CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3941	**Date: December 22, 2017**
	Change Request 10417

SUBJECT: January 2018 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 January 2018 OPPS update. The January 2018 Integrated Outpatient Code Editor (I/OCE) 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, Section 50.7.

The January 2018 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming January 2018 I/OCE CR.

EFFECTIVE DATE: January 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2018

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	4/10.1/Background
R	4/10.2.1/ Composite APCs
R	4/10.4/ Packaging
N	4/10.6.3.3/Payment Adjustment for Certain Cancer Hospitals Beginning CY 2015
N	4/10.6.3.4/ Payment Adjustment for Certain Cancer Hospitals Beginning CY 2016
N	4/10.6.3.5/Payment Adjustment for Certain Cancer Hospitals Beginning CY 2017
N	4/10.6.3.6/Payment Adjustment for Certain Cancer Hospitals Beginning CY 2018
D	4/20.1.1/Elimination of the 90-day Grace Period for HCPCS (Level I and Level II)
R	4/20.6.11/Use of HCPCS Modifier - PO
N	4/20.6.12/Use of HCPCS Modifier – PN
R	4/20.6.13/Use of HCPCS Modifier – CT
N	4/20.6.14/Use of HCPCS Modifier – FX
N	4/20.6.15/Use of HCPCS Modifier – FY
N	4/40.5/Transitional Pass-Throughs for Designated Drugs or Biologicals
R	4/50.1/Outpatient Provider Specific File
R	4/50.3/Transitional Pass Through Payments for Designated Devices
R	4/50.4/Changes to Pricer Logic Effective April 1, 2002
R	4/60.5/ Services Eligible for New Technology APC Assignment and Payments
R	4/180.7/Inpatient-only Services
R	4/200.3.2/Billing for Multi-Source Photon (Cobalt 60-Based) Stereotactic Radiosurgery (SRS) Planning and Delivery
R	4/231.11/Billing for Allogeneic Stem Cell Transplants
R	4/280/Hospital-Based Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Billing for Non RHC/FQHC Services
R	17/90.2/Drugs, Biologicals, and Radiopharmaceuticals

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: 3941	Date: December 22, 2017	Change Request: 10417

SUBJECT: January 2018 Update of the Hospital Outpatient Prospective Payment System (OPPS)

EFFECTIVE DATE: January 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2018

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the January 2018 OPPS update. The January 2018 Integrated Outpatient Code Editor (I/OCE) 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, section 50.7.

The January 2018 revisions to the I/OCE data files, instructions, and specifications are provided in the forthcoming January 2018 I/OCE CR.

B. Policy: 1. a. 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 two (2), but not more than three (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.

b. Policy

Effective January 1, 2018, there are no device categories eligible for pass-through payment. However, an existing device described by HCPCS code C2623 (*Catheter, transluminal angioplasty, drug coated, non laser*) was approved on August 25, 2017 by the Food and Drug Administration (FDA) for a new indication, specifically the treatment of patients with dysfunctional Arteriovenous (AV) fistulae. Accordingly, in this January 2018 update, devices described by HCPCS code C2623, are eligible for pass through status retroactive to August 25, 2017 when the device is billed with Current Procedural Terminology (CPT) code 36902 (*Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty*) or CPT code 36903 *(Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment).*This device pass through status will be applied retroactively from August 25, 2017 through December 31, 2017.

Also, refer to https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html for the most current device pass-through information.

c. Transitional Pass-Through Payments for Designated Devices

Certain designated new devices are assigned to APCs and identified by the OCE as eligible for payment based on the reasonable cost of the new device reduced by the amount included in the APC for the procedure that reflects the packaged payment for device(s) used in the procedure. OCE will determine the proper payment amount for these APCs as well as the coinsurance and any applicable deductible. All related payment calculations will be returned on the same APC line and identified as a designated new device. Refer to https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files-Items/2018-Annual-Policy-Files.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending for the most current OPPS HCPCS Offset File.

d. Device Offset from Payment for Device Category

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. With respect to device code C2623, we have previously determined that the costs associated with C2623 are not reflected in the APC payment amount. Therefore, we are not applying a device offset to the retroactive pass-through payments for C2623. Retroactive pass-through payments for August 25, 2017 through December 31, 2017, will only apply when HCPCS code C2623 is billed with CPT code 36902 or CPT code 36903. The device/procedure offset pair requirements for HCPCS code C2623 listed in Change Request 9553, Transmittal 3483 are no longer applicable effective January 1, 2018.

2. New Separately Payable Procedure Code

Effective January 1, 2018, new HCPCS code C9748 has been created as described in the Table 1, attachment A.

3. Argus Retinal Prosthesis Add-on Code (C1842)

Effective January 1, 2017, CMS created HCPCS code C1842 (Retinal prosthesis, includes all internal and external components; add-on to C1841) and assigned it a Status Indicator (SI) of N. HCPCS code C1842 was created to resolve a claims processing issue for Ambulatory Surgical Centers (ASCs) and should not be reported on institutional claims by hospital outpatient department providers. HCPCS code C1842 is included in the Calendar Year (CY) 2018 Annual HCPCS file.

4. Changes to New Technology APCs 1901 – 1908

Effective January 1, 2018, two additional New Technology APCs (1907 and 1908) have been created. In addition, the payment ranges for APCs 1901 – 1906 have been changed. All changes are documented in Table 2, attachment A.

5. Services Eligible for New Technology APC Assignment and Payments

Under OPPS, services eligible for payment through New Technology APCs are those codes that are assigned to the series of New Technology APCs published in Addendum A of the latest OPPS update. OPPS considers any HCPCS code assigned to the APCs below to be a “new technology procedure or service.” As of January 1, 2018, the range of New Technology APCs include:

• APCs 1491 through 1500

• APCs 1502 through 1537

• APCs 1539 through 1585

• APCs 1589 through 1599

• APCs 1901 through 1908

The application for consideration as a New Technology procedure or service is available at https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/HospitalOutpatientPPS/passthrough_payment.html.

Under the "Downloads" section, refer to the document titled "For a New Technology Ambulatory Payment Classification (APC) designation under the Hospital Outpatient Prospective Payment System (OPPS)" for information on the requirements for submitting an application. The list of HCPCS codes and payment rates assigned to New Technology APCs are in Addendum B of the latest OPPS update regulation each year at https://www.cms.gov/Medicare/Medicare-Feefor-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html.

6. Payment Changes for X-rays Taken Using Film and Computed Radiography Technology

On December 18, 2015, the Consolidated Appropriations Act of 2016 was signed into law (Public Law 114-113). Section 502 of the Consolidated Appropriations Act law requires that Medicare implement the following provisions under the hospital Outpatient Prospective Payment System (OPPS) for the technical component of imaging services: reduce payment by 20 percent for an x-ray taken using film beginning January 1, 2017, and reduce payment by 7 percent from January 1, 2018 through December 31, 2022, and thereafter to 10 percent beginning January 1, 2023 for an imaging service that is an x-ray taken using computed radiography technology. In response to these provisions, we established modifiers "FX" and "FY" effective January 1, 2017 and January 1, 2018, respectively. Below are additional information related to these modifiers. We note that section 502(b) of Division O, Title V of the Consolidated Appropriations Act of 2016 amended section 1833(t)(16) of the Act by adding new subparagraph (F).

a. Payment Modifier for X-ray Taken Using Film Effective January 1, 2017

Consistent with the requirements set forth in section 1833(t)(16)(F)(i) and in accordance with provisions allowed under section 1833(t)(16)(F)(iv) of the Act, we established modifier "FX" (*X-ray taken using film*) to identify imaging services that are x-rays taken using film. As stated in the CY 2017 OPPS/ASC final rule with comment period (81 FR 79729 through 79730) and in the January 2017 Update of the OPPS (Change Request 9930, Transmittal 3685 dated December 22, 2016), hospitals are required to use this modifier to report imaging services that are X-rays taken using film effective January 1, 2017.

The use of the FX modifier is applicable to all imaging services that are x-rays taken using film and results in a payment reduction of 20 percent beginning January 1, 2017. All imaging services are listed in the OPPS Addendum B, which is available via the Internet on the CMS website. Information about this modifier can be found in Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, Section 20.6.13.

b. Payment Modifier for X-ray Taken Using Computed Radiography Technology Effective January 1, 2018

Consistent with the requirements set forth in section 1833(t)(16)(F)(ii) and in accordance with provisions allowed under section 1833(t)(16)(F)(iv) of the Act, we are establishing modifier "FY" (*X-ray taken using computed radiography technology/cassette-based imaging*) to identify an imaging service that is an X-ray taken using computed radiography technology. Effective January 1, 2018, hospitals are required to use this modifier to report imaging services that are X-rays taken using computed radiography technology.

The use of this modifier results in a payment reduction of 7 percent from January 1, 2018 through December 31, 2022, and thereafter to 10 percent beginning January 1, 2023 for imaging services that are x-rays taken using computed radiography technology/cassette-based imaging. All imaging services are listed in the OPPS Addendum B, which is available via the Internet on the CMS website. Information about this modifier can be also be found in Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, new Section 20.6.14.

7. Deletion of Modifier "CP"

Modifier "CP" became effective in CY 2016 and was used to identify adjunctive services on a claim related to a procedure assigned to a Comprehensive Ambulatory Payment Classification (C-APC) procedure. The use of the modifier was required for CY 2016 and 2017 and the data collection period for this modifier was set to conclude on December 31, 2017. Accordingly, for CY 2018, we are deleting modifier "CP" and discontinuing its required use. Also, for CY 2018, for the comprehensive APC (C-APC) for Stereotactic Radio Surgery (SRS), specifically, C-APC 5627 (Level 7 Radiation Therapy), CMS will continue to make separate payments for the 10 planning and preparation services adjunctive to the delivery of the SRS treatment using either the Cobalt-60-based or LINAC-based technology when furnished to a beneficiary within 30 days of the SRS treatment. The ten planning and preparation codes listed in Table 3, attachment A, will be paid according to their assigned status indicator when furnished within 30 days of SRS treatment delivery.

8. Changes to the Inpatient-Only (IPO List)

The Medicare Inpatient-Only (IPO) list includes procedures that are typically only provided in the inpatient setting and therefore are not paid under the OPPS. For CY 2018, CMS is removing six procedures from the IPO list. CMS is also adding one procedure to the IPO list. The changes to the IPO list for CY 2018 are included in Table 4, attachment A.

