CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4204	**Date: January 17, 2019**
	Change Request 11099

Transmittal 4186, dated December 31, 2018, is being rescinded and replaced by Transmittal 4204, dated, January 17, 2019 to fix the links under policy section I.B.11.d. All other information remains the same.

SUBJECT: January 2019 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 2019 OPPS update. The January 2019 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 and chapter 17.

The January 2019 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming January 2019 I/OCE CR.

EFFECTIVE DATE: January 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 7, 2019

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	4/20.6.4/Use of Modifiers for Discontinued Services
R	4/20.6.11/ Use of HCPCS Modifier - PO
N	4/20.6.16/Use of HCPCS Modifier - JG
N	4/20.6.17/Use of HCPCS Modifier – TB
N	4/20.6.18 / Use of HCPCS Modifier - ER
R	4/260.1/Special Partial Hospitalization Billing Requirements for Hospitals, Community Mental Health Centers, and Critical Access Hospitals
R	4/260.1.1/Bill Review for Partial Hospitalization Services Provided in Community Mental Health Centers (CMHC)
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: 4204	Date: January 17, 2019	Change Request: 11099

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SUBJECT: January 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS)

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I. GENERAL INFORMATION

A. Background: This recurring update notification describes changes to and billing instructions for various payment policies implemented in the January 2019 OPPS update. The January 2019 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 and chapter 17.

The January 2019 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming January 2019 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.

We are establishing one new device pass-through category as of January 1, 2019. Table 1, attachment A, provides a listing of new coding and payment information concerning the new device category for transitional pass-through payment.

b. Device Offset from Payment:

Section 1833(t)(6)(D)(ii) of the Act requires that we deduct from pass-through payments for devices an amount that reflects the portion of the APC payment amount. We have determined that a portion of the APC payment amount associated with the cost of C1823 is reflected in APC 5464 (Level 4 Neurostimulator and Related Procedures). The C1823 device should always be billed with Current Procedural Terminology (CPT) Code 0424T (Insertion or replacement of neurostimulator system for treatment of central sleep apnea; complete system (transvenous placement of right or left stimulation lead, sensing lead, implantable pulse generator)) which is assigned to APC 5464 for Calendar Year (CY) 2019. The device offset from payment represents a deduction from pass-through payments for the device in category C1823.

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. We refer readers to Addendum P of the CY 2019 final rule with comment period for the most current OPPS HCPCS Offset file. Addendum P is available via the Internet on the CMS website.

2. New Separately Payable Procedure Code

Effective January 1, 2019, new HCPCS codes C9751, C9752, C9753, C9754, and C9755 have been created as described in Table 2, attachment A. We note that these codes were developed after display of the CY 2019 OPPS/ASC (Ambulatory Surgery Centers) Final Rule.

3. Device Intensive Procedures

Effective January 1, 2019, we are modifying the device-intensive criteria to lower the device offset percentage threshold from greater than 40 percent to greater than 30 percent and to allow procedures that involve single-use devices, regardless of whether or not they remain in the body after the conclusion of the procedure, to qualify as device-intensive procedures. Accordingly, effective January 1, 2019, all new procedures requiring the insertion of an implantable medical device will be assigned a default device offset percentage of at least 31 percent (previously at least 41 percent), and thereby assigned device intensive status, until claims data are available. In certain rare instances, we may temporarily assign a higher offset percentage if warranted by additional information.

In light of this policy change, we are modifying section 20.6.4 of chapter 4 of the Medicare Claims Processing Manual.

4. New HCPCS Code C1890 For When No Device Is Used in ASCs for Device-Intensive Procedures Effective January 1, 2019

In the CY2019 OPPS/ASC Final Rule, we finalized our policy to apply the ASC device-intensive procedure payment methodology to device-intensive procedures under the ASC payment system, when the device-intensive procedure is furnished with a surgically inserted or implanted device (including single use medical devices). Because devices are packaged into the procedure payment for device-intensive procedures, and ASCs do not report packaged codes, it is necessary to implement a mechanism to report when an ASC performs a device-intensive procedure without an implantable or inserted medical device. To implement this policy, we are establishing a new C-code that ASCs must report, specifically, HCPCS C1890, along with the device-intensive procedure code, to signify that the device was not furnished with the device-intensive procedure. This code is payable in the ASC setting only, and should not be reported on institutional claims by hospital outpatient department providers. Therefore, HCPCS code C1890 is assigned to SI=E1 (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) under the OPPS.

Since this HCPCS code is not included on the current 2019 Alphanumeric HCPCS release, contractors shall add this code to their system. The C1890 short descriptor is: No device w/dev-intensive px The long descriptor is: No implantable/insertable device used with device-intensive procedures

5. Three New Comprehensive APCs (C-APCs) Effective January 1, 2019

Comprehensive APCs provide a single payment for a primary service, and payment for all adjunctive services reported on the same claim is packaged into payment for the primary service. With few exceptions, all other services reported on a hospital outpatient claim in combination with the primary service are considered to be related to the delivery of the primary service and packaged into the single payment for the primary service.

Each year, in accordance with section 1833(t)(9)(A) of the Act, we review and revise the services within each APC group and the APC assignments under the OPPS. As stated in the CY 2019 OPPS/ASC final rule

with comment period, as a result of our annual review of the services and the APC assignments under the OPPS, we finalized the addition of three new C-APCs under the existing C-APC payment policy effective January 1, 2019. The new C-APCs include: C-APC 5163 (Level 3 Ear, Nose, and Throat (ENT) Procedures), C-APC 5183 (Level 3 Vascular Procedures), and C-APC 5184 (Level 4 Vascular Procedures). A list of these new C-APCs is found in Table 3, attachment A.

The addition of these new C-APCs increases the total number of C-APCs to 65 for CY 2019. We note that Addendum J to the CY 2019 OPPS/ASC final rule with comment period contains all of the data related to the C–APC payment policy methodology, including the list of complexity adjustments and other information for CY 2019. In addition, we note that HCPCS codes assigned to comprehensive APCs are designated with status indicator J1 in the latest OPPS Addendum B, which can be downloaded from this CMS website, specifically, at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html.

6. Changes to the Inpatient-Only List (IPO) for CY 2019

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 2019, CMS is removing four procedures from the IPO list. CMS is also adding one procedure to the IPO list. The changes to the IPO list for CY 2019 are included in Table 4, attachment A.

7. Modifier "ER"

Effective January 1, 2019, hospitals will be required to report new HCPCS modifier "ER" (Items and services furnished by a provider-based off-campus emergency department) with every claim line for outpatient hospital services furnished in an off-campus provider-based emergency department. Modifier ER would be reported on the UB–04 form (CMS Form 1450) for hospital outpatient services. Critical Access Hospitals (CAHs) would not be required to report this modifier.

Modifier ER is required to be reported in provider-based off-campus emergency departments that meet the definition of a "dedicated emergency department" as defined in 42 Code of Federal Regulations *(*CFR) 489.24 under the Emergency Medical Treatment and Labor Act (EMTALA) regulations. Per 42 CFR 489.24, a "dedicated emergency department" means any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:

(1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;

(2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or

(3) During the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

In light of this policy change we are creating a new section 20.6.18 of chapter 4 of the Medicare Claims Processing Manual.

