

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services



**MLN Matters® Number: MM9768**

**Related Change Request (CR) #: CR 9768**

**Related CR Release Date: August 26, 2019**

**Effective Date: October 1, 2016**

**Related CR Transmittal #: R3602CP**

**Implementation Date: October 3, 2016**

## October 2016 Update of the Hospital Outpatient Prospective Payment System (OPPS)

### Provider Types Affected

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This MLN Matters® Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs), including Home Health and Hospice (HH&H) MACs, for services provided to Medicare beneficiaries and which are paid under the Outpatient Prospective Payment System (OPPS).

### Provider Action Needed

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Change Request (CR) 9768 describes changes to and billing instructions for various payment policies implemented in the October 2016 OPPS update. It identifies the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, Status Indicators (SIs), and Revenue Code additions, changes, and deletions that are reflected in the October 2016 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer. Make sure that your billing staffs are aware of these changes.

### Key Points of CR9768

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Key changes to and billing instructions for various payment policies implemented in the July 2016 OPPS updates are as follows:

#### **New Separately Payable Procedure Code**

Effective October 1, 2016, a new HCPCS code C9744 has been created. See Table 1 below.

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**Table 1 – New Separately Payable Procedure Code Effective October 1, 2016**

<b>HCPCS</b>	<b>Short Descriptor</b>	<b>Long Descriptor</b>	<b>OPPS SI</b>	<b>OPPS APC</b>	<b>Effective Date</b>
C9744	Abd us w/contrast	Ultrasound, abdominal, with contrast	S	5571	10/01/2016

**Smoking Cessation Codes**

Effective September 30, 2016, HCPCS codes G0436 (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) and G0437 (Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes) are deleted. The services previously represented by HCPCS codes G0436 and G0437 should be billed under existing CPT codes 99406 (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) and 99407 (Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes) respectively. See Table 2 below.

**Table 2 – Deleted Smoking Cessation HCPCS Codes and the Existing Replacement CPT Codes**

<b>Deleted HCPCS Code</b>	<b>Long Description</b>	<b>Add Date</b>	<b>Termination Date</b>	<b>Existing Replacement CPT Code</b>
G0436	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	01/01/2008	09/30/2016	99406
G0437	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	01/01/2008	09/30/2016	99407

**Reporting for Certain Outpatient Department Services (That Are Similar to Therapy Services) (“Non-Therapy Outpatient Department Services”) That Are Adjunctive to Comprehensive APC Procedures**

Non-therapy outpatient department services are services such as physical therapy, occupational therapy, and speech-language pathology provided during the perioperative period (of a Comprehensive APC (C-APC) procedure) without a certified therapy plan of care. These are not therapy services as described in Section 1834(k) of the Social Security Act (the Act), regardless of whether the services are delivered by therapists or other non-therapist health care workers. Therapy services are those provided by therapists under a plan of care in accordance with Section 1835(a)(2)(C) and Section 1835(a)(2)(D) of the Act and

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are paid for under Section 1834(k) of the Act, subject to annual therapy caps as applicable (78 FR 74867 and 79 FR 66800). Because these services are outpatient department services and not therapy services, the requirement for functional reporting under the regulations at 42 CFR 410.59(a)(4) and 42 CFR 410.60(a)(4) does not apply.

The comprehensive APC payment policy packages payment for adjunctive items, services, and procedures into the most costly primary procedures under the OPSS at the claim level. When non-therapy outpatient department services are included on the same claim as a C-APC procedure (status indicator (SI) = J1) (see 80 FR 70326) or the specific combination of services assigned to the Observation Comprehensive APC 8011 (SI = J2), these services are considered adjunctive to the primary procedure. Payment for non-therapy outpatient department services is included as a packaged part of the payment for the C-APC procedure.

Effective for claims received on or after October 1, 2016, with dates of service on or after January 1, 2015, providers may report non-therapy outpatient department services (that are similar to therapy services) that are adjunctive to a C-APC procedure (SI = J1) or the specific combination of services assigned to the Observation Comprehensive APC 8011 (SI = J2), in one of two ways:

1. Without using the therapy CPT codes and instead reporting these non-therapy services with Revenue Code 0940 (Other Therapeutic Services); or
2. Reporting non-therapy outpatient department services that are adjunctive to J1 or J2 services with the appropriate occurrence codes, CPT codes, modifiers, revenue codes and functional reporting requirements.

### **Advanced Care Planning (ACP)**

Effective January 1, 2016, payment for the service described by CPT code 99497 (Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate) is conditionally packaged under the OPSS and is consequently assigned to a conditionally packaged payment status indicator of “Q1.” When this service is furnished with another service paid under the OPSS, payment is packaged; when it is the only service furnished, payment is made separately. CPT code 99498 (Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)) is an add-on code and therefore payment for the service described by this code is unconditionally packaged (assigned status indicator “N”) in the OPSS in accordance with 42 CFR 419.2(b)(18).