9. Revisions to the Laboratory Date of Service (DOS) Policy

a. Laboratory Test/Service Performed by An Independent Laboratory

In the CY 2018 OPPS/ASC final rule (82 FR 52533-52540) we discussed an additional exception to our current laboratory DOS regulations at 42 Code of Federal Regulations (CFR) 414.510. This new exception to the laboratory DOS policy permits independent laboratories to bill Medicare directly for molecular pathology tests and Advanced Diagnostic Laboratory Tests (ADLTs), which are excluded from the OPPS packaging policy, if the specimen was collected from a hospital outpatient during a hospital outpatient encounter and the test was performed following the patient's discharge from the hospital outpatient department. Consequently, Hospital Outpatient Departments (HOPDs) should no longer bill Medicare for molecular pathology tests and ADLTs performed by independent laboratories following the patient's discharge from the hospital outpatient department, and independent laboratories will no longer have to seek payment from the HOPD for these tests, if all of the conditions are met. We note there are no current codes designated as ADLTs, however, molecular pathology codes are currently assigned to OPPS status indicator "A" to indicate that they are not paid under the OPPS but may be paid under a different Medicare payment system.

b. Laboratory Test/Service Performed by A Hospital Laboratory

For a molecular pathology test or ADLT test performed by a hospital laboratory, refer to Section 50.3, Hospitals in Chapter 16, Laboratory Services, of the Medicare Claims Processing Manual.

10. OPPS Status Indicator Updates for Clinical Laboratory Fee Schedule (CLFS) Molecular Pathology Tests and Advanced Diagnostic Laboratory Tests (ADLTs)

Under the OPPS, Medicare conditionally packages laboratory tests and only pays separately for certain types of laboratory tests. Molecular pathology tests and ADLTs are paid separately at the CLFS rate rather than

the OPPS. The current list of molecular pathology tests can be found in the OPPS Addendum B and are identified with status indicator "A", however, for the January 2018 OPPS update, there are no laboratory tests currently designated by CMS as ADLTs under the CLFS. As we stated in the CY 2017 OPPS/ASC final rule with comment period (81 FR 79594), we will assign status indicator "A" (*Not paid under OPPS. Paid by Medicare Administrative Contractors (MACs) under a fee schedule or payment system other than OPPS)* to ADLTs once a laboratory test has been granted ADLT status under the CLFS. Prior to ADLT designation, applicants must submit an application to CMS requesting ADLT status for a laboratory test. Once a test is designated by CMS as an ADLT under paragraph (1) of the definition of advanced diagnostic laboratory test in 42 CFR 414.502, CMS will update the OPPS Addendum B on a quarterly basis to reflect the appropriate status indicator assignment.

11. Billing Instructions for 340B-Acquired Drugs

As finalized in the CY 2018 OPPS/ASC final rule with comment period, separately payable Part B drugs (assigned status indicator "K"), other than vaccines (assigned status indicator "L" or "M") and drugs on pass-through payment status (assigned status indicator "G"), that are acquired through the 340B Program or through the 340B prime vendor program will be paid at the ASP minus 22.5 percent when billed by a hospital paid under the OPPS that is not excepted from the payment adjustment. Hospital types that are excepted from the 340B payment policy in CY 2018 include rural Sole Community Hospitals (SCHs), children's hospitals, and Prospective Payment System (PPS)-exempt cancer hospitals. These excepted hospitals will continue to receive ASP + 6 percent payment for separately payable drugs.

Medicare will continue to pay separately payable drugs that were not acquired under the 340B Program at ASP + 6 percent.

In addition, effective January 1, 2018, hospitals paid under the OPPS that are not excepted from the 340B drug payment policy for CY 2018 are required to report modifier "JG" on the same claim line as the drug HCPCS code to identify a 340B-acquired drug. Since rural SCHs, children's hospitals and PPS-exempt cancer hospitals are excepted from the 340B payment adjustment in CY 2018, these hospitals will report informational modifier "TB" for 340B-acquired drugs, and will continue to be paid ASP + 6 percent.

The 340B modifiers and their descriptors are listed in Table 5, attachment A.

Contractors are being advised that guidance on use of two new modifiers related to drugs acquired under the 340B program is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Billing-340B-Modifiers-under-Hospital-OPPS.pdf.

12. Drugs, Biologicals, and Radiopharmaceuticals

a. New CY 2018 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

For CY 2018, several new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. These new codes are listed in Table 6, attachment A.

b. Other Changes to CY 2018 HCPCS and CPT Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals

Many HCPCS and CPT codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS and CPT code descriptors that will be effective in CY 2018. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2017 and replaced with permanent HCPCS codes effective CY 2018. Hospitals should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the active CY 2018 HCPCS and CPT codes.

Table 7, attachment A, notes those drugs, biologicals, and radiopharmaceuticals that have undergone changes in their HCPCS/CPT code, their long descriptor, or both. Each product's CY 2017 HCPCS/CPT code and long descriptor are noted in the two left hand columns and the CY 2018 HCPCS/CPT code and long descriptor are noted in the adjacent right hand columns.

c. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective January 1, 2018

For CY 2018, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals that were not acquired through the 340B Program is made at a single rate of ASP + 6 percent (or ASP - 22.5 percent if acquired under the 340B Program), which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2018, 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. Effective January 1, 2018, payment rates for many drugs and biologicals have changed from the values published in the CY 2018 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2017. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2018 FISS release. CMS is not publishing the updated payment rates in this Change Request implementing the January 2018 update of the OPPS. However, the updated payment rates effective January 1, 2018 can be found in the January 2018 update of the OPPS Addendum A and Addendum B on the CMS Web site at http://www.cms.gov/HospitalOutpatientPPS/.

d. 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 website on the first date of the quarter at https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html.

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

e. Biosimilar Payment Policy

Effective January 1, 2018, the payment rate for biosimilars in the OPPS will generally continue be the same as the payment rate in the physician office setting, calculated as the Average Sales Price (ASP) of the biosimilar described by the HCPCS code + 6 percent of the ASP of the reference product. Biosimilars will also be eligible for transitional pass-through payment for which payment will be made at ASP of the biosimilar described by the HCPCS code + 6 percent of the ASP of the reference product. A biosimilar that does not have pass-through status but instead has status indicator of "K" will be paid the ASP of the biosimilar minus 22.5 percent of the ASP of the reference product, effective January 1, 2018.

In addition, effective January 1, 2018, newly approved biosimilar biological products with a common reference product will no longer be grouped into the same billing code with other biosimilars. CMS will issue guidance on coding, including instructions for new codes for biosimilars that are currently grouped into a common payment code and the use of modifiers separate from this OPPS CR. However, until such guidance is released, providers should continue to use applicable existing HCPCS codes and report a biosimilar modifier that identifies the manufacturer of the specific product. The modifier does not affect payment determination, but is used to distinguish between biosimilar products that appear in the same HCPCS code but are made by different manufacturers. A list of the biosimilar biological product HCPCS codes and modifiers is available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/Part-B-Biosimilar-Biological-Product-Payment.html.

13. Skin Substitute Procedure Edits

The payment for skin substitute products that do not qualify for pass-through status will be packaged into the payment for the associated skin substitute application procedure. The skin substitute products are divided into two groups: 1) high cost skin substitute products and 2) low cost skin substitute products for packaging purposes. Table 8, attachment A, lists the skin substitute products and their assignment as either a high cost or a low cost skin substitute product, when applicable.

14. New HCPCS Codes for Pathogen Reduced Platelets and Pathogen Testing for Platelets

For the January 2018 update, the HCPCS Workgroup deleted HCPCS codes Q9987 and Q9988 for Medicare reporting and replaced the codes with two new HCPCS codes effective January 1, 2018. Specifically, to report the service described by HCPCS code Q9988 based on the code descriptor in effect for July 1, 2017 – December 31, 2017, providers must instead report HCPCS code P9073 (Platelets, pathogen reduced, each unit) instead of HCPCS code Q9988 effective January 1, 2018. Providers reporting the service described by HCPCS code Q9987 based on the code descriptor in effect for July 1, 2017 – December 31, 2017 shall instead report HCPCS code P9100 (Pathogen(s) test for platelets) instead of HCPCS code Q9987 effective January 1, 2018. We note that HCPCS code P9100 should be reported to describe the test used for the detection of bacterial contamination in platelets as well as any other test that may be used to detect pathogen contamination. Table 9, attachment A, of this instruction, describes blood platelet coding changes that are effective January 1, 2018. The coding changes associated with these codes were also published on the CMS HCPCS Quarterly Update website effective January 2018, at https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update.html. The payment rates for HCPCS codes P9073 and P9100 can be found in the January 2018 OPPS Addendum B, which is available via the Internet on the CMS website.

15. Payment Adjustment for Certain Cancer Hospitals Beginning CY 2018

For certain cancer hospitals that receive interim monthly payments associated with the cancer hospital adjustment at 42 CFR 419.43(i), Section 16002(b) of the 21st Century Cures Act requires that, for CY 2018 and subsequent calendar years, the target Payment-to-Cost Ratio (PCR) that should be used in the calculation of the interim monthly payments and at final cost report settlement is reduced by 0.01. For CY 2018, the target PCR, after including the reduction required by Section 16002(b), is 0.88.

16. Section 4011 of the 21st Century Cures Act

Section 4011 of the 21st Century Cures Act created a new subsection (t) in section 1834 of the Social Security Act that requires CMS to make available to the public a searchable Internet website that compares estimated payment and beneficiary liability for an appropriate number of items and services paid under the Outpatient Prospective Payment System (OPPS) and the Ambulatory Surgical Center (ASC) Payment System. Consistent with this statute, we plan to first make this website available during CY 2018.

We believe that making available a comparison for all services that receive separate payment under both the OPPS and ASC payment system would be most useful to the public, with regards to displaying the comparison for an “appropriate number of such items and services.” We believe that displaying the national unadjusted payments and copayment amounts will allow the user to make a meaningful comparison between the systems for items and services paid under both systems. We may consider providing payment and copayment comparisons at the locality or provider level for future years.

Along with the comparison information that we will make available to the public in accordance with the requirements of Section 4011, we also plan to include a disclaimer statement that notes some of the payment policy differences in each care setting and noting the limitations of the comparison tool, to provide users with some context for why there might be potential differences. In the case of the OPPS copayments, we plan to include an additional indicator where the service is likely to be capped at the Part A inpatient

deductible, based on the unadjusted copayments, under the OPPS coinsurance rules.