8. Method to Control for Unnecessary Increases in Utilization of Outpatient Services/G0463 with modifier PO

For CY 2019, CMS is finalizing a policy to use our authority under section 1833(t)(2)(F) of the Act to apply an amount equal to the site-specific Physician Fee Schedule (PFS) payment rate for nonexcepted items and services furnished by a nonexcepted off-campus Provider-Based Department (PBD) (the PFS payment rate) for the clinic visit service, as described by HCPCS code G0463, when provided at an off-campus PBD excepted from section 1833(t)(21) of the Act (departments that bill the modifier "PO" on claim lines).

The PFS-equivalent amount paid to nonexcepted off-campus PBDs is 40 percent of OPPS payment (that is, 60 percent less than the OPPS rate) for CY 2019. We are phasing this policy in over a two-year period. Specifically, half of the total 60-percent payment reduction, a 30-percent reduction, will apply in CY 2019. In other words, these departments will be paid 70 percent of the OPPS rate (100 percent of the OPPS rate minus the 30-percent payment reduction that applies in CY 2019) for the clinic visit service in CY 2019.

9. Partial Hospitalization Program (PHP)

a. Technical Change to the OPPS Revenue-Code-to-Cost-Center Crosswalk

For CY 2019 and subsequent years, hospital-based PHPs will follow a new PHP-only Revenue-Code-to-Cost-Center crosswalk, which maps all PHP revenue codes to cost center 93.99 "Partial Hospitalization Program" as the primary source for the Cost-to-Charge Ratios (CCR) used in hospital-based PHP rate setting. Cost center 93.99 ("Partial Hospitalization Program") is for recording costs providing partial hospitalization programs, and became effective for hospital cost reporting periods ending on or after September 30, 2017.

The new PHP-only Revenue-Code-to-Cost Center crosswalk is available online at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.html in the CY 2019 OPPS/ASC final rule with comment period.

b. Updates to PHP Allowable HCPCS Codes

In the CY 2019 OPPS/ASC final rule with comment period, we proposed to delete 6 existing PHP allowable HCPCS codes (96101, 96102, 96103, 96118, 96119, 96120) and to replace them with 9 new PHP allowable codes (96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146) for APCs 5853 and 5863, as of January 1, 2019, as detailed in Table 5, attachment A.

10. Payment Adjustment for Certain Cancer Hospitals Beginning CY 2019

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 2019, the target PCR, after including the reduction required by Section 16002(b), is 0.88.

11. Drugs, Biologicals, and Radiopharmaceuticals

a. New CY 2019 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

For CY 2019, 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 2019 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 2019. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2018 and replaced with permanent HCPCS codes effective in CY 2019. 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 2019 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 2018 HCPCS/CPT code and long descriptor are noted in the two left hand columns and the CY 2019 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)

For CY 2019, 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 2019, 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, 2019, payment rates for many drugs and biologicals have changed from the values published in the CY 2019 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 2018. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2019 Fiscal Intermediary Shared System (FISS) release. CMS is not publishing the updated payment rates in this Change Request implementing the January 2019 update of the OPPS. However, the updated payment rates effective January 1, 2019 can be found in the January 2019 update of the OPPS Addendum A and Addendum B on the CMS website 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-Service-Payment/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

For CY 2019, the payment rate for biosimilars in the OPPS will generally continue to be 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 continue to 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.

Effective January 1, 2019, a biosimilar acquired under the 340B Program 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 biosimilar's ASP. 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.

f. Payment of Drugs, Biologicals, and Radiopharmaceuticals If ASP Data Are Not Available

Starting in January 2019, we will pay separately payable drugs and biological products that do not have pass-through payment status and are not acquired under the 340B Program at Wholesale Acquisition Cost (WAC) + 3 percent instead of WAC + 6 percent, in cases where WAC-based payment applies.

12. 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.

13. Allow HCPCS Code Q4122 (Dermacell, per square centimeter) to Be Billed with Either Revenue Code 0278 (Other implants) or Revenue Code 0636 (Drugs requiring detailed coding)

HCPCS code Q4122 (Dermacell, per square centimeter) may be billed with either revenue code 0278 (Other implants) or revenue code 0636 (Drugs requiring detailed coding). HCPCS code Q4122 is used both as an applied skin substitute and as an implanted biologic used in breast reconstruction, and these procedures are reported with two different revenue codes. This request is described in Table 9, attachment A.

14. Billing Instructions for 340B-Acquired Drugs Furnished in Nonexcepted Off-Campus Provider-Based Departments (PBDs) of a Hospital

As finalized in the CY 2019 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 continue to be paid at the ASP minus 22.5 percent when billed by hospitals paid under the OPPS (other than a type of hospital excluded from the OPPS or excepted from the 340B drug payment policy for CY 2019) and will now also be paid at the ASP minus 22.5 percent when billed by nonexcepted off-campus PBDs of a hospital paid under the PFS. Hospital types that are excepted from the 340B payment policy in CY 2019 include rural Sole Community Hospitals (SCHs), children's hospitals, and Prospective Payment System (PPS)-exempt cancer hospitals. These 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.

To effectuate the payment adjustment for 340B-acquired drugs and biologicals, CMS implemented modifier "JG", effective January 1, 2018. Accordingly, beginning January 1, 2019, nonexcepted off-campus PBDs of a hospital paid under the PFS (departments that bill the "PN" modifier on claim lines) are required to report modifier "JG" on the same claim line as the drug or biological HCPCS code acquired under the 340B Program to identify a 340B-acquired drug or biological and will now be paid ASP minus 22.5 percent for that drug or biological. Since rural SCHs, children's hospitals, and PPS-exempt cancer hospitals are excepted from the 340B payment adjustment in CY 2019, 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 10, attachment A.

Contractors are being advised that guidance on use of the aforementioned 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.

15. 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 2019. 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, 2019. 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 2019 inpatient deductible of $1,364. 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 2019. 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 2019 relative to CY 2018. The estimated cost of a service must be greater than the APC payment amount plus $4,825 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 2019. 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 2019, 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, 2019, CMS is adopting the FY 2019 IPPS post-reclassification wage index values with application of the CY 2019 out-commuting adjustment authorized by Section 505 of the MMA to non-IPPS (non-Inpatient Prospective Payment System) hospitals as implemented through the Pricer logic.

h. Effective January 1, 2019, for claims with APCs, which require implantable devices and have significant device offsets (greater than 30%), 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.

16. Update the Outpatient Provider Specific File (OPSF)

For January 1, 2019, 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 2019, 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, 2019, 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 Medicare Administrative Contractors (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 publication 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 2019 OPPS, the OPPS Pricer will continue to 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 Federal Information Processing Standards (FIPS) county code where the hospital is located to maintain the accuracy of the OPSF data fields.

e) Updating the "Payment Core-Based Statistical Areas (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. We further note that whereas the IPPS Pricer allows the Payment CBSA, even when applied as the sole CBSA field (without a Wage Index CBSA), to be used for wage adjusting payment, that field is not used for wage adjustment the OPPS.

