CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3238	**Date: April 22, 2015**
	Change Request 9097

Transmittal 3235, dated April 14, 2015, is being rescinded and replaced by Transmittal 3238, dated April 22, 2015 to correct references to the tables. All other information remains the same.

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

I. SUMMARY OF CHANGES: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the April 2015 OPPS update. The April 2015 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 Change Request (CR). This Recurring Update Notification applies to Chapter 4, sections 10.12, 20.6.11, and 180.7.

The April 2015 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming April 2015 I/OCE CR.

EFFECTIVE DATE: April 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 6, 2015

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	4/Table of Contents
R	4/10.12/ Payment Window for Outpatient Services Treated as Inpatient Services
N	4/20.6.11/ Use of HCPCS Modifier - PO
R	4/180.7/ Inpatient-only Services

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question

and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Recurring Update Notification

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 3238	Date: April 22, 2015	Change Request: 9097

Transmittal 3235, dated April 14, 2015, is being rescinded and replaced by Transmittal 3238, dated April 22, 2015 to correct references to the tables. All other information remains the same.

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

EFFECTIVE DATE: April 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 6, 2015

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the April 2015 OPPS update. The April 2015 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 Change Request (CR). This Recurring Update Notification applies to Chapter 4, sections 10.12, 20.6.11, and 180.7.

The April 2015 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming April 2015 I/OCE CR.

B. Policy:

1. Changes to Device Edits for Apri1 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/. Failure to pass these edits will result in the claim being returned to the provider.

2. New Device Pass-Through Categories

Section 1833(t)(6)(B) of the Social Security Act requires that, under the OPPS, 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 Act requires that we create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

We are 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. (see Attachment A, Policy Section Tables).

a. Device Offset from Payment:

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

We have determined that a portion of the APC payment amount associated with the cost of C2623 is reflected in procedures assigned to various peripheral transluminal balloon 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.

3. New Services

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

4. 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 OPPS Addendum A and Addendum B on the CMS Web site at http://www.cms.gov/HospitalOutpatientPPS/.

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

Six drugs and biologicals have been granted OPPS pass-through status effective April 1, 2015. These items, along with their descriptors and APC assignments, are identified in Table 2. (see Attachment A, Policy Section Tables).

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 CMS Web site on the first date of the quarter at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html?redirect=/HospitalOutpatientPPS/01_overview.asp

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 list in Table 3. (see Attachment A, Policy Section Tables).

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 status indicator will remain G, "Pass-Through Drugs and Biologicals". Table 4 describes the HCPCS code change and effective date (see Attachment A, Policy Section Tables).

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 in the Attachment A. For claims impacted with HCPCS J7315, APC 1448, instructions for mass adjusting claims will be provided in future notification.

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 in the Attachment A, and has been installed in the April 2015 OPPS Pricer, effective for services furnished on January 1, 2015 through March 31, 2015.

h. New Vaccine CPT Codes

Three new vaccine CPT codes have been established. Table 11 in the Attachment A, lists these new vaccine codes, their OPPS status indicator, and effective date.

5. Inpatient Only List

We are revising our 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 our 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 our 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 Pub. 100-04, Medicare Claims Processing Manual, chapter 4, sections 10.12 and 180.7 to reflect the revised impatient only payment policy.

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

As stated in the CY 2015 OPPS Final Rule, we finalized our 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 modifiers 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 Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, sections 20.6.11 to include the use of the “PO” HCPCS modifier.

7. 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.

8. 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 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.

9. 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.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9097.1	Medicare contractors shall install the April 2015 OPPS Pricer.	X		X		X				BCRC
9097.2	Medicare contactors shall manually add to their systems, the HCPCS codes listed in tables 1, 2, and 4 of Attachment A, effective April 1, 2015. CPT code 90697 listed in table 11 of Attachment A, should be added effective January 1, 2015. It was included with the January I/OCE update. CPT codes 90620 and 90621 also listed in table 11 of the Attachment A, should be added effective February 1, 2015. They will be included with the April 2015 I/OCE update. **Note:** These HCPCS codes will be included with the April 2015 I/OCE update. Status and payment indicators for these HCPCS codes will be listed in the April 2015 update of the OPPS Addendum A and Addendum B on the CMS Web site at	X		X		X				BCRC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	https://www.cms.gov/Medicare/Medicare-Fee-for-Service Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html									
9097.3	Medicare Contractors shall adjust, as appropriate, claims brought to their attention that: 1. Contain HCPCS code listed in table 10; and 2. Have dates of service that fall on or after January 1, 2015 through April 1, 2015; and 3. Were originally processed prior to the installation of the April 2015 OPPS Pricer.	X		X						BCRC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9097.4	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information: N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Chuck Braver, 410-786-6719 or chuck.braver@cms.hhs.gov , Marina Kushnirova, 410-786-2682 or marina.kushnirova@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 1