17. Changes to OPPS Pricer Logic

a. Rural sole community hospitals and Essential Access Community Hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in CY 2018. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with section 1833(t)(13)(B) of the Act, as added by section 411 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

b. New OPPS payment rates and copayment amounts will be effective January 1, 2018. All copayment amounts will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the CY 2018 inpatient deductible of $1,340. For most OPPS services, copayments are set at 20 percent of the APC payment rate.

c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2018. This threshold of 1.75 is multiplied by the total line-item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount. The payment formula is (cost-(APC payment x 1.75))/2.

d. The fixed-dollar threshold for OPPS outlier payments increases in CY 2018 relative to CY 2017. The estimated cost of a service must be greater than the APC payment amount plus $4,150 in order to qualify for outlier payments.

e. For outliers for Community Mental Health Centers (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2017. This threshold of 3.4 is multiplied by the total line-item APC payment for APC 5853 to determine eligibility for outlier payments. This multiple amount is also used to determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment formula is (cost-(APC 5853 payment x 3.4))/2.

f. Continuing our established policy for CY 2018, the OPPS Pricer will apply a reduced update ratio of 0.980 to the payment and copayment for hospitals that fail to meet their hospital outpatient quality data reporting requirements or that fail to meet CMS validation edits. The reduced payment amount will be used to calculate outlier payments.

g. Effective January 1, 2018, CMS is adopting the FY 2018 IPPS post-reclassification wage index values with application of the CY 2018 out-commuting adjustment authorized by Section 505 of the MMA to non-IPPS hospitals as implemented through the Pricer logic.

h. Effective January 1, 2014, for claims with APCs, which require implantable devices and have significant device offsets (greater than 40%), a device offset cap will be applied based on the credit amount listed in the “FD” (Credit Received from the Manufacturer for a Replaced Medical Device) value code. The credit amount in value code “FD” which reduces the APC payment for the applicable procedure, will be capped by the device offset amount for that APC. The offset amounts for the above referenced APCs are available on the CMS website.

18. Update the Outpatient Provider Specific File (OPSF)

For January 1, 2018, contractors shall maintain the accuracy of the provider records in the Outpatient Provider Specific File (OPSF) as changes occur in data element values.

a) Updating the OPSF for Expiration of Transitional Outpatient Payments (TOPs)

Cancer and children's hospitals are held harmless under section 1833(t)(7)(D)(ii) of the Social Security Act and continue to receive hold harmless TOPs permanently. For CY 2018, cancer hospitals will continue to

receive an additional payment adjustment.

b) Updating the OPSF for the Hospital Outpatient Quality Reporting (HOQR) Program Requirements

Effective for OPPS services furnished on or after January 1, 2009, subsection (d) hospitals that have failed to submit timely hospital outpatient quality data as required in Section 1833(t)(17)(A) of the Act will receive payment under the OPPS that reflects a 2 percentage point deduction from the annual OPPS update for failure to meet the HOQR program requirements. This reduction will not apply to hospitals not required to submit quality data or hospitals that are not paid under the OPPS.

For January 1, 2018, contractors shall maintain the accuracy of the provider records in the OPSF by updating the Hospital Quality Indicator field. CMS will release a Technical Direction Letter that lists Subsection (d) hospitals that are subject to and fail to meet the HOQR program requirements. Once this list is released, A/B MACs will update the OPSF by removing the '1', (that is, ensure that the Hospital Quality Indicator field is blank) for all hospitals identified on the list and will ensure that the OPSF Hospital Quality Indicator field contains '1' for all hospitals that are not on the list. CMS notes that if these hospitals are later determined to have met the HOQR program requirements, A/B MACs shall update the OPSF. For greater detail regarding updating the OPSF for the HOQR program requirements, see Transmittal 368, CR 6072, issued on August 15, 2008.

c) Updating the OPSF for Cost to Charge Ratios (CCR)

As stated in Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, Section 50.1, contractors must maintain the accuracy of the data and update the OPSF as changes occur in data element values, including changes to provider cost–to-charge ratios and, when applicable, device department cost-to-charge ratios. The file of OPPS hospital upper limit CCRs and the file of Statewide CCRs are located on the CMS website at www.cms.gov/HospitalOutpatientPPS/ under "*Annual Policy Files.*"

d) Updating the "County Code" field

Prior to CY 2018, in order to include the outmigration in a hospital's wage index, we provided a separate table that assigned wage indexes for hospitals that received the outmigration adjustment. For the CY 2018 OPPS, the OPPS Pricer will assign the out migration adjustment using the "County Code" field in the OPSF. Therefore, MACs shall ensure that every hospital has listed in the "County Code" field the FIPS county code where the hospital is located to maintain the accuracy of the OPSF data fields.

e) Updating the "Payment CBSA" field

In the prior layout of the OPSF, there were only two CBSA related fields: the "Actual Geographic Location CBSA" and the "Wage Index Location CBSA." These fields are used to wage adjust OPPS payment through the Pricer if there is not an assigned Special Wage Index (as has been used historically to assign the wage index for hospitals receiving the outmigration adjustment).

In Transmittal 3750, dated April 19, 2017 for Change Request 9926, we created an additional field for the "Payment CBSA," similar to the IPPS, to allow for consistency between the data in the two systems and identify when hospitals receive dual reclassifications. In the case of dual reclassifications, similar to the IPPS, the "Payment CBSA" field will be used to note the Urban to Rural Reclassification Under Section 1886(d)(8)(E) of the Act (§ 412.103). This "Payment CBSA" field is not used for wage adjustment purposes, but to identify when the 412.103 reclassification applies, because rural status is considered for rural sole community hospital adjustment eligibility.

19. 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. 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	
10417.1	Medicare contractors shall install the January 2018 OPPS Pricer.	X		X		X				
10417.2	Medicare contactors shall manually add to their systems: • HCPCS code G9868, G9869, and G9870, listed in the upcoming January 2018 I/OCE CR, effective January 1, 2018; **Note:** These HCPCS codes will be included with the January 2018 I/OCE update. Status and payment indicators for these HCPCS codes will be listed in the January 2018 update of the OPPS Addendum A and Addendum B on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html	X		X						
10417.3	Medicare contractors shall adjust, as appropriate, claims brought to their attention with any retroactive changes that were received prior to implementation of January 2018 OPPS Pricer.	X		X						
10417.4	As quickly as possible, after the installation into production of the January release, as specified in Chapter 4, Section 50.1, Medicare contractors shall maintain the accuracy of the data and update the OPSF file as changes occur in data element values. For CY 2018, this includes all changes to the OPSF identified in Section 18 of this Change Request. **NOTE:**The file maintenance update must be completed before January 2018 claims are released	X		X						

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	from the quarterly release hook for processing.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10417.5	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:

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

V. CONTACTS

Pre-Implementation Contact(s): Marina Kushnirova, 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

Attachment A − Tables for the Policy Section

Table 1. ─ New Separately Payable Procedure Code Effective January 1, 2018

HCPCS Code	Short Descriptor	Long Descriptor	January 2018 OPPS SI	January 2018 OPPS APC
C9748	Prostatic rf water vapor tx	Transurethral destruction of prostate tissue; by radiofrequency water vapor (steam) thermal therapy	J1	5373

Table 2. ─ CY 2018 Additional New Technology APC Groups

CY 2018 APC	CY 2018 APC Title	CY 2018 SI	Updated or New APC
1901	New Technology - Level 49 ($100,001-$115,000)	S	Updated
1902	New Technology - Level 49 ($100,001-$115,000)	T	Updated
1903	New Technology - Level 50 ($115,001-$130,000)	S	Updated
1904	New Technology - Level 50 ($115,001-$130,000)	T	Updated
1905	New Technology - Level 51 ($130,001-$145,000)	S	Updated
1906	New Technology - Level 51 ($130,001-$145,000)	T	Updated
1907	New Technology - Level 52 ($145,001-$160,000)	S	New
1908	New Technology - Level 52 ($145,001-$160,000)	T	New

Table 3. – Excluded Planning and Preparation CPT Codes

CPT Code	CY 2018 Short Descriptor	CY 2018 Status Indicator
70551	Mri brain stem w/o dye	Q3
70552	Mri brain stem w/dye	Q3
70553	Mri brain stem w/o & w/dye	Q3
77011	Ct scan for localization	N
77014	Ct scan for therapy guide	N
77280	Set radiation therapy field	S
77285	Set radiation therapy field	S
77290	Set radiation therapy field	S
77295	3-d radiotherapy plan	S

CPT Code	CY 2018 Short Descriptor	CY 2018 Status Indicator
77336	Radiation physics consult	S

Table 4. — Changes to the Inpatient Only List for CY 2018

CY 2018 CPT Code	CY 2018 Long Descriptor	Status	CY 2018 OPPS APC Assignment	CY 2018 OPPS Status Indicator
27447	Arthroplasty, knee, condyle and plateau; medical and lateral compartments with or without patella resurfacing (total knee arthroplasty)	Removed	5115	J1
43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh	Removed	5362	J1
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only	Removed	5303	J1
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only	Removed	5361	J1
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components	Removed	5303	J1
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed	Removed	5362	J1
92941	Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel	Added	N/A	C

Table 5 – Modifiers for 340B-Acquired Drugs

2-Digit HCPCS Modifier	Short Descriptor	Long Descriptor	Effective Date

JG	340B acquired drug	Drug or biological acquired with 340B drug pricing program discount	01/01/2018
TB	Tracking 340B acquired drug	Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes	01/01/2018

Table 6 ─ New CY 2018 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2018 HCPCS Code	CY 2018 Long Descriptor	CY 2018 SI	CY 2018 APC
C9014	Injection, cerliponase alfa, 1 mg	G	9014
C9015	Injection, c-1 esterase inhibitor (human), Haegarda, 10 units	G	9015
C9016	Injection, triptorelin extended release, 3.75 mg	G	9016
C9024	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine	G	9302
C9028	Injection, inotuzumab ozogamicin, 0.1 mg	G	9028
C9029	Injection, guselkumab, 1 mg	G	9029
J0604	Cinacalcet, oral, 1 mg, (for esrd on dialysis)	B	N/A
J0606	Injection, etelcalcetide, 0.1 mg	K	9031
J1555	Injection, immune globulin (cuvitru), 100 mg	K	9034
J7211	Injection, factor viii, (antihemophilic factor, recombinant), (kovaltry), 1 i.u.	K	9075
J7345	Aminolevulinic acid hcl for topical administration, 10% gel, 10 mg	G	9301
J9203	Injection, gemtuzumab ozogamicin, 0.1 mg	G	9495
Q2040	Tisagenlecleucel, up to 250 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per infusion	K	9081
Q4176	Neopatch, per square centimeter	N	N/A
Q4177	Floweramnioflo, 0.1 cc	N	N/A
Q4178	Floweramniopatch, per square centimeter	N	N/A
Q4179	Flowerderm, per square centimeter	N	N/A
Q4180	Revita, per square centimeter	N	N/A
Q4181	Amnio wound, per square centimeter	N	N/A
Q4182	Transcyte, per square centimeter	N	N/A