17. Coverage Determinations

As a reminder, the fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. MACs determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

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	
11099.1	Medicare contractors shall install the January 2019 OPPS Pricer.	X		X		X				
11099.2	Medicare contactors shall manually add to their systems: • HCPCS codes: J1095, listed in table 7, attachment A, effective January 1, 2019; and • J2186, J2787, and Q5111, listed in table 6, attachment A, effective January 1, 2019; • C1890, listed in section 4 of the policy section. **Note:** These HCPCS codes will be included with the January 2019 I/OCE update. Status and payment indicators for these HCPCS codes will be listed in the January 2019 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. Their long descriptors will be listed in the 2019 HCPCS corrections file on the CMS website at https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html	X		X		X				
11099.3	Medicare contactors shall manually add termination dates for the following HCPCS code to their systems: • HCPCS code C9034, listed in table 7, attachment A, effective December 31, 2018. **Note:** This deletion will be reflected in the January 2019 I/OCE update and in the January 2019 Update of	X		X		X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	the OPPS Addendum A and Addendum B on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html									
11099.4	Medicare contractors shall manually update the HCPCS file for Q4122 to allow both revenue codes 0278 or 0636.	X		X		X				
11099.5	Medicare contractors shall adjust, as appropriate, claims brought to their attention with any retroactive changes that were received prior to implementation of January 2019 OPPS Pricer.	X		X						
11099.6	As specified in chapter 4, section 50.1, of the Claims Processing Manual, Medicare contractors shall maintain the accuracy of the data and update the OPSF file as changes occur in data element values. For CY 2019, this includes all changes to the OPSF identified in the Policy Section, subsection 16 of this Change Request.	X		X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
11099.7	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	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 Device Pass-Through Code Effective January 1, 2019

HCPCS Code	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Device Offset from Payment
C1823	01/01/2019	H	2993	Gen, neuro, trans sen/stim	Generator, neurostimulator (implantable), non-rechargeable, with transvenous sensing and stimulation leads	$20,626.59

Table 2. – New Separately Payable Procedure Codes Effective January 1, 2019

HCPCS Code	Short Descriptor	Long Descriptor	APC	SI
C9751	Microwave bronch, 3D, EBUS	Bronchoscopy, rigid or flexible, transbronchial ablation of lesion(s) by microwave energy, including fluoroscopic guidance, when performed, with computed tomography acquisition(s) and 3-D rendering, computer-assisted, image-guided navigation, and endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]) and all mediastinal and/or hilar lymph node stations or structures and therapeutic intervention(s)	1571	T
C9752	Intraosseous des lumb/sacrum	Destruction of intraosseous basivertebral nerve, first two vertebral bodies, including imaging guidance (e.g., fluoroscopy), lumbar/sacrum	5115	J1
C9753	Intraosseous destruct add'l	Destruction of intraosseous basivertebral nerve, each additional vertebral body, including imaging guidance (e.g., fluoroscopy), lumbar/sacrum (List separately in addition to code for primary procedure)	N/A	N
C9754	Perc AV fistula, any site	Creation of arteriovenous fistula, percutaneous; direct, any site, including all imaging and radiologic supervision and interpretation, when performed and secondary procedures to redirect blood flow (e.g., transluminal balloon angioplasty, coil embolization, when performed)	5193	J1
C9755	RF magnetic-guided AV fistula	Creation of arteriovenous fistula, percutaneous using magnetic-guided arterial and venous catheters and radiofrequency energy, including flow-directing procedures (e.g., vascular coil embolization with radiologic supervision and interpretation, when performed) and fistulogram(s), angiography, venography, and/or ultrasound, with radiologic supervision and interpretation, when performed	5193	J1

Table 3. — New Comprehensive APCs for CY 2019

CY 2019 APC	CY 2019 APC Descriptor
5163	Level 3 ENT Procedures
5183	Level 3 Vascular Procedures
5184	Level 4 Vascular Procedures

Table 4. — Changes to the IPO list for CY 2019

CY 2019 CPT Code	CY 2019 Long Descriptor	Action	CY 2019 OPPS APC Assignment	CY 2019 OPPS Status Indicator
31241	Nasal/sinus endoscopy, surgical; with ligation of sphenopalatine artery	Removed	5153	J1
01402	Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty	Removed	N/A	N
0266T	Implantation or replacement of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed).	Removed	5463	J1
00670	Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures)	Removed	N/A	N
C9606	Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel	Added	N/A	C

Table 5. — Proposed CY 2019 Changes to the Allowable HCPCS Codes for PHP APCs 5853 & 5863

Existing Code	Proposed CY 2019 Action	Proposed CY 2019 Replacement(s) Codes	Proposed CY 2019 APC Action
96101	Delete	96130, 96131, and may also include 96136, 96137, 96138, 96139, 96146	Add
96102	Delete	96130, 96131, and may also include 96136, 96137, 96138, 96139, 96146	Add
96103	Delete	96130, 96131, and may also include 96136 96137, 96138, 96139, 96146	Add

96118	Delete	96132, 96133, and may also include 96136, 96137, 96138, 96139, 96146	Add
96119	Delete	96132, 96133, and may also include 96136, 96137, 96138, 96139, 96146	Add
96120	Delete	96132, 96133, and may also include 96136, 96137, 96138, 96139, 96146	Add

Table 6. ─ New CY 2019 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2019 HCPCS Code	CY 2019 Long Descriptor	CY 2019 SI	CY 2019 APC
C9035	Injection, aripiprazole lauroxil (aristada initio), 1 mg	G	9179
C9036	Injection, patisiran, 0.1 mg	G	9180
C9037	Injection, risperidone (perseris), 0.5 mg	G	9181
C9038	Injection, mogamulizumab-kpkc, 1 mg	G	9182
C9039	Injection, plazomicin, 5 mg	G	9183
C9407	Iodine i-131 iobenguane, diagnostic, 1 millicurie	G	9184
C9408	Iodine i-131 iobenguane, therapeutic, 1 millicurie	G	9185
J0584	Injection, burosumab-twza 1 mg	K	9187
J0841	Injection, crotalidae immune f(ab')2 (equine), 120 mg	K	9188
J1746	Injection, ibalizumab-uiyk, 10 mg	K	9189
J2186	Injection, meropenem and vaborbactam, 10mg/10mg (20mg)	K	9178
J2787	Riboflavin 5'-phosphate, opthalmic solution, up to 3 mL	N	N/A
J3397	Injection, vestronidase alfa-vjbk, 1 mg	K	9190
J3591	Unclassified drug or biological used for esrd on dialysis	B	N/A
J7177	Injection, human fibrinogen concentrate (fibryga), 1 mg	K	9191
J7329	Hyaluronan or derivative, trivisc, for intra-articular injection, 1 mg	K	9196
J9044	Injection, bortezomib, not otherwise specified, 0.1 mg	K	9192
Q4183	Surgigraft, per square centimeter	N	N/A
Q4184	Cellesta, per square centimeter	N	N/A
Q4185	Cellesta flowable amnion (25 mg per cc); per 0.5 cc	N	N/A
Q4186	Epifix, per square centimeter	N	N/A
Q4187	Epicord, per square centimeter	N	N/A
Q4188	Amnioarmor, per square centimeter	N	N/A
Q4189	Artacent ac, 1 mg	N	N/A
Q4190	Artacent ac, per square centimeter	N	N/A
Q4191	Restorigin, per square centimeter	N	N/A
Q4192	Restorigin, 1 cc	N	N/A
Q4193	Coll-e-derm, per square centimeter	N	N/A
Q4194	Novachor, per square centimeter	N	N/A
Q4195	Puraply, per square centimeter	G	9175

