5– Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2013 through December 31, 2013

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J2788	K	9023	Rho d immune globulin 50 mcg	$25.15	$5.03

f. Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2014, through March 31, 2014

The payment rate for one HCPCS code was incorrect in the January 2014 OPPS Pricer. The corrected payment rate is listed below in Table 6, and it has been installed in the July 2014 OPPS

Pricer, effective for services furnished on January 1, 2014, through March 31, 2014. Your MAC will adjust any claims incorrectly processed if you bring those claims to the attention of your MAC.

Table 6 – Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2014, through March 31, 2014

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J0775	K	1340	Collagenase, clost hist inj	$38.49	$7.70

Operational Change to Billing Lab Tests for Separate Payment

As delineated in MLN Matters Special Edition Article (SE)1412, issued on March 5, 2014, (see **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1412.pdf**), effective July 1, 2014, OPPS hospitals should begin using modifier L1 on type of bill (TOB) 13X when seeking separate payment for outpatient lab tests under the Clinical Laboratory Fee Schedule (CLFS) in the following circumstances:

1) A hospital collects specimen and furnishes only the outpatient labs on a given date of service; or
2) A hospital conducts outpatient lab tests that are clinically unrelated to other hospital outpatient services furnished the same day.

"Unrelated" means the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services, for a different diagnosis. Hospitals should no longer use TOB 14X in these circumstances.

CMS is providing related updates to the "Medicare Claims Processing Manual" (Publication 100-04; Chapter 2, Section 90; and Chapter 16, Sections 30.3, 40.3, and 40.3.1) which are included as an attachment to CR 8766.

Clarification of Payment for Certain Hospital Part B Inpatient Labs

As recently provided in Change Request (CR) 8445, Transmittal 2877, published on February 7, 2014 (see **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8445.pdf** on the CMS website), and CR 8666, Transmittal 182, published on March 21, 2014 (see **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8666.pdf** on the CMS website), hospitals may only bill for a limited set of Part B inpatient services when beneficiaries who have Part B coverage are treated as hospital inpatients, and:

1) They are not eligible for or entitled to coverage under Part A, or
2) They are entitled to Part A but have exhausted their Part A benefits.

CMS is clarifying its general payment policy that, for hospitals paid under the OPPS, these Part B inpatient services are separately payable under Part B, and are excluded from OPPS packaging, if the primary service with which the service would otherwise be bundled is not a payable Part B inpatient service.

CMS has adjusted its claims processing logic to make separate payment for Laboratory services paid under the CLFS pursuant to this policy that would otherwise be OPPS-packaged beginning in 2014. Hospitals should consult their MAC for reprocessing of any 12X TOB claims with dates of service on or after January 1, 2014 that were denied and should be paid under this policy.

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.

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

Additional Information

The official instruction, CR8776 issued to your MAC regarding this change is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2971CP.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.