

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



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Implementation Date: April 6, 2015

April 2015 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Note: This article was revised on April 23, 2015, to reflect updated Change Request (CR) 9097 on April 14, 2015 and April 22, 2015. **The first update** corrected the payment rate for C9447. There was also a correction made to the business requirement 9097.3 (see g. below on page 7). In addition, references to HCPCS codes J0365 and J7180 were removed from Section 4 of the Business Requirements document (and page 4 below) and the table “Drugs and Biological with Revised Status Indicators” was deleted from attachment in CR 9097 (and on page 4 below). The **second update** corrected table references. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers that submit claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice (HH&H) MACs, for services provided to Medicare beneficiaries.

Provider Action Needed

CR 9097 describes changes to and billing instructions for various payment policies implemented in the April 2015 Outpatient Prospective Payment System (OPPS) update. Make sure your billing staffs are aware of these changes.

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Background

The April 2015 Integrated Outpatient Code Editor (I/OCE) and OPSS 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 CR9097.

The April 2015 revisions to I/OCE data files, instructions, and specifications are provided in CR9107. Upon release of CR9107, a MLN Matters® Article related to CR9107 will be available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9107.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

The key changes to and billing instructions for various payment policies implemented in the April 2015, OPSS update are as follows:

Changes to Device Edits for April 2015

The most current list of device edits can be found 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 Device Pass-Through Categories

The Social Security Act (Section 1833(t)(6)(B)); see http://www.ssa.gov/OP_Home/ssact/title18/1833.htm requires that, under the OPSS, categories of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. Section 1833(t)(6)(B)(ii)(IV) of the Social Security Act requires that CMS create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

CMS is establishing one new device pass-through category as of April 1, 2015. Table 1 provides a listing of new coding and payment information concerning the new device category for transitional pass-through payment.

Table 1 – New Device Pass-Through Categories

HCPCS	Effective Date	SI	Short Descriptor	Long Descriptor
C2623	04/01/15	H	Cath, translumin, drug-coat	Catheter, transluminal angioplasty, drug-coated, non-laser

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a. Device Offset from Payment

Section 1833(t)(6)(D)(ii) of the Social Security Act requires that CMS deduct from pass-through payments for devices an amount that reflects the portion of the APC payment amount that CMS determines is associated with the cost of the device (70 FR 68627-8).

CMS has determined that a portion of the APC payment amount associated with the cost of C2623 is reflected in procedures assigned to various peripheral transluminal angioplasty codes in APC 0083, APC 0229, and APC 0319. The C2623 device may be billed with various peripheral transluminal balloon angioplasty codes that are assigned to these three APCs for CY 2015. The device offset from payment represents a deduction from pass-through payments for the device in category C2623.

New Services

No New services have been assigned for payment under the OPSS effective April 1, 2015.

Drugs, Biologicals, and Radiopharmaceuticals**a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective April 1, 2015**

For CY 2015, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP+6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2015, 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. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective April 1, 2015 and drug price restatements can be found in the April 2015 update of the OPSS Addendum A and Addendum B at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html> on the CMS website.

b. Drugs and Biologicals with OPSS Pass-Through Status Effective April 1, 2015

Six drugs and biologicals have been granted OPSS pass-through status effective April 1, 2015. These items, along with their descriptors and APC assignments, are identified in Table 2 below.

Table 2 – Drugs and Biologicals with OPSS Pass-Through Status Effective April 1, 2015

HCPCS Code ¹	Short Descriptor	Long Descriptor	APC	Status Indicator
C9445	C-1 esterase, Ruconest	Injection, c-1 esterase inhibitor (recombinant), Ruconest, 10 units	9445	G
C9448	Oral netupitant palonosetron	Netupitant 300mg and palonosetron 0.5 mg, oral	9448	G

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HCPCS Code	Short Descriptor	Long Descriptor	APC	Status Indicator
C9449	Inj, blinatumomab	Injection, blinatumomab, 1 mcg	9449	G
C9450 ²	Fluocinolone acetonide implt	Injection, fluocinolone acetonide intravitreal implant, 0.01 mg	9450	G
C9451	Injection, peramivir	Injection, peramivir, 1 mg	9451	G
C9452	Inj, ceftolozane/tazobactam	Injection, ceftolozane 50 mg and tazobactam 25 mg	9452	G

Notes: ¹. HCPCS codes listed in Table 2 are new codes effective April 1, 2015.