CY 2019 HCPCS Code	CY 2019 Long Descriptor	CY 2019 SI	CY 2019 APC
Q4196	Puraply am, per square centimeter	G	9176
Q4197	Puraply xt, per square centimeter	N	N/A
Q4198	Genesis amniotic membrane, per square centimeter	N	N/A
Q4200	Skin te, per square centimeter	N	N/A
Q4201	Matrion, per square centimeter	N	N/A
Q4202	Keroxx (2.5g/cc), 1cc	N	N/A
Q4203	Derma-gide, per square centimeter	N	N/A
Q4204	Xwrap, per square centimeter	N	N/A
Q5107	Injection, bevacizumab-awwb, biosimilar, (mvasi), 10 mg	E2	N/A
Q5108	Injection, pegfilgrastim-jmdb, biosimilar, (fulphila), 0.5 mg	K	9173
Q5109	Injection, infliximab-qbtx, biosimilar, (ixifi), 10 mg	E2	N/A
Q5110	Injection, filgrastim-aafi, biosimilar, (nivestym), 1 microgram	K	9193
Q5111	Injection, Pegfilgrastim-cbqv, biosimilar, (udenyca), 0.5 mg	K	9195

Table 7. – Other CY 2019 HCPCS and CPT Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2018 HCPCS Code	CY 2018 Long Descriptor	CY 2019 HCPCS Code	CY 2019 Long Descriptor
C9031	Lutetium Lu 177, dotatate, therapeutic, 1 millicurie	A9513	Lutetium Lu 177, dotatate, therapeutic, 1 millicurie
C9275	Injection, hexaminolevulinate hydrochloride, 100 mg, per study dose	A9589	Instillation, hexaminolevulinate hydrochloride, 100 mg
C9463	Injection, aprepitant, 1 mg	J0185	Injection, aprepitant, 1 mg
C9466	Injection, benralizumab, 1 mg	J0517	Injection, benralizumab, 1 mg
C9014	Injection, cerliponase alfa, 1 mg	J0567	Injection, cerliponase alfa, 1 mg
C9015	Injection, c-1 esterase inhibitor (human), (haegarda), 10 units	J0599	Injection, c-1 esterase inhibitor (human), (haegarda), 10 units
C9034	Injection, dexamethasone 9%, intraocular, 1 mcg	J1095	Injection, dexamethasone 9 percent, intraocular, 1 microgram
C9493	Injection, edaravone, 1 mg	J1301	Injection, edaravone, 1 mg
C9033	Injection, fosnetupitant 235 mg and palonosetron 0.25 mg	J1454	Injection, fosnetupitant 235 mg and palonosetron 0.25 mg
C9029	Injection, guselkumab, 1 mg	J1628	Injection, guselkumab, 1 mg
C9497	Loxapine, inhalation powder, 10 mg	J2062	Loxapine for inhalation, 1 mg
C9464	Injection, rolapitant, 0.5 mg	J2797	Injection, rolapitant, 0.5 mg
Q9993	Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg	J3304	Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg
C9016	Injection, triptorelin, extended-release, 3.75 mg	J3316	Injection, triptorelin, extended-release, 3.75 mg
C9032	Injection, voretigene neparvovec-rzyl, 1 billion vector genomes	J3398	Injection, voretigene neparvovec-rzyl, 1 billion vector genomes
Q9995	Injection, emicizumab-kxwh, 0.5	J7170	Injection, emicizumab-kxwh, 0.5 mg

CY 2018 HCPCS Code	CY 2018 Long Descriptor	CY 2019 HCPCS Code	CY 2019 Long Descriptor
	mg		
C9468	Injection factor ix, (antihemophilic factor, recombinant), glycopegylated, (rebinyn), 1 iu	J7203	Injection factor ix, (antihemophilic factor, recombinant), glycopegylated, (rebinyn), 1 iu
C9465	Hyaluronan or derivative, durolane, for intra-articular injection, per dose	J7318	Hyaluronan or derivative, durolane, for intra-articular injection, 1 mg
C9030	Injection, copanlisib, 1 mg	J9057	Injection, copanlisib, 1 mg
C9024	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine	J9153	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine
C9492	Injection, durvalumab, 10 mg	J9173	Injection, durvalumab, 10 mg
C9028	Injection, inotuzumab ozogamicin, 0.1 mg	J9229	Injection, inotuzumab ozogamicin, 0.1 mg
C9467	Injection, rituximab and hyaluronidase, 10 mg	J9311	Injection, rituximab 10 mg and hyaluronidase
J9310	Injection, rituximab, 100 mg	J9312	Injection, rituximab, 10 mg
Q2040	Tisagenlecleucel, up to 250 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per infusion	Q2042	Tisagenlecleucel, up to 600 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose

Table 8.—Skin Substitute Assignments to High Cost and Low Cost Groups for CY 2019

CY 2019 HCPCS Code	CY 2019 Short Descriptor	CY 2018 High/Low Assignment	CY 2019 High/Low Assignment
C9363	Integra meshed bil wound mat	High	High
Q4100	Skin substitute, nos	Low	Low
Q4101	Apligraf	High	High
Q4102	Oasis wound matrix	Low	Low
Q4103	Oasis burn matrix	High	High*
Q4104	Integra bmwd	High	High
Q4105	Integra drt or omnigraft	High	High*
Q4106	Dermagraft	High	High
Q4107	Graftjacket	High	High
Q4108	Integra matrix	High	High
Q4110	Primatrix	High	High*
Q4111	Gammagraft	Low	Low
Q4115	Alloskin	Low	Low
Q4116	Alloderm	High	High
Q4117	Hyalomatrix	Low	Low
Q4121	Theraskin	High	High*
Q4122	Dermacell	High	High
Q4123	Alloskin	High	High
Q4124	Oasis tri-layer wound matrix	Low	Low
Q4126	Memoderm/derma/tranz/integup	High	High*
Q4127	Talymed	High	High
Q4128	Flexhd/allopatchhd/matrixhd	High	High

CY 2019 HCPCS Code	CY 2019 Short Descriptor	CY 2018 High/Low Assignment	CY 2019 High/Low Assignment
Q4132	Grafix core, grafixpl core	High	High
Q4133	Grafix stravix prime pl sqcm	High	High
Q4134	Hmatrix	Low	Low
Q4135	Mediskin	Low	Low
Q4136	Ezderm	Low	Low
Q4137	Amnioexcel biodexcel, 1 sq cm	High	High
Q4138	Biodfence dryflex, 1cm	High	High
Q4140	Biodfence 1cm	High	High
Q4141	Alloskin ac, 1cm	High	High*
Q4143	Repriza, 1cm	High	High
Q4146	Tensix, 1cm	High	High
Q4147	Architect ecm px fx 1 sq cm	High	High*
Q4148	Neox neox rt or clarix cord	High	High
Q4150	Allowrap ds or dry 1 sq cm	High	High
Q4151	Amnioband, guardian 1 sq cm	High	High
Q4152	Dermapure 1 square cm	High	High
Q4153	Dermavest, plurivest sq cm	High	High
Q4154	Biovance 1 square cm	High	High
Q4156	Neox 100 or clarix 100	High	High
Q4157	Revitalon 1 square cm	High	High*
Q4158	Kerecis omega3, per sq cm	High	High*
Q4159	Affinity1 square cm	High	High
Q4160	Nushield 1 square cm	High	High
Q4161	Bio-connekt per square cm	High	High
Q4163	Woundex, bioskin, per sq cm	High	High
Q4164	Helicoll, per square cm	High	High*
Q4165	Keramatrix, per square cm	Low	Low
Q4166	Cytal, per square centimeter	Low	Low
Q4167	Truskin, per sq centimeter	Low	Low
Q4169	Artacent wound, per sq cm	High	High*
Q4170	Cygnus, per sq cm	Low	Low
Q4173	Palingen or palingen xplus	High	High
Q4175	Miroderm	High	High
Q4176	Neopatch, per sq centimeter	Low	Low
Q4178	Floweramniopatch, per sq cm	High	High
Q4179	Flowerderm, per sq cm	Low	Low
Q4180	Revita, per sq cm	High	High
Q4181	Amnio wound, per square cm	High	High*
Q4182	Transcyte, per sq centimeter	Low	Low
Q4183	Surgigraft, 1 sq cm	Low	Low
Q4184	Cellesta, 1 sq cm	Low	Low
Q4186	Epifix 1 sq cm	High	High
Q4187	Epicord 1 sq cm	High	High
Q4188	Amnioarmor 1 sq cm	Low	Low
Q4190	Artacent ac 1 sq cm	Low	Low
Q4191	Restorigin 1 sq cm	Low	Low
Q4193	Coll-e-derm 1 sq cm	Low	Low
Q4194	Novachor 1 sq cm	Low	Low
Q4195+	Puraply 1 sq cm	High	High
Q4196+	Puraply am 1 sq cm	High	High
Q4197	Puraply xt 1 sq cm	High	High