### **Drugs, Biologicals, and Radiopharmaceuticals**

#### ***Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective October 1, 2016***

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Payment for separately payable nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals (status indicator “K”) 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 addition, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals (status indicator “G”) 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 October 1, 2016, and drug price restatements are available in the October 2016 update of the OPSS Addendum A and Addendum B at <http://www.cms.gov/HospitalOutpatientPPS/>.

### ***Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates***

Some drugs and biologicals paid based on the 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>.

Providers may resubmit claims that were impacted by adjustments to previous quarter’s payment files.

### ***Drugs and Biologicals with OPSS Pass-Through Status Effective October 1, 2016***

Four drugs and biologicals have been granted OPSS pass-through status effective October 1, 2016. These items, along with their descriptors and APC assignments, are shown in Table 3.

**Table 3 – Drugs and Biologicals with OPSS Pass-Through Status Effective October 1, 2016**

<b>HCPCS Code</b>	<b>Long Descriptor</b>	<b>SI</b>	<b>APC</b>
C9139	Injection, Factor IX, albumin fusion protein (recombinant), Idelvion, 1 i.u.	G	9171
C9481	Injection, reslizumab, 1 mg	G	9481
C9482	Injection, sotalol hydrochloride, 1 mg	G	9482
C9483	Injection, atezolizumab, 10 mg	G	9483

### ***Revised Status Indicator for Biosimilar Biological Product***

On April 5, 2016, a biosimilar biological product, Inflectra®, was approved by the Food and Drug Administration (FDA).

Due to the unavailability of pricing information, Inflectra®, described by CPT code Q5102 (Injection, Infliximab, Biosimilar, 10 mg), is assigned SI= E (Not paid under OPSS or any other Medicare payment system.) Inflectra® was previously assigned SI= K (Separately

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paid nonpass-through drugs and biologicals, including therapeutic radiopharmaceuticals) in the July 2016 update of the OPSS. This change is effective July 1, 2016.

Below, Table 4 lists the code and the effective date for the status indicator change.

**Table 4 – Drugs and Biologicals with Revised Status Indicators**

<b>HCPCS Code</b>	<b>Long Descriptor</b>	<b>OPSS SI</b>	<b>Effective Date</b>
Q5102	Injection, Infliximab, Biosimilar, 10 mg	E	07/01/2016

***Billing Guidance for the Topical Application of Mitomycin During or Following Ophthalmic Surgery***

Hospital outpatient departments should only bill HCPCS code J7315 (Mitomycin, ophthalmic, 0.2 mg) or HCPCS code J7999 (Compounded drug, not otherwise classified) for the topical application of mitomycin during or following ophthalmic surgery. J7315 may be reported only if the hospital uses mitomycin with the trade name MitoSol®. Any other topical mitomycin should be reported with J7999. Hospital outpatient departments are not permitted to bill HCPCS code J9280 (Injection, mitomycin, 5 mg) for the topical application of mitomycin.

**Changes to OPSS Pricer Logic**

***ASP Fee Amounts Moves from the OPSS Pricer to the Fiscal Intermediary Shared System (FISS)***

OPSS drug pricing will now apply the ASP fee schedule amounts from the FISS standard system and not the OPSS Pricer. OPSS covered drugs with allowed payment amounts will continue to have Status Indicators “G” and “K” applied. Drugs that are listed as packaged under OPSS will continue to be packaged with this change of payment application systems.

***Outpatient Coinsurance Cap Logic as ASP Payment for Drugs Moves from the OPSS Pricer to the Fiscal Intermediary Shared System (FISS)***

Outpatient procedure coinsurance is capped to the inpatient deductible limit (IP Limit). The cap is calculated by adding the highest wage adjusted national coinsurance amount for the procedure line (identified by status indicators S, T, V, P, J1 or J2) plus the coinsurance for the blood products (identified by status indicator “R”) and comparing to the inpatient Part A deductible. The difference is the amount of coinsurance to be applied to the ASP drug lines. The coinsurance of the ASP drug lines with the same dates of service as the procedure code are added together. The coinsurance reduction percentage is calculated by dividing the amount of coinsurance to be applied to the ASP drug lines by the total coinsurance of the ASP drug lines. The coinsurance amount for each of ASP drug lines should be reduced by the multiplication of the drug line coinsurance and the coinsurance reduction percentage. The difference between the original coinsurance and the reduced coinsurance is then added to the payment. CMS’ shared system will cap the coinsurance for the drugs with status

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indicator G or K (except for Pass-Through drugs with a Payment Adjustment Flags (PAF) 10, or 18-20 [indicating no coinsurance applies]) that was not assigned to the IP Limit for the calendar year. Several claim examples are as follows:

**Example 1 of inpatient deductible capped amount:**

Drug Line A has a fee of \$2,000.00, a payment of \$1,600.00, and coinsurance of \$400.00.