Table 7 ─ Other CY 2018 HCPCS and CPT Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2017 HCPCS Code	CY 2017 Long Descriptor	CY 2018 HCPCS Code	CY 2018 Long Descriptor
C9490	Injection, bezlotoxumab, 10 mg	J0565	Injection, bezlotoxumab, 10 mg
C9484	Injection, eteplirsen, 10 mg	J1428	Injection, eteplirsen, 10 mg
C9486	Injection, granisetron extended release, 0.1 mg	J1627	Injection, granisetron, extended release, 0.1 mg
Q9986	Injection, hydroxyprogesterone caproate (Makena), 10 mg	J1726	Injection, hydroxyprogesterone caproate (Makena), 10 mg
Q9985	Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg	J1729	Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg
C9489	Injection, nusinersen, 0.1 mg	J2326	Injection, nusinersen, 0.1 mg
C9494	Injection, ocrelizumab, 1 mg	J2350	Injection, ocrelizumab, 1 mg
Q9989	Ustekinumab, for Intravenous Injection, 1 mg	J3358	Ustekinumab, for intravenous injection, 1 mg
C9140	Injection, Factor VIII (antihemophilic factor, recombinant) (Afstyla), 1 I.U.	J7210	Injection, factor viii, (antihemophilic factor, recombinant), (afstyla), 1 i.u.
Q9984	Levonorgestrel-releasing intrauterine contraceptive system (Kyleena), 19.5 mg	J7296	Levonorgestrel-releasing intrauterine contraceptive system (Kyleena), 19.5 mg
C9483	Injection, atezolizumab, 10 mg	J9022	Injection, atezolizumab, 10 mg
C9491	Injection, avelumab, 10 mg	J9023	Injection, avelumab, 10 mg
C9485	Injection, olaratumab, 10 mg	J9285	Injection, olaratumab, 10 mg

Table 8.—Skin Substitute Assignments to High Cost and Low Cost Groups for CY 2018

HCPCS Code	2018 Short Descriptor	CY 2018 Status Indicator	CY 2018 High/Low Assignment
C9363	Integra meshed bil wound mat	N	High
Q4100	Skin substitute, nos	N	Low
Q4101	Apligraf	N	High
Q4102	Oasis wound matrix	N	Low
Q4103	Oasis burn matrix	N	High

HCPCS Code	2018 Short Descriptor	CY 2018 Status Indicator	CY 2018 High/Low Assignment
Q4104	Integra bmwd	N	High
Q4105	Integra drt or omnigraft	N	High
Q4106	Dermagraft	N	High
Q4107	Graftjacket	N	High
Q4108	Integra matrix	N	High
Q4110	Primatrix	N	High
Q4111	Gammagraft	N	Low
Q4115	Alloskin	N	Low
Q4116	Alloderm	N	High
Q4117	Hyalomatrix	N	Low
Q4121	Theraskin	N	High
Q4122	Dermacell	N	High
Q4123	Alloskin	N	High
Q4124	Oasis tri-layer wound matrix	N	Low
Q4126	Memoderm/derma/tranz/integup	N	High
Q4127	Talymed	N	High
Q4128	Flexhd/allopatchhd/matrixhd	N	High
Q4131	Epifix or epicord	N	High
Q4132	Grafix core, grafixpl core	N	High
Q4133	Grafix prime grafix pl prime	N	High
Q4134	Hmatrix	N	Low
Q4135	Mediskin	N	Low
Q4136	Ezderm	N	Low
Q4137	Amnioexcel or biodexcel, 1cm	N	High
Q4138	Biodfence dryflex, 1cm	N	High
Q4140	Biodfence 1cm	N	High
Q4141	Alloskin ac, 1cm	N	High
Q4143	Repriza, 1cm	N	High
Q4146	Tensix, 1 cm	N	High
Q4147	Architect ecm px fx 1 sq cm	N	High

HCPCS Code	2018 Short Descriptor	CY 2018 Status Indicator	CY 2018 High/Low Assignment
Q4148	Neox neox rt or clarix cord	N	High
Q4150	Allowrap ds or dry 1 sq cm	N	High
Q4151	Amnioband, guardian 1 sq cm	N	High
Q4152	Dermapure 1 square cm	N	High
Q4153	Dermavest, plurivest sq cm	N	High
Q4154	Biovance 1 square cm	N	High
Q4156	Neox 100 or clarix 100	N	High
Q4157	Revitalon 1 square cm	N	High
Q4158	Kerecis omega3, per sq cm	N	High
Q4159	Affinity1 square cm	N	High
Q4160	Nushield 1 square cm	N	High
Q4161	Bio-Connekt per square cm	N	High
Q4163	Woundex, bioskin, per sq cm	N	High
Q4164	Helicoll, per square cm	N	High
Q4165	Keramatrix, per square cm	N	Low
Q4166	Cytal, per square cm	N	Low
Q4167	Truskin, per square cm	N	Low
Q4169	Artacent wound, per square cm	N	High
Q4170	Cygnus, per square cm	N	Low
Q4172*	Puraply or puraply am	N	High
Q4173	Palingen or palingen xplus	N	High
Q4175	Miroderm	N	High
Q4176*	Neopatch, per sq centimeter	N	Low
Q4178*	Floweramniopatch, per sq cm	N	Low
Q4179*	Flowerderm, per sq cm	N	Low
Q4180*	Revita, per sq cm	N	Low
Q4181*	Amnio wound, per square cm	N	Low
Q4182*	Transcyte, per sq centimeter	N	Low

* HCPCS codes Q4176, Q4178, Q4179, Q4180, Q4181, and Q4182 were assigned to the low cost group in CY 2018 OPPS/ASC final rule with comment period. Pass-through status for HCPCS code Q4172 ended on December 31, 2017.

Table 9. –Blood Platelet Coding Changes Effective January 1, 2018

HCPCS Code	Short Descriptor	Long Descriptor	January 2018 OPPS SI	January 2018 OPPS APC
P9073	Platelets, pathogen reduced	Platelets, pathogen reduced, each unit	R	9536
P9100	Pathogen test for platelets	Pathogen(s) test for platelets	S	1493

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

Table of Contents
(Rev.3941, 12-22-17)

Transmittals for Chapter 4

10.6.3.3 - Payment Adjustment for Certain Cancer Hospitals Beginning CY 2015

10.6.3.4 - Payment Adjustment for Certain Cancer Hospitals Beginning CY 2016

10.6.3.5 - Payment Adjustment for Certain Cancer Hospitals Beginning CY 2017

10.6.3.6 - Payment Adjustment for Certain Cancer Hospitals Beginning CY 2018

20.6.12 - Use of HCPCS Modifier – PN

20.6.13 - *Use of HCPCS Modifier – CT*

*20.6.*14 - *Use of HCPCS Modifier – FX*

20.6.15 - *Use of HCPCS Modifier - FY*

40.5 - Transitional Pass - Throughs for Designated Drugs or Biologicals

50.3- *Transitional Pass-Through Payments for Designated Devices*

50.4- *Changes to Pricer Logic Effective April 1, 2002*

50.5 - *Changes to the OPPS Pricer Logic Effective January 1, 2003*

50.6- *Changes to the OPPS Pricer Logic Effective January 1, 2003 Through January 1, 2006*

50.7 - *Annual Updates to the OPPS Pricer for Calendar Year (CY) 2007 and Later*

10.1 - Background
(Rev. 3941; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

Section 1833(t) of the Social Security Act (the Act) as amended by §4533 of the Balanced Budget Act (BBA) of 1997, authorizes CMS to implement a Medicare PPS for:

- Hospital outpatient services, including partial hospitalization services;
- Certain Part B services furnished to hospital inpatients who have no Part A coverage;
- Partial hospitalization services furnished by CMHCs;

- Hepatitis B vaccines and their administration, splints, cast, and antigens provided by HHAs that provide medical and other health services;

- Hepatitis B vaccines and their administration provided by CORFs; and

- Splints, casts, and antigens provided to hospice patients for treatment of non-terminal illness.

The Balanced Budget Refinement Act of 1999 (BBRA) contains a number of major provisions that affect the development of the OPPS. These are:

- Establish payments under OPPS in a budget neutral manner based on estimates of amounts payable in 1999 from the Part B Trust Fund and as beneficiary coinsurance under the system in effect prior to OPPS (Although the base rates were calculated using the 1999 amounts, these amounts are increased by the hospital inpatient market basket, minus one percent, to arrive at the amounts payable in the year 2000. See §10.3 for Benefits and Improvement Protection Act (BIPA) changes in market basket updates.);

- Extend the 5.8 percent reduction in operating costs and 10 percent reduction in capital costs (which had been due to sunset on December 31, 1999) through the first date the OPPS is implemented;

- Require annual updating of the OPPS payment weights, rates, payment adjustments and groups;

- Require annual consultation with an expert provider advisory panel in review and updating of payment groups;

- Establish budget neutral outlier adjustments based on the charges, adjusted to costs, for all OPPS services included on the submitted outpatient bill for services furnished before January 1, 2002, and thereafter based on the individual services billed;

- Provide transitional pass-through *payment* for the additional costs of new and current medical devices, drugs, and biologicals for at least two years but not more than three years;

- Provide payment under OPPS for implantable devices including durable medical equipment (DME), prosthetics and those used in diagnostic testing;

- Establish transitional payments to limit provider's losses under OPPS; the additional payments are for 3 1/2 years for CMHCs and most hospitals, and permanent for the 10 cancer hospitals; and

- Limit beneficiary coinsurance for an individual service paid under OPPS to the inpatient hospital deductible.

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), which was signed into law on December 21, 2000, made a number of revisions to the Outpatient Prospective Payment System (OPPS). These are:

- Accelerated reductions of beneficiary copayments;

- Increase in market basket update for 2001;

- Transitional corridor provision for transitional outpatient payments (TOPs) for providers that did not file 1996 cost reports; and

- Special transitional corridor treatment for children's hospitals.

The Secretary has the authority under §1883(t) of the Act to determine which services are included (with the exception of ambulance services for which a separate fee schedule is applicable starting April 1, 2002). Medicare will continue to pay for clinical diagnostic laboratory services, orthotics, prosthetics (except as noted above), and for take-home surgical dressings on their respective fee schedules. Medicare will also continue to pay for chronic dialysis using the composite rate (certain CRNA services, PPV, and influenza vaccines and their administration, orphan drugs, and ESRD drugs and supplies are not included in the composite rate), for screening mammographies based on the current payment limitation, which changes to payment under the Medicare Physician Fee Schedule (MPFS), effective January 1, 2002, and for outpatient rehabilitation services (physical therapy including speech language pathology and occupational therapy) under the MPFS. Acute dialysis, e.g., for poisoning, will be paid under OPPS. The 10 cancer centers exempt from inpatient PPS are included in this system, but are eligible for hold harmless payment under the Transitional Corridor provision.