CY 2019 HCPCS Code	CY 2019 Short Descriptor	CY 2018 High/Low Assignment	CY 2019 High/Low Assignment
Q4198	Genesis amnio membrane 1sqcm	Low	Low
Q4200	Skin te 1 sq cm	Low	Low
Q4201	Matrion 1 sq cm	Low	Low
Q4203	Derma-gide, 1 sq cm	Low	Low
Q4204	Xwrap 1 sq cm	Low	Low

* These products do not exceed either the MUC or PDC threshold for CY 2019, but are assigned to the high cost group because they were assigned to the high cost group in CY 2018.
+ Pass-through payment status in CY 2019.

Table 9. ─ Allow HCPCS Code Q4122 (Dermacell, per square centimeter) to Be Billed with Either Revenue Code 0278 (Other implants) or Revenue Code 0636 (Drugs requiring detailed coding)

CY 2019 HCPCS Code	CY 2019 Long Descriptor	CY 2019 SI	Allowed Revenue Codes for Billing
Q4122	Dermacell, per square centimeter	N	0278, 0636

Table 10. – 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	Hospitals paid under the OPPS - 01/01/2018 Nonexcepted off-campus PBDs paid under the PFS - 01/01/2019
TB	Tracking 340b acquired drug	Drug or biological acquired with 340b drug pricing program discount, reported for informational purposes	Hospitals paid under the OPPS - 01/01/2018 Nonexcepted off-campus PBDs paid under the PFS - 01/01/2019

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20.6.4 - Use of Modifiers for Discontinued Services

(Rev. 4204, Issued: 01-17-19, Effective: 01-01-19, Implementation: 01-07-19)

A. General

Modifiers provide a way for hospitals to report and be paid for expenses incurred in preparing a patient for a procedure and scheduling a room for performing the procedure where the service is subsequently discontinued. This instruction is applicable to both outpatient hospital departments and to ambulatory surgical centers.

Modifier -73 is used by the facility to indicate that a procedure requiring anesthesia was terminated due to extenuating circumstances or to circumstances that threatened the well being of the patient after the patient had been prepared for the procedure (including procedural pre-medication when provided), and been taken to the room where the procedure was to be performed, but prior to administration of anesthesia. For purposes of billing for services furnished in the hospital outpatient department, anesthesia is defined to include local, regional block(s), moderate sedation/analgesia (“conscious sedation”), deep sedation/analgesia, or general anesthesia. This modifier code was created so that the costs incurred by the hospital to prepare the patient for the procedure and the resources expended in the procedure room and recovery room (if needed) could be recognized for payment even though the procedure was discontinued.

Modifier -74 is used by the facility to indicate that a procedure requiring anesthesia was terminated after the induction of anesthesia or after the procedure was started (e.g., incision made, intubation started, scope inserted) due to extenuating circumstances or circumstances that threatened the well being of the patient. This modifier may also be used to indicate that a planned surgical or diagnostic procedure was discontinued, partially reduced or cancelled at the physician's discretion after the administration of anesthesia. For purposes of billing for services furnished in the hospital outpatient department, anesthesia is defined to include local, regional block(s), moderate sedation/analgesia (“conscious sedation”), deep sedation/analgesia, and general anesthesia. This modifier code was created so that the costs incurred by the hospital to initiate the procedure (preparation of the patient, procedure room, recovery room) could be recognized for payment even though the procedure was discontinued prior to completion.

Coinciding with the addition of the modifiers -73 and -74, modifiers -52 and -53 were revised. Modifier -52 is used to indicate partial reduction, cancellation, or discontinuation of services for which anesthesia is not planned. The modifier provides a means for reporting reduced services without disturbing the identification of the basic service. Modifier -53 is used to indicate discontinuation of physician services and is not approved for use for outpatient hospital services.
The elective cancellation of a procedure should not be reported.

Modifiers -73 and -74 are only used to indicate discontinued procedures for which anesthesia is planned or provided.

B. Effect on Payment

Procedures that are discontinued after the patient has been prepared for the procedure and taken to the procedure room but before anesthesia is provided will be paid at 50 percent of the full OPPS payment amount. Modifier -73 is used for these procedures. As of January 1, 2016, for device-intensive procedures that append modifier -73, we will reduce the APC payment amount for the discontinued device-intensive procedure, by 100 percent of the device offset amount prior to applying the additional payment adjustments that apply when the procedure is discontinued as modified by means of a final rule with comment period and published in the November 13, 2015 “Federal Register” (80 FR 70424). Beginning January 1, 2017, device-intensive procedures are defined as those procedures requiring the insertion of an implantable device, that also have a HCPCS- level device offset greater than 40 percent. From January 1, 2016 through December 31, 2016 device-intensive procedures were defined as those procedures that involve implantable devices that are assigned to a device-intensive APC (defined as those APCs with a device offset greater than 40 percent). *Beginning January 1, 2019, device-intensive procedures are defined as procedures that involve the surgical*

implantation or insertion of an implantable device that is assigned a CPT or HCPCS code (including single-use devices) and has a device offset amount that exceeds 30 percent of the procedure's mean cost.

Procedures that are discontinued, partially reduced or cancelled after the procedure has been initiated and/or the patient has received anesthesia will be paid at the full OPPS payment amount. Modifier -74 is used for these procedures.

Procedures for which anesthesia is not planned that are discontinued, partially reduced or cancelled after the patient is prepared and taken to the room where the procedure is to be performed will be paid at 50 percent of the full OPPS payment amount. Modifier -52 is used for these procedures.

20.6.11 - Use of HCPCS Modifier - PO

(Rev. 4204, Issued: 01-17-19, Effective: 01-01-19, Implementation: 01-07-19)

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.

We note that beginning in CY 2019 we are finalizing a policy to pay for clinic visits (G0463) billed at excepted off-campus provider based departments (departments that bill modifier "PO" on their claim lines) at the PFS-equivalent amount. The PFS-equivalent amount paid to nonexcepted off-campus PBDs is 40 percent of OPPS payment (that is, 60 percent less than the OPPS rate) for CY 2019. We are phasing this policy in over a two year period. Specifically, half of the total 60-percent payment reduction, a 30-percent reduction, will apply in CY 2019. In other words, these departments will be paid 70 percent of the OPPS rate (100 percent of the OPPS rate minus the 30-percent payment reduction that applies in CY 2019) for the clinic visit service in CY 2019.