Drug Line B has a fee of \$1,000.00, a payment of \$800.00, and coinsurance of \$200.00.

Drug Line C has a fee of \$500.00, a payment of \$400.00 and coinsurance of \$100.00.

Drug Line D has a fee of \$500.00, a payment of \$400.00 and coinsurance of \$100.00.

Highest wage adjusted national coinsurance amount for a procedure line is \$888.00.

The Inpatient Part A deductible is \$1,288.00 for 2016.

$\$1,288.00 - \$888.00 = \$400.00$  remaining coinsurance to be applied toward inpatient deductible cap.

Drug Lines A-D coinsurance is \$800.00.

$\$400.00$  cap remaining /  $\$800.00$  drug line(s) coinsurance = 50% reduction to coinsurance due to inpatient deductible cap

Apply 50% reduction of the coinsurance amounts for each line and add the remaining 50% back into the payment amount.

Drug Line A has a final payment of \$1,800.00, and coinsurance of \$200.00.

Drug Line B has a final payment of \$900.00, and coinsurance of \$100.00.

Drug Line C has a final payment of \$450.00, and coinsurance of \$50.00.

Drug Line D has a final payment of \$450.00, and coinsurance of \$50.00.

**Example 2 of inpatient deductible capped amount:**

Drug Line A has a fee of \$2,000.00, a payment of \$1,600.00, and coinsurance of \$400.00.

Drug Line B has a fee of \$1,000.00, a payment of \$800.00, and coinsurance of \$200.00.

Drug Line C has a fee of \$500.00, a payment of \$400.00 and coinsurance of \$100.00.

Drug Line D has a fee of \$500.00, a payment of \$400.00 and coinsurance of \$100.00.

Highest wage adjusted national coinsurance amount for a procedure line is \$1,588.00.

The Inpatient Part A deductible is \$1,288.00 for 2016.

$\$1,588.00$  is greater than  $\$1,288.00$ . The OPPS Pricer will cap the coinsurance amount to be applied on the highest wage adjusted national coinsurance procedure line prior to application of the cap on the drug lines.

Drug Lines A-D coinsurance is \$800.00.

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\$0 cap remaining / \$800.00 = 100% reduction to coinsurance due to inpatient deductible cap

Drug Line A has a final payment of \$2,000.00, and no coinsurance.

Drug Line B has a final payment of \$1,000.00, and no coinsurance.

Drug Line C has a final payment of \$500.00, and no coinsurance.

Drug Line D has a final payment of \$500.00, and no coinsurance.

**Example 3 of inpatient deductible capped amount with procedure, blood, and drug lines:**

Drug Line A has a fee of \$2,000.00, a payment of \$1,600.00, and coinsurance of \$400.00.

Drug Line B has a fee of \$1,000.00, a payment of \$800.00, and coinsurance of \$200.00.

Drug Line C has a fee of \$500.00, a payment of \$400.00 and coinsurance of \$100.00.

Drug Line D has a fee of \$500.00, a payment of \$400.00 and coinsurance of \$100.00.

Highest wage adjusted national coinsurance amount for a procedure line is \$800.00.

Coinsurance on blood line is 88.00.

The Inpatient Part A deductible is \$1,288.00 for 2016.

$\$1,288.00 - \$888.00 = \$400.00$  remaining coinsurance to be applied toward inpatient deductible cap.

Drug Lines A-D coinsurance is \$800.00.

$\$400.00$  cap remaining /  $\$800.00$  drug line(s) coinsurance = 50% reduction to coinsurance due to inpatient deductible cap

Apply 50% reduction of the coinsurance amounts for each line and add the remaining 50% back into the payment amount.

Drug Line A has a final payment of \$1,800.00, and coinsurance of \$200.00.

Drug Line B has a final payment of \$900.00, and coinsurance of \$100.00.

Drug Line C has a final payment of \$450.00, and coinsurance of \$50.00.

Drug Line D has a final payment of \$450.00, and coinsurance of \$50.00.

**Example 4 of inpatient deductible capped amount equals procedure, blood, and drug line coinsurance:**

Drug Line A has a fee of \$200.00, a payment of \$160.00, and coinsurance of \$40.00.

Drug Line B has a fee of \$100.00, a payment of \$80.00, and coinsurance of \$20.00.

Drug Line C has a fee of \$50.00, a payment of \$40.00 and coinsurance of \$10.00.