The Outpatient Prospective Payment System (OPPS) applies to all hospital outpatient departments except for hospitals that provide Part B only services to their inpatients; Critical Access Hospitals (CAHs); Indian Health Service hospitals; hospitals located in American Samoa, Guam, and Saipan; hospitals located in the Virgin Islands*; and effective January 1, 2017 non-excepted off-campus provider-based departments of a hospital. The OPPS also* applies to partial hospitalization services furnished by Community Mental Health Centers (CMHCs).

Certain hospitals in Maryland that are paid under Maryland waiver provisions are also excluded from payment under OPPS but not from reporting Healthcare Common Procedure Coding System (HCPCS) and line item dates of service.

10.2.1 - Composite APCs

(Rev. 3941; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

Composite APCs provide a single payment for a comprehensive diagnostic and/or treatment service that is defined, for purposes of the APC, as a service typically reported with multiple HCPCS codes. When HCPCS codes that meet the criteria for payment of the composite APC are billed on the same date of service, CMS makes a single payment for all of the codes as a whole, rather than paying individually for each code.

*S*ee Addendum A at www.cms.hhs.gov/HospitalOutpatientPPS/ for the national unadjusted payment rates for these composite APCs.

10.3 - Calculation of APC Payment Rates

10.4 - Packaging

(Rev. 3941; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

Under the OPPS, packaged services are items and services that are considered to be an integral part of another service that is paid under the OPPS. No separate payment is made for packaged services, because the cost of these items and services is included in the APC payment for the service of which they are an integral part. For example, routine supplies, anesthesia, recovery room use, and most drugs are considered to be an integral part of a surgical procedure so payment for these items is packaged into the APC payment for the surgical procedure.

A. Packaging for Claims Resulting in APC Payments

If a claim contains services that result in an APC payment but also contains packaged services, separate payment for the packaged services is not made since payment is included in the APC. However, charges related to the packaged services are used for outlier and Transitional Corridor Payments (TOPs) as well as for future rate setting. Therefore, it is extremely important that hospitals report all HCPCS codes consistent with their descriptors; CPT and/or CMS instructions and correct coding principles, and all charges for all services they furnish, whether payment for the services is made separately paid or is packaged.

B. Packaging for Claims Resulting in No APC Payments

If the claim contains only services payable under cost reimbursement, such as corneal tissue, and services that would be packaged services if an APC were payable, then the packaged services are not separately payable. In addition, these charges for the packaged services are not used to calculate TOPs.

If the claim contains only services payable under a fee schedule, such as clinical diagnostic laboratory tests, and also contains services that would be packaged services if an APC were payable, the packaged services are not separately payable. In addition, the charges are not used to calculate TOPs.

If a claim contains services payable under cost reimbursement, services payable under a fee schedule, and services that would be packaged services if an APC were payable, the packaged services are not separately payable. In addition, the charges are not used to calculate TOPs payments.

C. Packaging Types Under the OPPS

1. Unconditionally packaged services are services for which separate payment is never made because the payment for the service is always packaged into the payment for other services. Unconditionally packaged services are identified in the OPPS Addendum B with status indictor of N. See the OPPS Web site at http://www.cms.hhs.gov/HospitalOutpatientPPS/ for the most recent Addendum B (HCPCS codes with status indicators). In general, the charges for unconditionally packaged services are used to calculate outlier and TOPS payments when they appear on a claim with a service that is separately paid under the OPPS because the packaged service is considered to be part of the package of services for which payment is being made through the APC payment for the separately paid service.

2. STV-packaged services are services for which separate payment is made only if there is no service with status indicator S, T, or V reported on the same claim. If a claim includes a service that is assigned status indicator S, T, or V reported on the same claim as the STV- packaged service, the payment for the STV-packaged service is packaged into the payment for the service(s) with status indicator S, T, V and no separate payment is made for the STV-packaged service. STV-packaged services are assigned status indicator Q1. See the OPPS Webpage at http://www.cms.hhs.gov/HospitalOutpatientPPS/ for identification of STV-packaged codes.

3. T-packaged services are services for which separate payment is made only if there is no service with status indicator T reported on the same claim. When there is a claim that includes a service that is assigned status indicator T reported on the same claim as the T-packaged service, the payment for the T-packaged service is packaged into the payment for the service(s) with status indicator T and no separate payment is made for the T-packaged service. T-packaged services are assigned status indicator Q2. See the OPPS Web site at http://www.cms.hhs.gov/HospitalOutpatientPPS/ for identification of T-packaged codes.

4. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Services mapped to composite APCs are assigned status indicator Q3. See the discussion of composite APCs in section 10.2.1.

5. Q4 services are assigned to laboratory HCPCS codes that appear on the Clinical Laboratory Fee Schedule (CLFS). Status indicator Q4 designates packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "J1," "J2," "S," "T," "V," "Q1," "Q2," or "Q3." When a Q4 service is not billed on the same claim as another separately payable service then the IOCE automatically changes their status indicator to "A" and separate payment is made at the CLFS payment rate.

6. J1 services are assigned to comprehensive APCs. Payment for all adjunctive services reported on the same claim as a J1 service is packaged into payment for the primary J1 service. See the discussion of comprehensive APCs in section 10.2.3.

7. J2 services are assigned to comprehensive APCs when a specific combination of services are reported on the claim. Payment for all adjunctive services reported on the same claim as a J2 service is packaged into payment for the J2 service when certain conditions are met. See the discussion of comprehensive APCs in section 10.2.3.

10.6.3.3 - *Payment Adjustment for Certain Cancer Hospitals Beginning CY 2015*
(Rev. 3941; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

The target PCR that should be used in the calculation of the interim monthly payments associated with the cancer hospital adjustment, as described above in section 10.6.3, and at final cost report settlement is 0.90 for hospital outpatient services furnished on or after January 1, 2015 through December 31, 2015.

10.6.3.4 - *Payment Adjustment for Certain Cancer Hospitals Beginning CY 2016*
(Rev. 3941; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

The target PCR that should be used in the calculation of the interim monthly payments associated with the cancer hospital adjustment, as described above in section 10.6.3, and at final cost report settlement is 0.92 for hospital outpatient services furnished on or after January 1, 2016 through December 31, 2016.

10.6.3.5 - *Payment Adjustment for Certain Cancer Hospitals Beginning CY 2017*
(Rev. 3941; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

The target PCR that should be used in the calculation of the interim monthly payments associated with the cancer hospital adjustment, as described above in section 10.6.3, and at final cost report settlement is 0.91 for hospital outpatient services furnished on or after January 1, 2017 through December 31, 2017.

10.6.3.6 - *Payment Adjustment for Certain Cancer Hospitals Beginning CY 2018*
(Rev. 3941; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

Section 16002(b) of the 21st Century Cures Act requires that, for CY 2018 and subsequent calendar years, the target PCR that should be used in the calculation of the interim monthly payments associated with the cancer hospital adjustment, as described above in section 10.6.3, and at final cost report settlement is reduced by 0.01. After including this reduction, for hospital outpatient services furnished on or after January 1, 2018 through December 31, 2018, the target PCR is 0.88.

20.6.11 - Use of HCPCS Modifier - PO

(Rev. 3941; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

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

20.6.12 - Use of HCPCS Modifier – PN

(Rev. 3941; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

A. General

*Effective January 1, 2017, the definition of modifier "PN" is "**Nonexcepted service provided at an off-campus, outpatient, provider - based department of a hospital**." This modifier was established to identify and pay nonexcepted items and services billed by an off-campus department of a provider. Nonexcepted items and services are described in the regulations at 42 CFR 419.48.*

B. Effect on Payment

Payment for nonexcepted items and services furnished at nonexcepted off-campus provider-based departments reported with modifier "PN" will result in a payment rate under the PFS effective January 1, 2017. The PN modifier is required to be reported on each claim line with each nonexcepted item and service including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services. A table of PFS payment for nonexcepted items and services in nonexcepted off-campus provider- based departments of a hospital by OPPS status indicator is available via the Internet on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/CY2018-PFS-FR-Nonexcepted-Items.zip.

20.6.*13* - *Use of HCPCS Modifier – C*T

(Rev. 3941; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

*Effective January 1, 2016, the definition of modifier – CT is **"Computed tomography services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) XR-29-2013 standard."** This modifier is required to be reported on claims for computed tomography (CT) scans described by applicable HCPCS codes that are furnished on non-NEMA Standard XR-29-2013-compliant equipment. The applicable CT services are identified by HCPCS codes 70450 through 70498; 71250 through 71275; 72125 through 72133; 72191 through 72194; 73200 through 73206; 73700 through 73706; 74150 through 74178; 74261 through 74263; and 75571 through 75574 (and any succeeding codes).*

This modifier should not be reported with codes that describe CT scans not listed above.

20.6.14 - *Use of HCPCS Modifier – FX*

(Rev. 3941; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

A. General

On December 18, 2015, the Consolidated Appropriations Act of 2016 was signed into law (Public Law 114-113). Section 502 of the Consolidated Appropriations Act requires that Medicare implement the following provisions under the hospital outpatient prospective payment system (OPPS): reduce payment by 20 percent for an X-ray taken using film and that is furnished beginning January 1, 2017, and reduce payment by 7 percent from January 1, 2018 through December 31, 2022, and thereafter to 10 percent beginning January 1, 2023 for an imaging service that is an x-ray taken using computed radiography technology.

*Effective January 1, 2017, the definition of modifier FX is "**X-ray taken using film.**" This modifier is required to be reported on claims for imaging services that are x-rays using film.*

B. Effect on Payment

Payment for x-ray services taken using film reported with modifier "FX" will be reduced by 20 percent effective January 1, 2017. We note that when payment for an x-ray service taken using film is packaged into the payment for another item or service under the OPPS, no separate payment for the x-ray service taken using film is made. Accordingly, the payment reduction in this instance would be 0 percent (that is, 20 percent of $0). All imaging services that are x-rays are listed in the OPPS Addendum B, which is available via the Internet on the CMS Web site.

20.6.15 - Use of HCPCS Modifier – FY

(Rev. 3941; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

A. General

On December 18, 2015, the Consolidated Appropriations Act of 2016 was signed into law (Public Law 114-113). Section 502 of the Consolidated Appropriations Act requires that Medicare implement the following provisions under the hospital outpatient prospective payment system (OPPS): reduce payment by 20 percent for an x-ray taken using film and that is furnished beginning January 1, 2017, and reduce payment by 7 percent from January 1, 2018 through December 31, 2022, and thereafter to 10 percent beginning January 1, 2023 for an x-ray taken using computed radiography technology.