20.6.16 - Use of HCPCS Modifier – JG

(Rev. 4204, Issued: 01-17-19, Effective: 01-01-19, Implementation: 01-07-19)

A. General

Effective January 1, 2018, CMS established a new HCPCS Level II modifier, modifier "JG", to identify and pay 340B-acquired drugs and biologicals. The definition of modifier "JG" is ***"Drug or biological acquired with 340B drug pricing program discount."*** *Specifically, beginning January 1, 2018, hospitals paid under the OPPS that are not excepted from the 340B drug payment adjustment, and beginning January 1, 2019, nonexcepted off-campus PBDs of a hospital (that is not otherwise excepted from the 340B drug payment adjustment) paid under the PFS are required to report modifier "JG" on the same claim line as the drug or biological HCPCS code to identify if a drug or biological was acquired under the 340B Program. This requirement is aligned with the modifier requirement already mandated in several States under their Medicaid programs. The phrase "acquired under the 340B Program" is inclusive of all drugs acquired under the 340B Program or PVP, regardless of the level of discount applied to the drug.*

B. Effect on Payment

Effective January 1, 2018, payment for certain drugs and biologicals (reported with status indicator "K") acquired through the 340B Program that are furnished by providers paid under the OPPS, and beginning January 1, 2019, payment for certain drugs and biologicals furnished by nonexcepted off-campus PBDs of a hospital paid under the PFS (departments that bill modifier "PN" on their claim lines), are required to report modifier "JG" on the same claim line as the drug or biological HCPCS code to identify if a drug or biological was acquired under the 340B Program, which will trigger a payment adjustment such that the 340B-acquired drug is paid at the drug's average sales price minus 22.5 percent. A document explaining the use of this modifier is available via the Internet on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Billing-340B-Modifiers-under-Hospital-OPPS.pdf.

20.6.17 - Use of HCPCS Modifier – TB

(Rev. 4204, Issued: 01-17-19, Effective: 01-01-19, Implementation: 01-07-19)

A. General

Effective January 1, 2018, CMS established a new HCPCS Level II modifier, modifier "TB", to facilitate the collection and tracking of 340B claims data for OPPS providers that are excepted from the 340B payment adjustment in CY 2018. The definition of modifier "TB" is ***"Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes."*** *Beginning January 1, 2019, modifier "TB" shall be reported by both hospitals paid under the OPPS and by nonexcepted off-campus PBDs of a hospital paid under the PFS if the hospital is excepted from the 340B drug payment adjustment to identify if a drug or biological was acquired under the 340B Program.*

B. Effect on Payment

Effective January 1, 2018, providers that are exempt from the 340B drug payment adjustment including, rural SCHs, children's hospitals, and PPS-exempt cancer hospitals, shall report the informational modifier "TB" to identify OPPS separately payable drugs (reported with status indicator "K") purchased with a 340B discount. The informational modifier "TB" will facilitate the collection and tracking of 340B claims data for OPPS providers that are excepted from the payment adjustment. However, use of modifier "TB" will not trigger a payment adjustment and these providers will receive ASP+6 percent for separately payable drugs furnished in CY's 2018 and 2019, even if such drugs were acquired under the 340B Program. Furthermore, beginning January 1, 2019, nonexcepted off-campus PBDs paid under the PFS (department that bill the modifier "PN" on their claim lines) that furnish 340B-acquired drugs and biologicals and are exempt from the 340B payment adjustment (because their hospital is a rural SCH or children's hospital) will be required to bill under the PFS using the institutional claim form and report the informational modifier "TB" for 340B-acquired drugs and biologicals, which will not trigger a payment adjustment, and these providers will continue to receive ASP+6 percent for separately payable drugs furnished in CY 2019, even if such drugs were acquired under the 340B Program. A document explaining the use of this modifier is available via the Internet on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Billing-340B-Modifiers-under-Hospital-OPPS.pdf.

20.6.18 - Use of HCPCS Modifier - ER

(Rev. 4204, Issued: 01-17-19, Effective: 01-01-19, Implementation: 01-07-19)

*Effective January 1, 2019, the definition of modifier -ER is "****Items and services furnished by a provider-based off-campus emergency department."*** *This modifier is required to be reported on every claim line for outpatient hospital services furnished in an off-campus provider-based emergency department. See 42 CFR 413.65(a)(2) for a definition of "campus."*

This modifier would be reported on the UB–04 form (CMS Form 1450) for hospital outpatient services. Reporting of this modifier is not required for Critical access hospitals (CAHs). While this modifier is required, it does not have an effect on payment.

260.1 - Special Partial Hospitalization Billing Requirements for Hospitals, Community Mental Health Centers, and Critical Access Hospitals

(Rev. 4204, Issued: 01-17-19, Effective: 01-01-19, Implementation: 01-07-19)

Medicare Part B coverage is available for hospital outpatient partial hospitalization services.

A. Billing Requirement

Section 1861 (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act defines the services under the partial hospitalization benefit in a hospital.

Section 1866(e)(2) of the Act (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm)recognizes CMHCs as "providers of services" but only for furnishing partial hospitalization services. See §261.1.1 of this chapter for CMHC partial hospitalization bill review directions.

Hospitals and CAHs report condition code 41 in FLs 18-28 (or electronic equivalent) to indicate the claim is for partial hospitalization services. They must also report a revenue code and the charge for each individual covered service furnished. In addition, hospital outpatient departments are required to report HCPCS codes. CAHs are not required to report HCPCS code for this benefit.

Under component billing, hospitals are required to report a revenue code and the charge for each individual covered service furnished under a partial hospitalization program. In addition, hospital outpatient departments are required to report HCPCS codes. Component billing assures that only those partial hospitalization services covered under §1861(ff) of the Act are paid by the Medicare program.

Effective January 1, 2017, non-excepted off-campus provider-based departments of a hospital are required to report a "PN" modifier on each claim line for non-excepted items and services. The use of modifier "PN" will trigger a payment rate under the Medicare Physician Fee Schedule. We expect the PN modifier to be reported with each non-excepted item and service including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services.

Excepted off-campus provider-based departments of a hospital must continue to report existing modifier "PO" (Services, procedures and/or surgeries provided at off-campus provider-based outpatient departments) for all excepted items and services furnished. Use of the off-campus PBD modifier became mandatory beginning January 1, 2016.

All hospitals are required to report condition code 41 in FLs 18-28 to indicate the claim is for partial hospitalization services. Hospitals use bill type 13X and CAHs use bill type 85X. The following special procedures apply.

Bills must contain an acceptable revenue code. They are as follows:

Revenue Code	Description
0250	Drugs and Biologicals

Revenue Code	Description
043X	Occupational Therapy
0900	Behavioral Health Treatment/Services
0904	Activity Therapy
0910	Psychiatric/Psychological Services (Dates of Service prior to October 16, 2003)
0914	Individual Therapy
0915	Group Therapy
0916	Family Therapy
0918	*Behavioral Health/*Testing
0942	Education/Training

Hospitals other than CAHs are also required to report appropriate HCPCS codes as follows:

Revenue Code	Description	HCPCS Code
043X	Occupational Therapy	*G0129 *(Partial Hospitalization)*
0900	Behavioral Health Treatment/Services	****90791 or ***** 90792
0904	Activity Therapy	**G0176 *(Partial Hospitalization)*
0914	Individual Psychotherapy	90785, 90832, 90833, 90834, 90836, 90837, 90838, 90845, 90865, or 90880
0915	Group Therapy	G0410 or G0411
0916	Family Psychotherapy	90846 or 90847
0918	*Behavioral Health/*Testing	96116, *96130, 96131, 96132, 96133, 96136, 96137, 96138. 96139, 96146*
0942	Education/Training	***G0177

The A/B MAC (A) will edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. The A/B MAC (A) will not edit for matching the revenue code to HCPCS.