Drug Line D has a fee of \$50.00, a payment of \$40.00 and coinsurance of \$10.00.

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Highest wage adjusted national coinsurance amount for a procedure line is \$1,120.00.

Coinsurance on blood line is 88.00.

The Inpatient Part A deductible is \$1,288.00 for 2016.

$\$1,288.00 - \$1208.00 = \$80.00$  remaining coinsurance to be applied toward inpatient deductible cap.

Drug Lines A-D coinsurance is \$80.00.

$\$80.00$  cap remaining -  $\$80.00$  drug line(s) coinsurance = reduction to coinsurance due to inpatient deductible cap does not apply

Drug Line A has a fee of \$200.00, a payment of \$160.00, and coinsurance of \$40.00.

Drug Line B has a fee of \$100.00, a payment of \$80.00, and coinsurance of \$20.00.

Drug Line C has a fee of \$50.00, a payment of \$40.00 and coinsurance of \$10.00.

Drug Line D has a fee of \$50.00, a payment of \$40.00 and coinsurance of \$10.00.

**Example 5 of procedure and blood coinsurance equal inpatient deductible cap:**

Drug Line A has a fee of \$2,000.00, a payment of \$1,600.00, and coinsurance of \$400.00.

Drug Line B has a fee of \$1,000.00, a payment of \$800.00, and coinsurance of \$200.00.

Drug Line C has a fee of \$500.00, a payment of \$400.00 and coinsurance of \$100.00.

Drug Line D has a fee of \$500.00, a payment of \$400.00 and coinsurance of \$100.00.

Highest wage adjusted national coinsurance amount for a procedure line is \$1200.00.

Coinsurance on blood line is 88.00.

The Inpatient Part A deductible is \$1,288.00 for 2016.

$\$1,288.00 - \$1,288.00 = \$0.00$  remaining coinsurance to be applied toward inpatient deductible cap.

Drug Lines A-D coinsurance is \$800.00.

$\$0.00$  cap remaining /  $\$800.00$  drug line(s) coinsurance = 100% reduction to coinsurance due to inpatient deductible cap.

Apply 100% reduction of the coinsurance amounts for each line and add the remaining 100% back into the payment amount.

Drug Line A has a final payment of \$2,000.00, and coinsurance of \$0.00.

Drug Line B has a final payment of \$1,000.00, and coinsurance of \$0.00.

Drug Line C has a final payment of \$500.00, and coinsurance of \$0.00.

Drug Line D has a final payment of \$500.00, and coinsurance of \$0.00.

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**Example 6 of part B deductible applies to drug charges prior to inpatient deductible capped amount:**

Drug Line A has a fee of \$2,166.00, a deductible of \$166.00, a payment of \$1,600.00, and coinsurance of \$400.00.

Drug Line B has a fee of \$1,000.00, a payment of \$800.00, and coinsurance of \$200.00.

Drug Line C has a fee of \$500.00, a payment of \$400.00 and coinsurance of \$100.00.

Drug Line D has a fee of \$500.00, a payment of \$400.00 and coinsurance of \$100.00.

Highest wage adjusted national coinsurance amount for a procedure line is \$888.00.

The Inpatient Part A deductible is \$1,288.00 for 2016.

$\$1,288.00 - \$888.00 = \$400.00$  remaining coinsurance to be applied toward inpatient deductible cap.

Drug Lines A-D coinsurance is \$800.00.

$\$400.00$  cap remaining /  $\$800.00$  drug line(s) coinsurance = 50% reduction to coinsurance due to inpatient deductible cap.

Apply 50% reduction of the coinsurance amounts for each line and add the remaining 50% back into the payment amount.

Drug Line A has a deductible of \$166.00, a final payment of \$1,800.00, and coinsurance of \$200.00.

Drug Line B has a final payment of \$900.00, and coinsurance of \$100.00.

Drug Line C has a final payment of \$450.00, and coinsurance of \$50.00.

Drug Line D has a final payment of \$450.00, and coinsurance of \$50.00.

***Pass-through Drug Offset Moves from the OPPS Pricer to the FISS Shared System***

Outpatient Pass-Through drugs with offsets will be identified by the I/OCE payer only value codes (QR, QS, and QT) when appropriate pairings are found on the claim. Offsets will continue to be wage-adjusted prior to application and will apply to the drug line(s) payment amount. Pass-Through Drugs with are eligible for an offset continue to not have coinsurance applied whether the off-set is made or not.

**Coverage Determinations**

As a reminder, 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, 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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MACs will adjust, as appropriate, claims brought to their attention with any retroactive changes that were received prior to implementation of October 2016 OPPS Pricer.

### Additional Information

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The official instruction, CR9768, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3602CP.pdf>.

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>.

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