². HCPCS code C9450 is associated with Iluvien® and should not be used to report any other fluocinolone acetonide intravitreal implant (e.g., Retisert®). Hospitals should note that the dosage descriptor for Iluvien is 0.01 mg. Because each implant is a fixed dose containing 0.19 mg of fluocinolone acetonide, hospitals should report 19 units of C9450 for each implant.

c. Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates

Some drugs and biologicals based on ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the first date of the quarter at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html> on the CMS website. Providers may resubmit claims that were impacted by adjustments to previous quarter's payment files.

d. Reassignment of Skin Substitute Products from the Low Cost Group to the High Cost Group

Two existing skin substitute products have been reassigned from the low cost skin substitute group to the high cost skin substitute group based on updated pricing information. These products are listed in Table 3 below.

Table 3 – Updated Skin Substitute Product Assignment to High Cost Status Effective April 1, 2015

HCPCS Code	Short Descriptor	Status Indicator	Low/High Cost Status
Q4150	Allowrap DS or Dry 1 sq cm	N	High
Q4153	Dermavest 1 square cm	N	High

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e. Other Changes to CY 2015 HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals

Effective April 1, 2015, HCPCS code Q9975 Factor VIII FC Fusion Recomb, will replace HCPCS code C9136 Factor viii (Eloctate). The SI will remain G, “Pass-Through Drugs and Biologicals.” Table 4 describes the HCPCS code change and effective date.

Table 4 – New HCPCS Codes for Certain Drugs and Biologicals Effective April 1, 2015

HCPCS Code	Short Descriptor	Long Descriptor	Status Indicator	APC	Added Date	Termination Date
C9136	Factor viii (Eloctate)	Injection, factor viii, fc fusion protein, (recombinant), per i.u.	G	1656	01/01/2015	03/31/2015
Q9975	Factor VIII FC Fusion Recomb	Injection, factor viii, fc fusion protein, (recombinant), per i.u.	G	1656	04/01/2015	

f. Corrected Copayment Rate for HCPCS code J7315 Effective January 1, 2014, Through March 31, 2015

The beneficiary copayment for HCPCS code J7315 was erroneously set to 20 percent of the APC payment rate in the OPPS Pricer from January 1, 2014, through March 31, 2015. The corrected copayment is listed in Tables 5 through 9 below. For claims impacted with HCPCS J7315, APC 1448, instructions for mass adjusting claims will be provided in future notification.

Table 5 – Corrected Copayment Rate for HCPCS Code J7315 Effective January 1, 2014, Through March 31, 2014

HCPCS Code	Status Indicator	APC	Short Descriptor	Payment Rate	Corrected Minimum Unadjusted Copayment
J7315	G	1448	Ophthalmic mitomycin	\$379.47	\$0

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**Table 6 – Corrected Copayment Rate for HCPCS Code J7315 Effective
April 1, 2014, Through June 30, 2014**

HCPCS Code	Status Indicator	APC	Short Descriptor	Payment Rate	Corrected Minimum Unadjusted Copayment
J7315	G	1448	Ophthalmic mitomycin	\$379.66	\$0

**Table 7 – Corrected Copayment Rate for HCPCS Code J7315 Effective
July 1, 2014, Through September 30, 2014**

HCPCS Code	Status Indicator	APC	Short Descriptor	Payment Rate	Corrected Minimum Unadjusted Copayment
J7315	G	1448	Ophthalmic mitomycin	\$379.59	\$0

**Table 8 – Corrected Copayment Rate for HCPCS Code J7315 Effective
October 1, 2014, Through December 31, 2014**

HCPCS Code	Status Indicator	APC	Short Descriptor	Payment Rate	Corrected Minimum Unadjusted Copayment
J7315	G	1448	Ophthalmic mitomycin	\$366.88	\$0

**Table 9 – Corrected Copayment Rate for HCPCS Code J7315 Effective
January 1, 2015, Through March 31, 2015**

HCPCS Code	Status Indicator	APC	Short Descriptor	Payment Rate	Corrected Minimum Unadjusted Copayment
J7315	G	1448	Ophthalmic mitomycin	\$372.80	\$0

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g. Corrected Copayment Rate for HCPCS Code C9447 Effective January 1, 2015, Through March 31 2015

The beneficiary copayment for HCPCS code C9447 was erroneously set to 20 percent of the APC payment rate in the OPPS Pricer from January 1, 2015, through March 31, 2015. The corrected copayment is listed in Table 10 below, and has been installed in the April 2015 OPPS Pricer, effective for services furnished on January 1, 2015, through March 31, 2015. **The MACs will adjust claims, as appropriate, that is brought to their attention that contain HCPCS code listed in table 10; have dates of service that fall on or after January 1, 2015, through April 1, 2015; and were originally processed prior to the installation of the April 2015 OPPS Pricer.**

Table 10 – Corrected Copayment Rate for HCPCS Code C9447 Effective January 1, 2015, Through March 31, 2015

HCPCS Code	Status Indicator	APC	Short Descriptor	Payment Rate	Corrected Minimum Unadjusted Copayment
C9447	G	1663	Inj, phenylephrine ketorolac	\$492.90	\$0

h. New Vaccine CPT Codes

Three new vaccine CPT codes have been established. The following table lists these new vaccine codes, their OPPS status indicator, and effective date.