*The definition of code G0129 is as follows:

> Occupational therapy services requiring skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per session (45 minutes or more).

**The definition of code G0176 is as follows:

> Activity therapy, such as music, dance, art or play therapies not for recreation, related to care and treatment of patient's disabling mental problems, per session (45 minutes or more).

***The definition of code G0177 is as follows:

> Training and educational services related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more).

****The definition of code 90791 is as follows:

Psychiatric diagnostic evaluation (no medical services) completed by a non-physician.

*****The definition of code 90792 is as follows:

Psychiatric diagnostic evaluation (with medical services) completed by a physician.

Codes G0129 and G0176 are used only for partial hospitalization programs.

Code G0177 may be used in both partial hospitalization program and outpatient mental health settings.

Revenue code 250 does not require HCPCS coding. However, Medicare does not cover drugs that can be self-administered.

Edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. Do not edit for the matching of revenue code to HCPCS.

B. <u>Professional Services</u>

The professional services listed below when provided in all hospital outpatient departments are separately covered and paid as the professional services of physicians and other practitioners. These professional services are unbundled and these practitioners (other than physician assistants (PA) bill the Medicare A/B MAC (B) directly for the professional services furnished to hospital outpatient partial hospitalization patients. The hospital can also serve as a billing agent for these professionals by billing the A/B MAC (B) on their behalf under their billing number for their professional services. The professional services of a PA can be billed to the A/B MAC (B) only by the PAs employer. The employer of a PA may be such entities or individuals as a physician, medical group, professional corporation, hospital, SNF, or nursing facility. For example, if a physician is the employer of the PA and the PA renders services in the hospital, the physician and not the hospital would be responsible for billing the A/B MAC (B) on Form CMS-1500 for the services of the PA. The following direct professional services are unbundled and not paid as partial hospitalization services.

- Physician services that meet the criteria of 42 CFR 415.102, for payment on a fee schedule basis;

- Physician assistant (PA) services as defined in §1861(s)(2)(K)(i) of the Act;

- Nurse practitioner and clinical nurse specialist services, as defined in §1861(s)(2)(K)(ii) of the Act; and

- Clinical psychologist services as defined in §1861(ii) of the Act.

The services of other practitioners (including clinical social workers and occupational therapists), are bundled when furnished to hospital patients, including partial hospitalization patients. The hospital must bill the contractor for such nonphysician practitioner services as partial hospitalization services. Make payment for the services to the hospital.

C. <u>Outpatient Mental Health Treatment Limitation</u>

The outpatient mental health treatment limitation <u>may apply</u> to services to treat mental, psychoneurotic, and

personality disorders when furnished by physicians, clinical psychologists, NPs, CNSs, and PAs to partial hospitalization patients. However, the outpatient mental health treatment limitation does not apply to such mental health treatment services billed to the A/B MAC (A) by a CMHC or hospital outpatient department as partial hospitalization services.

D. Reporting of Service Units

Hospitals report the number of times the service or procedure, as defined by the HCPCS code, was performed. CAHs report the number of times the revenue code visit was performed.

NOTE: Service units are not required to be reported for drugs and biologicals (Revenue Code 250).

E. Line Item Date of Service Reporting

Hospitals other than CAHs are required to report line item dates of service per revenue code line for partial hospitalization claims. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are reported in FL 45 “Service Date” (MMDDYY). See §260.5 for a detailed explanation.

F. Payment

Starting in CY 2017 and subsequent years, the payment structure for partial hospitalization services provided in hospital outpatient departments and CMHCs has been reduced from four APCs (two for CMHCs and two for hospital-based PHPs) to a single APC by provider type. Effective January 2, 2017, we are replacing existing CMHC APCs 5851 (Level 1 Partial Hospitalization (3 services)) and 5852 (Level 2 Partial Hospitalization (4 or more services)) with a new CMHC APC 5853 (Partial Hospitalization (3 or More Services Per Day)), and replacing existing hospital-based PHP APCs 5861 (Level 1 Partial Hospitalization (3 services)) and 5862 (Level 2 Partial Hospitalization (4 or more services)) with a new hospital-based PHP APC 5863 (Partial Hospitalization (3 or More Services Per Day)). The following chart displays the CMHC and hospital-based PHP APCs:

Hospital-Based and Community Mental Health Center PHP APCs

CY 2017 APC	Group Title
5853	Partial Hospitalization (3 or more services per day) for CMHCs
5863	Partial Hospitalization (3 or more services per day) for hospital-based PHPs

Apply Part B deductible, if any, and coinsurance.

G. Data for CWF and PS&R

Include revenue codes, HCPCS/CPT codes, units, and covered charges in the financial data section (fields 65a - 65j), as appropriate. Report the billed charges in field 65h, "Charges," of the CWF record.

Include in the financial data portion of the PS&R UNIBILL, revenue codes, HCPCS/CPT codes, units, and charges, as appropriate.

Future updates will be issued in a Recurring Update Notification.

260.1.1 - Bill Review for Partial Hospitalization Services Provided in Community Mental Health Centers (CMHC)

(Rev. 4204, Issued: 01-17-19, Effective: 01-01-19, Implementation: 01-07-19)

A. General

Medicare Part B coverage for partial hospitalization services provided by CMHCs is available effective for services provided on or after October 1, 1991.

B. Special Requirements

Section 1866(e)(2) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act recognizes CMHCs as "providers of services" but only for furnishing partial hospitalization services. Applicable provider ranges are 1400-1499, 4600-4799, and 4900-4999.

C. Billing Requirements

The CMHCs bill for partial hospitalization services under bill type 76X. The A/B MACs (A) follow bill review instructions in chapter 25 of this manual, except for those listed below.

The acceptable revenue codes are as follows:

Revenue Code	Description
0250	Drugs and Biologicals
043X	Occupational Therapy
0900	Behavioral Health Treatments/Services
0904	Activity Therapy
0910	Psychiatric/Psychological Services (Dates of Service prior to October 16, 2003)
0914	Individual Therapy
0915	Group Therapy
0916	Family Therapy
0918	*Behavioral Health/*Testing
0942	Education/Training

The CMHCs are also required to report appropriate HCPCS codes as follows:

Revenue Codes	Description	HCPCS Code
043X	Occupational Therapy	*G0129 *(Partial Hospitalization)*
0900	Behavioral Health Treatments/Services	****90791 or *****90792
0904	Activity Therapy	**G0176 *(Partial Hospitalization)*
0914	Individual Psychotherapy	90785, 90832, 90833, 90834, 90836, 90837, 90838, 90845, 90865, or 90880
0915	Group Psychotherapy	G0410 or G0411
0916	Family Psychotherapy	90846 or 90847
0918	*Behavioral Health/*Testing	96116*, 96130, 96131, 96132, 96133, 96136, 96137, 96138. 96139, 96146*
0942	Education/Training	***G0177

The A/B MAC(s) (A) edit to assure that HCPCS are present when the above revenue codes are billed and

that they are valid HCPCS codes. They do not edit for the matching of revenue codes to HCPCS.

Definitions each of the asterisked HCPCS codes follows:

*The definition of code G0129 is as follows:
Occupational therapy services requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per session (45 minutes or more).

**The definition of code G0176 is as follows:
Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more).

***The definition of code G0177 is as follows:
Training and educational services related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more).

****The definition of code 90791 is as follows:
Psychiatric diagnostic evaluation (no medical services) completed by a non-physician.