*Effective January 1, 2017, the definition of modifier FY is "**X-ray taken using computed radiography technology/cassette-based imaging**." This modifier is required to be reported on claims for imaging services that are x-rays taken using computed radiography technology/cassette-based imaging.*

B. Effect on Payment

Payment for x-ray services taken using computed radiography technology will be reduced by 7 percent from January 1, 2018 through December 31, 2022, and thereafter to 10 percent beginning January 1, 2023. We note that when payment for an x-ray service taken using computed radiography technology is packaged into the payment for another item or service under the OPPS, no separate payment for the x-ray service taken using computed radiography technology is made. Accordingly, the payment reduction in this instance would be 0 percent (that is, 20 percent of $0). All imaging services that are x-rays are listed in the OPPS Addendum B, which is available via the Internet on the CMS Web site.

40.5 - Transitional Pass-Throughs for Designated Drugs or Biologicals

(Rev. 3941; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

Certain current designated drugs and biologicals are assigned to special APCs. I/OCE identifies these and assigns the appropriate APC. Fiscal Intermediary Shared System (FISS) establishes payment at the average sales price (ASP) drug fee amount minus the portion of the otherwise applicable APC payment amount. I/OCE and FISS will determine the proper payment amount for these APCs as well as the coinsurance and any applicable deductible. All related payment calculations will be returned by the I/OCE and FISS, identified as a designated drug and biological with status indicator (SI) "K". Certain new designated drugs and biologicals may be approved for payment, and their payment will be calculated in the same manner as listed above for current designated drugs and biologicals. IOCE identifies these new designated drugs and biologicals (SI "G") separately from the current designated drugs and biologicals (SI "K").

Note: See section 40.1 for the I/OCE instructions and specifications

50.1 - Outpatient Provider Specific File

(Rev. 3941; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

The Outpatient Provider Specific File (OPSF) contains the required information about each provider to enable the pricing software to calculate the payment amount. Data elements and formats are shown below. Contractors must maintain the accuracy of the data, and update the file as changes occur in data element values, e.g., changes in metropolitan statistical area (MSA), bed size, cost to charge ratio. An update is accomplished by preparing and adding an additional complete record showing new current values and the effective date of the change. The old record is retained without change.

Contractors must also furnish CMS a quarterly file in the same format.

NOTE: All data elements, whether required or optional, must have a default value of "0" (zero) if numerical, or blank if alphanumerical.

File Position	Format	Title	Description
1-10	X(10)	National Provider Identifier (NPI)	Alpha-numeric 10 character provider number.
11-16	X(6)	Provider Oscar Number	Alpha-numeric 6 character provider number.
17-24	9(8)	Effective Date	Must be numeric, CCYYMMDD. This is the effective date of the provider's first OPPS period. For subsequent OPPS periods, the effective date is the date of a change to the PROV file. If a termination date is present for this record, the effective date must be equal to or less than the termination date.
25-32	9(8)	Fiscal Year Beginning Date	Must be numeric, CCYYMMDD. Month: 01-12 Day: 01-31 The date must be greater than 19990630.
33-40	9(8)	Report Date	Must be numeric, CCYYMMDD. Month: 01-12 Day: 01-31 The created/run date of the PROV report for submittal to CO.

41-48	9(8)	Termination Date	Must be numeric, CCYYMMDD. Must be zeroes or contain a termination date. (Once the official "tie-out" notice from CMS is received). Must be equal to or greater than the effective date. (Termination date is the date on which the reporting contractor ceased servicing the provider in question).
49	X(1)	Waiver Indicator	Enter a "Y" or "N." Y = waived (provider is not under OPPS) For End Stage Renal Disease (ESRD) facilities provider waived blended payment, pay full PPS. N = not waived (provider is under OPPS) For ESRD facilities provider did not waive blended payment. Pay according to transitional payment method for ESRD PPS through 2013.
50-54	9(5)	Intermediary Number	Enter the Contractor #.

55-56	X(2)	Provider Type	This identifies providers that require special handling. Enter one of the following codes as appropriate. 00 or blanks = Short Term Facility 02 Long Term 03 Psychiatric 04 Rehabilitation Facility 05 Pediatric 06 Hospital Distinct Parts (Provider type "06" is effective until July 1, 2006. At that point, provider type "06" will no longer be used. Instead, contractors will assign a hospital distinct part as one of the following provider types: 49, 50, 51, 52, 53, or 54) 07 Rural Referral Center 08 Indian Health Service 13 Cancer Facility 14 Medicare Dependent Hospital (during cost reporting periods that began on or after April 1, 1990. 15 Medicare Dependent Hospital/Referral Center (during cost reporting periods that began on or after April 1, 1990. Invalid October 1, 1994 through September 30, 1997). 16 Re-based Sole Community Hospital 17 Re-based Sole Community Hospital /Referral Center 18 Medical Assistance Facility 21 Essential Access Community Hospital 22 Essential Access Community Hospital/Referral Center 23 Rural Primary Care Hospital 32 Nursing Home Case Mix Quality Demonstration Project – Phase II 33 Nursing Home Case Mix Quality Demonstration Project – Phase III – Step 1 34 Reserved 35 Hospice 36 Home Health Agency 37 Critical Access Hospital

			38 Skilled Nursing Facility (SNF) – For nondemo PPS SNFs – effective for cost reporting periods beginning on or after July 1, 1998 40 Hospital Based ESRD Facility 41 Independent ESRD Facility 42 Federally Qualified Health Centers 43 Religious Non-Medical Health Care Institutions 44 Rural Health Clinics-Free Standing 45 Rural Health Clinics-Provider Based 46 Comprehensive Outpatient Rehab Facilities 47 Community Mental Health Centers 48 Outpatient Physical Therapy Services 49 Psychiatric Distinct Part 50 Rehabilitation Distinct Part 51 Short-Term Hospital – Swing Bed 52 Long-Term Care Hospital – Swing Bed 53 Rehabilitation Facility – Swing Bed 54 Critical Access Hospital – Swing Bed
57	X(1)	Special Locality Indicator	Indicates the type of special locality provision that applies. For End Stage Renal Disease (ESRD) facilities value "Y" equals low volume adjustment applicable.
58	X(1)	Change Code For Wage Index Reclassification	Enter "Y" if the hospital's wage index location has been reclassified for the year. Enter "N" if it has not been reclassified for the year. Adjust annually. Does not apply to ESRD Facilities.
59-62	X(4)	Actual Geographic Location—MSA	Enter the appropriate code for MSA, 0040–9965, or the rural area, (blank) (blank) 2-digit numeric State code, such as _ _ 3 6 for Ohio, where the facility is physically located.
63-66	X(4)	Wage Index Location—MSA	The appropriate code for the MSA, 0040-9965, or the rural area, (blank)(blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified for wage index. Leave blank or enter the actual location MSA if not reclassified. Does not apply to ESRD Facilities.
67-70	9V9(3)	Payment-to-Cost Ratio	Enter the provider's payment-to-cost ratio. Does not apply to ESRD Facilities.

71-72	9(2)	State Code	Enter the 2-digit state where the provider is located. Enter only the first (lowest) code for a given state. For example, effective October 1, 2005, Florida has the following State Codes: 10, 68 and 69. Contractors shall enter a "10" for Florida's State Code. List of valid State Codes is located in Pub. 10007, Chapter 2, Section 2779A1.
73	X(1)	TOPs Indicator	Enter the code to indicate whether TOPs applies or not. Y = qualifies for TOPs N = does not qualify for TOPs
74	X(1)	Quality Indicator Field	Hospital: Enter the code to indicate whether the hospital meets data submission criteria per HOP QDRP requirements. 1 = Hospital quality reporting standards have been met or hospital is not required to submit quality data (e.g., hospitals that are specifically excluded from the IPPS or which are not paid under the OPPS, including psychiatric, rehabilitation, long-term care and children's and cancer hospitals, Maryland hospitals, Indian Health Service hospitals, or hospital units; or hospitals that are located in Puerto Rico or the U.S. territories). The reduction does not apply to hospices, CORFs, HHAs, CMHCs, critical access hospitals or to any other provider type that is not a hospital. Blank = Hospital does not meet criteria. Independent and Hospital-based End Stage Renal Disease (ESRD)Facilities: Enter the code applicable to the ESRD Quality Incentive Program (QIP): Blank = no reduction = ½ percent payment reduction = 1 percent payment reduction = 1 ½ percent paymentreduction = 2 percent payment reduction * Please refer to file position 101 for ESRD Children's Hospitals Quality Indicator.
75	X(1)	Filler	Blank.

76-79	9V9(3)	Outpatient Costto-Charge Ratio	Derived from the latest available cost report data. See §10.11 of this chapter for instructions on how to calculate and report the Cost-to-Charge Ratio. Does not apply to ESRD Facilities.
80-84	X(5)	Actual Geographic Location CBSA	00001-89999, or the rural area, (blank) (blank) (blank) 2 digit numeric State code such as _ _ _ 3 6 for Ohio, where the facility is physically located.
85-89	X(5)	Wage Index Location CBSA	Enter the appropriate code for the CBSA, 0000189999, or the rural area, (blank)(blank)(blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the Actual Geographic Location CBSA, if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank. Does not apply to ESRD Facilities.
90-95	9(2) V9(4)	Special Wage Index	Enter the special wage index that certain providers may be assigned. Enter zeroes unless the Special Payment Indicator equals a “1” or “2.”
96	X(1)	Special Payment Indicator	The following codes indicate the type of special payment provision that applies. Blank = not applicable Y = reclassified = special wage index indicator = both special wage index indicator and reclassified *D = Dual Reclassified*
97-100	9(4)	Reduced Coinsurance Trailer Count	Enter the number of APCs the provider has elected to reduce coinsurance for. The number cannot be greater than 999.
101	X(1)	Quality Indicator ESRD Children’s Hospitals	Children’s Hospitals for End Stage Renal Disease (ESRD) Facilities: Enter the code applicable to the ESRD Quality Incentive Program (QIP): Blank = no reduction = ½ percent payment reduction = 1 percent payment reduction = 1 ½ percent payment reduction = 2 percent payment reduction

102-105	9V9(3)	Device department's Cost-to-Charge Ratio	Derived from the latest available cost report data. Does not apply to ESRD Facilities.
106-112	X(7)	Carrier/Locality code	The carrier/locality code for the provider service facility. The first five positions represent the carrier code and the last two positions represent the locality code.
113-117	9(5)	County Code	Enter the County Code. Must be 5 numbers.
118-122	X(5)	Payment CBSA	Enter the appropriate code for the CBSA, 0000189999, or the rural area, (blank)(blank)(blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the Actual Geographic Location CBSA, if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank. Does not apply to ESRD Facilities.
123-162	X(40)	FILLER	

The contractor enters the number of APCs for which the provider has elected to reduce coinsurance. Cannot be greater than 999. Reduced Coinsurance Trailer Record - Occurs 0-999 times depending on the reduced Coinsurance Trailer Count in positions 97-100. Due to system's capacity limitations the maximum number of reduced coinsurance trailers allowable is 999 at this time.