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS)

Table of Contents
(Rev.3238, Issued: 04-22-15)

10.12 – Payment Window for Outpatient Services Treated as Inpatient Services

(Rev.3238, Issued: 04-22-15, Effective: 04-01-15 Implementation: 04-06-15)

The policy for the payment window for outpatient services treated as inpatient services is discussed in chapter 3 § 40.3 of this manual. The policy requires payment for certain outpatient services provided to a beneficiary on the date of an inpatient admission or during the 3 calendar days (or 1 calendar day for a non-IPPS hospital) prior to the date of an inpatient admission to be bundled (i.e., included) with the Medicare Part A payment for the beneficiary's inpatient admission if those outpatient services are provided by the admitting hospital or an entity that is wholly owned or wholly operated by the admitting hospital. The policy applies to all diagnostic outpatient services (including non-patient laboratory tests) and non-diagnostic services (i.e., therapeutic) that are related to the inpatient stay. Ambulance and maintenance renal dialysis services are not subject to the payment window.

All diagnostic services (including non-patient laboratory tests) provided to a Medicare beneficiary by a hospital (or an entity wholly owned or wholly operated by the hospital) on the date of the beneficiary's inpatient admission or during the 3 calendar days (or, in the case of a non-subsection (d) hospital, 1 calendar day) immediately preceding the date of admission are required to be included on the Part A bill for the inpatient stay.

Outpatient non-diagnostic services that are related to an inpatient admission must be bundled with the Part A billing for the inpatient stay. An outpatient service is related to the admission if it is clinically associated with the reason for a patient's inpatient admission. In accordance with section 102 of Pub. L. 111-192, for services furnished on or after June 25, 2010, all outpatient non-diagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the date of a beneficiary's inpatient admission are deemed related to the admission, and thus, must be billed to Part A with the inpatient stay. Also, outpatient non-diagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the first, second, and third calendar days for a subsection (d) hospital paid under the IPPS (first calendar day for non-subsection (d) hospitals) preceding the date of a beneficiary's inpatient admission are deemed related to the admission, and thus, must be billed to Part A with the inpatient stay, unless the hospital attests to specific non-diagnostic services as being unrelated to the hospital claim (that is, the preadmission non-diagnostic services are clinically distinct or independent from the reason for the beneficiary's admission). Outpatient non-diagnostic services provided during the payment window that are unrelated to the admission, and are covered by Part B, may be separately billed to Part B. The June 25, 2010 effective date of section 102 of Pub. L. 111-192 applies to outpatient services provided on or after June 25, 2010.

In the event that there is no Part A coverage for the inpatient stay, the hospital may bill Part B for the services provided to the beneficiary prior to the point of inpatient admission (i.e., the time of formal admission pursuant to the inpatient admission order) that would otherwise be included in the payment window for Part A payment, including services requiring an outpatient status. Certain Part B inpatient services provided to the beneficiary after the point of inpatient admission (i.e., the time of formal admission pursuant to the inpatient admission order) may also be billed to Part B when Part A payment cannot be made. See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 6, §10 "Medical and Other Health Services Furnished to Inpatients of Participating Hospital" for a full description of this policy.

A hospital may attest to specific non-diagnostic services as being unrelated to the hospital Part A claim (that is, the preadmission non-diagnostic services are clinically distinct or independent from the reason for the beneficiary's admission) by adding a condition code 51 (definition "51 - Attestation of Unrelated Outpatient Non-diagnostic Services") to the separately billed outpatient non-diagnostic services claim. Providers may submit outpatient claims with condition code 51 starting April 1, 2011, for outpatient claims that have a date of service on or after June 25, 2010. Outpatient claims with a date of service on or after June 25, 2010, that did not contain condition code 51 received prior to April 1, 2011, will need to be adjusted by the provider if they were rejected by FISS or CWF.