*****The definition of code 90792 is as follows:
Psychiatric diagnostic evaluation (with medical services) completed by a physician.

Codes G0129 and G0176 are used only for partial hospitalization programs.

Code G0177 may be used in both partial hospitalization program and outpatient mental health settings.

Revenue code 0250 does not require HCPCS coding. However, drugs that can be self-administered are not covered by Medicare.

HCPCS includes CPT-4 codes. See the ASC X12 837 institutional claim guide for how to report HCPCS electronically. CMHCs report HCPCS codes on Form CMS-1450 in FL44, "HCPCS/Rates." HCPCS code reporting is effective for claims with dates of service on or after April 1, 2000.

The A/B MACs (A) are to advise their CMHCs of these requirements. CMHCs should complete the remaining items on the claim in accordance with the ASC X12 837 Institutional Claim implementation guide and the Form CMS-1450 instructions in Chapter 25 of this manual.

The professional services listed below are separately covered and are paid as the professional services of physicians and other practitioners. These professional services are unbundled and these practitioners (other than physician assistants (PAs)) bill the A/B MAC (B) directly for the professional services furnished to CMHC partial hospitalization patients. The ASC X12 837 professional claim format or the paper form 1500 is used. The CMHC can also serve as a billing agent for these professionals by billing the A/B MAC (B) on their behalf for their professional services. The professional services of a PA can be billed to the A/B MAC (B) only by the PAs employer. The employer of a PA may be such entities or individuals as a physician, medical group, professional corporation, hospital, SNF, or nursing facility. For example, if a physician is the employer of the PA and the PA renders services in the CMHC, the physician and not the CMHC would be responsible for billing the A/B MAC (B) for the services of the PA.

The following professional services are unbundled and not paid as partial hospitalization services:

- Physician services that meet the criteria of 42 CFR 415.102, for payment on a fee schedule basis;

- PA services, as defined in §1861(s)(2)(K)(i) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act;

- Nurse practitioner and clinical nurse specialist services, as defined in §1861(s)(2)(K)(ii) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act; and,

- Clinical psychologist services, as defined in §1861(ii) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act.

The services of other practitioners (including clinical social workers and occupational therapists) are bundled when furnished to CMHC patients. The CMHC must bill the A/B MAC (A) for such nonphysician practitioner services as partial hospitalization services. The A/B MAC (A) makes payment for the services to the CMHC.

D. Outpatient Mental Health Treatment Limitation

The outpatient mental health treatment limitation **may apply** to services to treat mental, psychoneurotic, and personality disorders when furnished by physicians, clinical psychologists, NPs, CNSs, and PAs to partial hospitalization patients. However, the outpatient mental health treatment limitation **does not** apply to such mental health treatment services billed to the A/B MAC (A) as partial hospitalization services.

E. Reporting of Service Units

Visits should no longer be reported as units. Instead, CMHCs report in the field, "Service Units," the number of times the service or procedure, as defined by the HCPCS code, was performed when billing for partial hospitalization services identified by revenue code in subsection C.

EXAMPLE: A beneficiary received psychological testing *performed by a physician for a total of 3 hours during one day* (HCPCS code *96130, first hour; HCPCS code 96131 for 2 additional hours)*. The CMHC reports revenue code 0918, HCPCS code *96130, and 1 unit; and a second line on the claim showing revenue code 918, HCPCS code 96131, and 2 units.*

When reporting service units for HCPCS codes where the definition of the procedure does not include any reference to time (either minutes, hours or days), CMHCs should not bill for sessions of less than 45 minutes.

The CMHC need not report service units for drugs and biologicals (Revenue Code 0250)

NOTE: Information regarding the Form CMS-1450 form locators that correspond with these fields is found in Chapter 25 of this manual. See the ASC X12 837 Institutional Claim implementation guide for related guidelines for the electronic claim.

F. Line Item Date of Service Reporting

Dates of service per revenue code line for partial hospitalization claims that span two or more dates. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are reported in "Service Date". See examples below of reporting line item dates of service. These examples are for group therapy

services provided twice during a billing period.

For claims, report as follows:

Revenue Code	HCPCS	Dates of Service	Units	Total Charges
0915	G0176	20090505	1	$80
0915	G0176	20090529	2	$160

NOTE: Information regarding the Form CMS-1450 form locators that correspond with these fields is found in Chapter 25 of this manual. See the ASC X12 837 Institutional Claim Implementation Guide for related guidelines for the electronic claim.

The A/B MACs (A) return to provider claims that span two or more dates if a line item date of service is not entered for each HCPCS code reported or if the line item dates of service reported are outside of the statement covers period. Line item date of service reporting is effective for claims with dates of service on or after June 5, 2000.

G. Payment

Section 1833(a)(2)(B) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act provides the statutory authority governing payment for partial hospitalization services provided by a CMHC. A/B MAC(s) (A) made payment on a reasonable cost basis until OPPS was implemented. The Part B deductible and coinsurance applied.

Payment principles applicable to partial hospitalization services furnished in CMHCs are contained in §2400 of the Medicare Provider Reimbursement Manual.

The A/B MACs (A) make payment on a per diem basis under the hospital outpatient prospective payment system for partial hospitalization services. CMHCs must continue to maintain documentation to support medical necessity of each service provided, including the beginning and ending time.

Effective January 1, 2011, there were four separate APC payment rates for PHP: two for CMHCs (for Level I and Level II services based on only CMHC data) and two for hospital-based PHPs (for Level I and Level II services based on only hospital-based PHP data).

The two CMHC APCS for providing partial hospitalization services were: APC 5851 (Level 1 Partial Hospitalization (3 services)) and APC 5852 (Level 2 Partial Hospitalization (4 or more services)). Effective January 1, 2017, we are combining APCs 5851 and 5852 into one new APC 5853 (Partial Hospitalization (3 or more services) for CMHCs).

Community Mental Health Center PHP APC

APC	Group Title
5853	Partial Hospitalization (3 or more services per day) for CMHCs

NOTE: Occupational therapy services provided to partial hospitalization patients are not subject to the prospective payment system for outpatient rehabilitation services, and therefore the financial limitation required under §4541 of the Balanced Budget Act (BBA) does not apply.

H. Medical Review

The A/B MACs (A) follow medical review guidelines in Pub. 100-08, Medicare Program Integrity Manual.

I. Coordination *w*ith CWF

See chapter 27 of this manual. All edits for bill type 74X apply, except provider number ranges 4600-4799 are acceptable only for services provided on or after October 1, 1991.

Medicare Claims Processing Manual

Chapter 17 - Drugs and Biologicals

90.2 - Drugs, Biologicals, and Radiopharmaceuticals

(Rev. 4204, Issued: 01-17-19, Effective: 01-01-19, Implementation: 01-07-19)

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. ***Biosimilars***

The payment rate for biosimilars is calculated as the Average Sales Price (ASP) of the biosimilar described by the HCPCS code + 6 percent of the ASP of the biosimilar reference product. Biosimilars will also continue to 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 biosimilar reference product.

F. **340B-Acquired Drugs**

Beginning January 1, 2018, separately payable Part B drugs *and biologicals* (assigned status indicator "K"), other than vaccines (assigned status indicator "L" or "M") and drugs *and biologicals* 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 *of the ASP of the drug or biological* when billed by a hospital paid under the OPPS that is not excepted from the payment adjustment. *Biosimilars that are acquired through the 340B Program or through the 340B prime vendor program will be paid at the ASP minus 22.5 percent of the ASP of the drug or biological 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 *and biologicals* 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.