1-4	9(4)	APC Classification - Enter the 4-digit APC classification for which the provider has elected to reduce coinsurance.
5-10	9(4)V9(2)	Reduced Coinsurance Amount - Enter the reduced coinsurance amount elected by the provider

The Shared system will verify that the last position of the record is equal to the number in file positions 97 through 100 multiplied by 10 plus 100 (last position of record = (# in file position 97-100)(10) + 100).

50.3 - *Transitional Pass Through Payments for Designated Devices*

(Rev. 3941; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

Certain designated new devices are assigned to APCs and identified by the OCE as eligible for payment based on the reasonable cost of the new device reduced by the amount included in the APC for the procedure that reflects the packaged payment for devices used with the procedure. OCE will determine the proper payment amount for these APCs as well as the coinsurance and any applicable deductible. All related payment calculations will be returned on the same APC line and identified as a designated new device.

Refer to https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html for the most current OPPS APC Offset File.

50.4 - *Changes to Pricer Logic Effective April 1, 2002*

(Rev. 3941; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

The following list contains a description of all OPPS Pricer logic changes that are effective beginning April 1, 2002.

A. *New OPPS wage indexes will be effective April 1, 2002. These are the same wage indexes that were implemented on October 1, 2001, for inpatient hospitals. Some corrections have been made since the publication of the inpatient rule, and CMS is using the corrected wage indexes where applicable.*

B. *Inpatient hospitals considered reclassified on October 1, 2001, will be considered reclassified for OPPS on April 1, 2002.*

C. *Section 401 designations and floor MSA designations will be considered effective for OPPS on April 1, 2002.*

D. *New payment rates and coinsurance amounts were effective for OPPS on April 1, 2002, except those 55 APCs with coinsurance amounts limited to 55 percent of the payment rate, which were effective January 1, 2002. The coinsurance limit equal to the inpatient deductible of $812 remains effective January 1, 2002.*

E. *APC 339, for Observation, will be priced at 1 unit no matter how many units are submitted.*

F. *If a claim has more than 1 service with a status indicator (SI) of S or T and any lines with SI of S or T have less than $1.01 as charges, charges for all S and/or T lines will be summed and the charges will then be divided up proportionately to the payment rate for each S or T line. The new charge amount will be used in place of the submitted charge amount in the line item outlier calculation.*

EXAMPLE:

SI	*Charges*	*Payment Rate*	*New Charges Amount*
S	*$19,999*	*$6,000*	*$12,000*
T	*$1*	*$3,000*	*$6,000*
S	*$0*	*$1,000*	*$2,000*
	$20,000	*$10,000*	*$20,000*

*Because total charges here are $20,000 and the first SI of S gets 6,000 of 10,000 total payment, the new charge for that line is 6,000/10,000 * $20,000 = $12,000.*

G. *All charges on lines with a SI of N (bundled services) on the claim will be summed and the charges will then be divided up proportionately to the payment rate for each S, T, V or X line. This proportional amount will be added to the new charges amount from item F above or, if that doesn't apply, they will be added to the actual submitted charges for each S, T, V or X before making a line item outlier calculation.*

H. *Outliers will be calculated at a line item level. No outlier payment will be calculated for SIs of G, N or H, although charges for packaged services (SI=N) will be used in calculating outlier payments for other*

services as described in G. above. Pricer will use submitted charges as modified by items F and G above. The CMS changed the factor multiplied times the total claim payments from 2.5 to 3.5 and factor used to multiply the difference between claim payments and costs from .75 to .50. Pricer will keep the cost to charge ratio adjustment factor at .981956. Pricer will sum all line item outlier amounts and output them as a single total claim outlier amount, just as it outputs the outlier amount that contractors are to place in value code 17.

I. Any claim with one or more APCs that match those listed in Table 1 of the March 1, 2002, "Federal Register" will have all applicable APC offset amounts summed and wage adjusted. The total wage adjusted offset amount will be subtracted proportionately from the charges reduced to costs for any SI H devices that have a HCPCS code beginning with a C, i.e., C1713 through C2631.

J. A pro rata reduction of 63.6 percent applies to all SI G and/or H payments. For H, devices, the offset (or reduction) is applied to the final payment amount after all device offset amounts (see item I above) have been taken. For SI G, pass thru drugs, CMS determines the pass-through amount (PTA) by subtracting 5 times the minimum coinsurance from the Medicare payment amount. The CMS will multiply .364 times the PTA and add that amount to 5 times the minimum coinsurance to get the new Medicare payment amount.

K. The provider specific file for SNFs and HHAs that may be reimbursed for splints, casts and/or antigens under OPPS should have a cost to charge ratio of 0.000 (or 0.001 if the shared system will not allow 0.000. Pricer will not pay outliers for these services.

L. Pricer Drug Copayment Changes

M. APC	*N. Drug Name*	*O. Corrected Copayment*
P. 726	*Q. Dexrazoxane*	*R. $27.85*
S. 1607	*T. Eptifibatide*	*U. $1.62*

50.5 - *Changes to the OPPS Pricer Logic Effective January 1, 2003*

(Rev. 3941; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

50.6 - *Changes to the OPPS Pricer Logic, Effective January 1, 2003 Through January 1, 2006*

(Rev. 3941; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

50.7 - *Annual Updates to the OPPS Pricer for Calendar Year (CY) 2007 and Later*

(Rev. 3941; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

60.5 - Services Eligible for New Technology APC Assignment and Payments

(Rev. 3941; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

Under OPPS, services eligible for payment through New Technology APCs are those codes that are assigned to the series of New Technology APCs published in Addendum A of the latest OPPS update. As of January 1, 2018, the range of New Technology APCs include

- APCs 1491 through 1500
- APCs 1502 through 1537
- APCs 1539 through 1585
- APCs 1589 through 1599, and
- APCs 1901 through *1908*

OPPS considers any HCPCS code assigned to the above APCs to be a "new technology procedure or service."

Application procedures for consideration as a New Technology procedure or service may be found on the CMS Web site, currently at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html. Under the "Downloads" section, refer to the document titled "For a New Technology Ambulatory Payment Classification (APC) Designation under the Hospital Outpatient Prospective Payment System (OPPS)" for information on the requirements for submitting an application.

The list of HCPCS codes and payment rates assigned to New Technology APCs can be found in Addendum B of the latest OPPS update regulation each year at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html. Please note that this link may change depending on CMS Web design requirements

61.4.2 - Definition of Brachytherapy Source for Separate Payment

180.7 - Inpatient-only Services

(Rev. 3941; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

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 *or OPPS SI = J1 on the same claim 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 reported on the claim, including the "inpatient only" procedure, through one unit of APC 5881, (Ancillary outpatient services when the patient dies.) Hospitals should report modifier CA on only one procedure.

200.3.2 - Billing for Multi-Source Photon (Cobalt 60-Based) Stereotactic Radiosurgery (SRS) Planning and Delivery

(Rev. 3941; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

Effective for services furnished on or after January 1, 2014, hospitals must report SRS planning and delivery services using only the CPT codes that accurately describe the service furnished. For the delivery services, hospitals must report CPT code 77371, 77372, or 77373.

CPT Code	Long Descriptor
77371	Radiation treatment delivery, stereotactic radiosurgery (srs), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source cobalt 60 based
77372	Radiation treatment delivery, stereotactic radiosurgery (srs), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions

As instructed in the CY 2014 OPPS/ASC final rule, CPT code 77371 is to be used only for single session cranial SRS cases performed with a Cobalt-60 device, and CPT code 77372 is to be used only for single session cranial SRS cases performed with a linac- based device. The term "cranial" means that the pathological lesion(s) that are the target of the radiation is located in the patient's cranium or head. The term "single session" means that the entire intracranial lesion(s) that comprise the patient's diagnosis are treated in their entirety during a single treatment session on a single day. CPT code 77372 is never to be used for the first fraction or any other fraction of a fractionated SRS treatment. CPT code 77372 is to be used only for single session cranial linac-based SRS treatment. Fractionated SRS treatment is any SRS delivery service requiring more than a single session of SRS treatment for a cranial lesion, up to a total of no more than five fractions, and one to five sessions (but no more than five) for non-cranial lesions. CPT code 77373 is to be used for any fraction (including the first fraction) in any series of fractionated treatments, regardless of the anatomical location of the lesion or lesions being radiated. Fractionated cranial SRS is any cranial SRS that exceeds one treatment session and fractionated non-cranial SRS is any non-cranial SRS, regardless of the number of fractions but never more than five. Therefore, CPT code 77373 is the exclusive code (and the use of no other SRS treatment delivery code is permitted) for any and all fractionated SRS treatment services delivered anywhere in the body, including, but not limited to, the cranium or head. 77372 is not to be used for the first fraction of a fractionated cranial SRS treatment series and must only be used in cranial SRS when there is a single treatment session to treat the patient's entire condition.

In addition, for the planning services, hospitals must report the specific CPT code that accurately describes the service provided. The planning services may include but are not limited to CPT code 77290, 77295,

77300, 77334, or 77370.

CPT Code	Long Descriptor
77290	Therapeutic radiology simulation-aided field setting; complex
77295	Therapeutic radiology simulation-aided field setting; 3-dimensional
77300	Basic radiation dosimetry calculation, central axis depth dose calculation, tdf, nsd, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician
77334	Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)
77370	Special medical radiation physics consultation

Effective for cranial single session stereotactic radiosurgery procedures (CPT code 77371 or 77372) furnished on or after January 1, 2016, costs for certain adjunctive services (e.g., planning and preparation) are not factored into the APC payment rate for APC 5627 (Level 7 Radiation Therapy). Rather, the ten planning and preparation codes, will be paid according to their assigned status indicator when furnished 30 days prior or 30 days post SRS treatment delivery. *A list of the excluded planning and preparation CPT codes is provided in the CY 2018 OPPS/ASC final rule with comment period.*

231.11 - Billing for Allogeneic Stem Cell Transplants

(Rev. 3941; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

1. Definition of Acquisition Charges for Allogeneic Stem Cell Transplants

Acquisition charges for allogeneic stem cell transplants include, but are not limited to, charges for the costs of the following services:

- National Marrow Donor Program fees, if applicable, for stem cells from an unrelated donor;
- Tissue typing of donor and recipient;
- Donor evaluation;
- Physician pre-procedure donor evaluation services;
- Costs associated with harvesting procedure (e.g., general routine and special care services, procedure/operating room and other ancillary services, apheresis services, etc.);
- Post-operative/post-procedure evaluation of donor; and
- Preparation and processing of stem cells.