20.6.11 - Use of HCPCS Modifier - PO

(Rev.3238, Issued: 04-22-15, Effective: 04-01-15 Implementation: 04-06-15)

*Effective January 1, 2015, the definition of modifier -PO is "**Services, procedures, and/or surgeries furnished at off-campus provider-based outpatient departments.**" This modifier is to be reported with every HCPCS code for outpatient hospital services furnished in an off-campus provider-based department of a hospital. See 42 CFR 413.65(a)(2) for a definition of "campus".*

This modifier should not be reported for remote locations of a hospital (defined at 42 CFR 412.65), satellite facilities of a hospital (defined at 42 CFR 412.22(h)), or for services furnished in an emergency department.

Reporting of this modifier is voluntary for CY 2015; reporting of this modifier is required beginning January 1, 2016.

180.7 - Inpatient-only Services

(Rev.3238, Issued: 04-22-15, Effective: 04-01-15 Implementation: 04-06-15)

Section 1833(t)(1)(B)(i) of the Act allows CMS to define the services for which payment under the OPPS is appropriate and the Secretary has determined that the services designated to be "inpatient only" services are not appropriate to be furnished in a hospital outpatient department. "Inpatient only" services are generally, but not always, surgical services that require inpatient care because of the nature of the procedure, the typical underlying physical condition of patients who require the service, or the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged. An example of an "inpatient only" service is CPT code 33513, "Coronary artery bypass, vein only; four coronary venous grafts." The designation of services to be "inpatient-only" is open to public comment each year as part of the annual rulemaking process. Procedures removed from the "inpatient only" list may be appropriately furnished in either the inpatient or outpatient settings and such procedures continue to be payable when furnished in the inpatient setting.

There is no payment under the OPPS for services that CMS designates to be "inpatient-only" services. These services have an OPPS status indicator of "C" in the OPPS Addendum B and are listed together in Addendum E of each year's OPPS/ASC final rule. For the most current Addendum B and for Addendum E published with the OPPS notices and regulations, see http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html.

Excluding the handful of exceptions discussed below, CMS does not pay for an "inpatient-only" service furnished to a person who is registered in the hospital as an outpatient and reports the service on the outpatient hospital bill type (TOB 13X). CMS also does not pay for all other services on the same day as the "inpatient only" procedure.

There are two exceptions to the policy of not paying for outpatient services furnished on the same day with an "inpatient-only" service that would be paid under the OPPS if the inpatient service had not been furnished:

Exception 1: If the "inpatient-only" service is defined in CPT to be a "separate procedure" and the other services billed with the "inpatient-only" service contain a procedure that can be paid under the OPPS and that has an OPPS SI=T on the same date as the "inpatient-only" procedure, then the "inpatient-only" service is denied but CMS makes payment for the separate procedure and any remaining payable OPPS services. The list of "separate procedures" is available with the Integrated Outpatient Code Editor (I/OCE) documentation. See http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/.

Exception 2: If an "inpatient-only" service is furnished but the patient expires before inpatient admission or transfer to another hospital and the hospital reports the "inpatient only" service with modifier "CA", then CMS makes a single payment for all services provided on that day, including the "inpatient only" procedure,

through one unit of APC 0375, (Ancillary outpatient services when the patient expires.) Hospitals should report modifier CA on only one procedure.

Attachment A

Policy Section Tables

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

Table 2 – Drugs and Biologicals with OPPS 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
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 fluocinlone acetonide, hospitals should report 19 units of C9450 for each implant.

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

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	

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	Opthalmic mitomycin	$379.47	$0

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	Opthalmic 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	Opthalmic 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	Opthalmic 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	Opthalmic mitomycin	$372.80	$0

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

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,	E	1/1/2015

CPT Code	Short Descriptor	Long Descriptor	CY 2015 SI	Effective Date
		Haemophilus influenza type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use		