Table 11 – New Vaccine CPT Codes

CPT Code	Short Descriptor	Long Descriptor	CY 2015 SI	Effective Date
90620	Menb rp w/omv vaccine im	Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B, 2 dose schedule, for intramuscular use	E	2/1/2015
90621	Menb rlp vaccine im	Meningococcal recombinant lipoprotein vaccine, serogroup B, 3 dose schedule, for intramuscular use	E	2/1/2015
90697	Dtap-ipv-hib-hepb vaccine im	Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenza type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP- IPV-Hib-HepB), for intramuscular use	E	1/1/2015

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Inpatient Only List

CMS is revising billing instructions to allow payment for inpatient only procedures that are provided to a patient in the outpatient setting on the date of the inpatient admission or during the 3 calendar days (or 1 calendar day for a non-subsection (d) hospital) preceding the date of the inpatient admission that would otherwise be deemed related to the admission to be bundled into billing of the inpatient admission, according to Medicare policy for the payment window for outpatient services treated as inpatient services.

Effective April 1, 2015, inpatient only procedures that are provided to a patient in the outpatient setting on the date of the inpatient admission or during the 3 calendar days (or 1 calendar day for a non-subsection (d) hospital) preceding the date of the inpatient admission that would otherwise be deemed related to the admission, according to the policy for the payment window for outpatient services treated as inpatient services will be covered by CMS and are eligible to be bundled into the billing of the inpatient admission.

CMS is updating the “Medicare Claims Processing Manual,” (Chapter 4, Sections 10.12 and 180.7) to reflect the revised inpatient only payment policy. This revised section is included as an attachment to CR9097.

Reporting of the “PO” HCPCS Modifier for Outpatient Service Furnished at an Off-Campus Provider-Based Department (PBD)

As stated in the CY 2015 OPPI Final Rule, CMS finalized the instructions related to the reporting of the “PO” modifier (the short descriptor “Serv/proc off-campus pbd,” and the long descriptor “Services, procedures and/or surgeries furnished at off-campus provider-based outpatient departments.”). The “PO” HCPCS modifier is to be reported with every code for outpatient hospital services furnished in an off-campus PBD of a hospital. Reporting of this new modifier will be voluntary for 1 year (CY 2015), with reporting required beginning on January 1, 2016. The modifier should not be reported for remote locations of a hospital, satellite facilities of a hospital, or for services furnished in an emergency department.

CMS is updating the “Medicare Claims Processing Manual,” (Chapter 4, Section 20.6.11) to include the use of the “PO” HCPCS modifier. The revised manual section is included as an attachment to CR9097.

Clarification Regarding Propel and Propel Mini coding

Hospitals may report C2625 (Stent, non-coronary, temporary, with delivery system) when utilizing the Propel™ and Propel Mini™ drug eluting sinus implants by Intersect ENT. These implants are appropriately described by C2625.

Clarification Regarding Cysview® Coding

When billing for cystoscopy procedures using Cysview® (hexaminolevulinate hydrochloride), hospitals are reminded to report HCPCS code C9275 (Injection, Hexaminolevulinate Hydrochloride, 100 mg, per study dose) on a separate claim line from

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the cystoscopy procedure code. Consistently reporting charges for C9275 in addition to the appropriate cystoscopy procedure code will ensure that CMS has accurate claims data for future ratesetting.

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. Medicare Administrative Contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs 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, CR9097, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3238CP.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-Net/work-MLN/MLNMattersArticles/index.html> under - How Does It Work.

Seasonal Flu Vaccinations - For information on coverage and billing of the influenza vaccine and its administration, please refer to [MLN Matters® Article #MM8890](#), "Influenza Vaccine Payment Allowances - Annual Update for 2014-2015 Season" and [MLN Matters® Article #SE1431](#), "2014-2015 Influenza (Flu) Resources for Health Care Professionals."

Also, check out the following resources from the Centers for Disease Control and Prevention (CDC): [Influenza \(Flu\)](#) web page for the latest information on flu including the CDC 2014-2015 recommendations for the prevention and control of influenza, antiviral information, CDC flu mobile app, Q&As, toolkit for long term care employers, and other free resources. Review the CDC's [Antiviral Drugs](#) website for information about how antiviral medications can be used to prevent or treat influenza when influenza activity is present in your community, and view the updated "Influenza Antiviral Medications: Summary for Clinicians." A CDC Health Update reminding clinicians about the importance of flu antiviral medications was distributed via the CDC Health Alert Network on January 9, 2015, and is available at <http://emergency.cdc.gov/HAN/han00375.asp> on the Internet.

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