Payment for these acquisition services is included in the OPPS C-APC payment for the allogeneic stem cell transplant when the transplant occurs in the hospital outpatient setting, and in the MS-DRG payment for the allogeneic stem cell transplant when the transplant occurs in the inpatient setting. The Medicare contractor does not make separate payment for these acquisition services, because hospitals may bill and receive payment only for services provided to the Medicare beneficiary who is the recipient of the stem cell

transplant and whose illness is being treated with the stem cell transplant. Unlike the acquisition costs of solid organs for transplant (e.g., hearts and kidneys), which are paid on a reasonable cost basis, acquisition costs for allogeneic stem cells are included in prospective payment. Recurring update notifications describing changes to and billing instructions for various payment policies implemented in the OPPS are issued annually.

Acquisition charges for stem cell transplants apply only to allogeneic transplants, for which stem cells are obtained from a donor (other than the recipient himself or herself). Acquisition charges do not apply to autologous transplants (transplanted stem cells are obtained from the recipient himself or herself), because autologous transplants involve services provided to the beneficiary only (and not to a donor), for which the hospital may bill and receive payment (see Pub. 100-04, chapter 3, §90.3.1 and §231.10 of this chapter for information regarding billing for autologous stem cell transplants).

2. Billing for Acquisition Services

The hospital bills and shows acquisition charges for allogeneic stem cell transplants based on the status of the patient (i.e., inpatient or outpatient) when the transplant is furnished. See Pub. 100-04, chapter 3, §90.3.1 for instructions regarding billing for acquisition services for allogeneic stem cell transplants that are performed in the inpatient setting.

Effective January 1, 2017, when the allogeneic stem cell transplant occurs in the outpatient setting, the hospital identifies stem cell acquisition charges for allogeneic bone marrow/stem cell transplants separately in FL 42 of Form CMS-1450 (or electronic equivalent) by using revenue code 0815 (Other Organ Acquisition). Revenue code 0815 charges should include all services required to acquire stem cells from a donor, as defined above, and should be reported on the same *claim* as the transplant procedure in order to be appropriately packaged for payment purposes.

The transplant hospital keeps an itemized statement that identifies the services furnished, the charges, the person receiving the service (donor/recipient), and whether this is a potential transplant donor or recipient. These charges will be reflected in the transplant hospital's stem cell/bone marrow acquisition cost center. For allogeneic stem cell acquisition services in cases that do not result in transplant, due to death of the intended recipient or other causes, hospitals include the costs associated with the acquisition services on the Medicare cost report.

In the case of an allogeneic transplant in the hospital outpatient setting, the hospital reports the transplant itself with the appropriate CPT code, and a charge under revenue center code 0362 or another appropriate cost center. Selection of the cost center is up to the hospital.

280 - Hospital-Based Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Billing for Non RHC/FQHC Services

(Rev. 3941; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

A-01-93, A-03-066

Hospitals sometimes operate hospital based RHCs or FQHCs. Prior to implementation of outpatient PPS, hospital based RHCs/*FQHCs* were permitted to include both RHC/FQHC and non-RHC/FQHC services on the same claim, under the RHC/FQHC bill type, with appropriate revenue codes.

Beginning with the implementation of OPPS, non-RHC/FQHC services provided by the hospital based RHC/FQHC, including RHCs/FQHCs that are parts of CAHs or other exempted or excluded (from OPPS) hospitals, must be billed under the host hospital’s provider number, using hospital billing procedures and bill types. These services are not covered or paid as RHC/FQHC services but instead may be covered hospital outpatient services and paid under the applicable methodology for the hospital.

The RHC/FQHC services remain subject to the encounter rate payment methodology and are billed using the RHC/FQHC provider number, bill type and revenue codes.
See the Medicare Benefit Policy Manual for a description of covered RHC/FQHC services.

See chapter 9, in this manual for billing instructions for provider based and independent RHC/FQHC services.

Medicare Claims Processing Manual
Chapter 17 - Drugs and Biologicals

90.2 - Drugs, Biologicals, and Radiopharmaceuticals
(Rev. 3941; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

A. General Billing and Coding for Hospital Outpatient Drugs, Biologicals, and Radiopharmaceuticals

Hospitals should report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. It is also of great importance that hospitals billing for these products make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used in the care of the patient.

Payment for drugs, biologicals and radiopharmaceuticals under the OPPS is inclusive of both the acquisition cost and the associated pharmacy overhead or nuclear medicine handling cost. Hospitals should include these costs in their line-item charges for drugs, biologicals, and radiopharmaceuticals.

Under the OPPS, if commercially available products are being mixed together to facilitate their concurrent administration, the hospital should report the quantity of each product (reported by HCPCS code) used in the care of the patient. Alternatively, if the hospital is compounding drugs that are not a mixture of commercially available products, but are a different product that has no applicable HCPCS code, then the hospital should report an appropriate unlisted drug code (J9999 or J3490). In these situations, it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, Unclassified drug or biological, is for new drugs and biologicals that are approved by FDA on or after January 1, 2004, for which a specific HCPCS code has not been assigned.

The HCPCS code list of retired codes and new HCPCS codes reported under the hospital OPPS is published quarterly via Recurring Update Notifications. The latest payment rates associated with each APC and HCPCS code may be found in the most current Addendum A and Addendum B, respectively that can be found under the CMS quarterly provider updates on the CMS Web site at:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html

Future updates will be issued in a Recurring Update Notification.

B. Pass-Through Drugs, Biologicals, and Radiopharmaceuticals

Payment for drugs, biologicals, and radiopharmaceuticals may be made under the pass-through provision which provides additional payments for drugs, biologicals, and radiopharmaceuticals that meet certain requirements relating to newness and relative costs. According to section 1833(t) of the Social Security Act, transitional pass-through payments can be made for at least 2 years, but no more than 3 years. For the process and information required to apply for transitional pass-through payment status for drugs, biologicals, and radiopharmaceuticals, go to the main OPPS Web page, currently at:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html to see the latest instructions. (**NOTE:** Due to the continuing development of the new cms.hhs.gov Web site, this link may change.) Payment rates for pass-through drugs, biologicals, and radiopharmaceuticals are updated quarterly. The all-inclusive list of billable drugs, biologicals, and radiopharmaceuticals for pass-through payment is included in the current quarterly Addendum B. The most current Addendum B can be found under the CMS quarterly provider updates on the CMS website.

C. Non Pass-Through Drugs and Biologicals

Under the OPPS, drugs and biologicals that are not granted pass-through status receive either packaged payment or separate payment. Payment for drugs and biologicals with estimated per day costs equal to or

below the applicable drug packaging threshold is packaged into the payment for the associated procedure, commonly a drug administration procedure. Drugs and biologicals with per day costs above the applicable drug packaging threshold are paid separately through their own APCs.

D. Radiopharmaceuticals

1. General

Beginning in CY 2008, the OPPS divides radiopharmaceuticals into two groups for payment purposes: diagnostic and therapeutic. Diagnostic radiopharmaceuticals function effectively as products that enable the provision of an independent service, specifically, a diagnostic nuclear medicine scan. Therapeutic radiopharmaceuticals are themselves the primary therapeutic modality.

Beginning January 1, 2008, the I/OCE requires claims with separately payable nuclear medicine procedures to include a radiolabeled product (i.e., diagnostic radiopharmaceutical, therapeutic radiopharmaceutical, or brachytherapy source). Hospitals are required to submit the HCPCS code for the radiolabeled product on the same claim as the HCPCS code for the nuclear medicine procedure. Hospitals are also instructed to submit the claim so that the services on the claim each reflect the date the particular service was provided. Therefore, if the nuclear medicine procedure is provided on a different date of service from the radiolabeled product, the claim will contain more than one date of service. More information regarding these edits is available on the OPPS Web site at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html

There are rare situations where a hospital provides a radiolabeled product to an inpatient, and then the patient is discharged and later returns to the outpatient department for a nuclear medicine imaging procedure but does not require additional radiolabeled product. In these situations, hospitals are to include HCPCS code C9898 (Radiolabeled product provided during a hospital inpatient stay) with a token charge (of less than $1.01) on the same claim as the nuclear medicine procedure in order to receive payment for the nuclear medicine procedure. HCPCS code C9898 should only be reported under the circumstances described above, and the date of service for C9898 should be the same as the date of service for the diagnostic nuclear medicine procedure.

2. Diagnostic Radiopharmaceuticals

Beginning in CY 2008, payment for nonpass-through diagnostic radiopharmaceuticals is packaged into the payment for the associated nuclear medicine procedure.

3. Therapeutic Radiopharmaceuticals

The OPPS will continue to pay for therapeutic radiopharmaceuticals at charges adjusted to cost from January 1, 2008 through December 31, 2009

E. 340B-Acquired Drugs

Beginning January 1, 2018, separately payable Part B drugs (assigned status indicator "K"), other than vaccines (assigned status indicator "L" or "M") and drugs on pass-through payment status (assigned status indicator "G"), that are acquired through the 340B Program or through the 340B prime vendor program will be paid at the ASP minus 22.5 percent when billed by a hospital paid under the OPPS that is not excepted from the payment adjustment. Hospital types that are excepted from the 340B payment policy in CY 2018 include rural sole community hospitals (SCHs), children's hospitals, and PPS-exempt cancer hospitals. Critical Access Hospitals and Maryland waiver hospitals are not paid under the OPPS and therefore are not impacted by this policy.

Medicare will continue to pay separately payable drugs that were not purchased with a 340B discount at ASP+6 percent.

In addition, effective January 1, 2018, hospitals paid under the OPPS that are not excepted from the 340B drug payment policy for CY 2018, are required to report modifier "JG"((Drug or biological acquired with 340B Drug Pricing Program Discount) on the same claim line as the drug HCPCS code to identify a 340B-acquired drug. Since rural SCHs, children's hospitals and PPS-exempt cancer hospitals are excepted from the 340B payment adjustment in CY 2018, these hospitals will be required to report informational modifier "TB" (Drug or Biological Acquired With 340B Drug Pricing Program Discount, Reported for Informational Purposes) for 340B-acquired drugs, and will continue to be paid ASP+6 percent.