CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3156	**Date: December 22, 2014**
	Change Request 9014

Transmittal 3150, dated December 12, 2014, is being rescinded and replaced by Transmittal 3156, dated December 22, 2014, to correct some values in Attachment A, table 8. All other information remains the same.

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

I. SUMMARY OF CHANGES: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the January 2015 OPPS update. The January 2015 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this Change Request (CR). This Recurring Update Notification applies to Chapter 4, section 200.9.

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

EFFECTIVE DATE: January 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 5, 2015

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	4/Table of Contents
N	4/10.2.3/Comprehensive APCs
R	4/10.4/Packaging
D	4/200.3.4/Billing for Linear Accelerator (Robotic Image-Guided and Non-Robotic Image-Guided) SRS Planning and Delivery
R	4/200.9/Billing for “Sometimes Therapy” Services that May be Paid as Non-Therapy Services for Hospital Outpatients

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 obliged 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: 3156	Date: December 22, 2014	Change Request: 9014

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

EFFECTIVE DATE: January 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 5, 2015

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the January 2015 OPPS update. The January 2015 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this Change Request (CR).

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

B. Policy:

1. New Service

New service listed in table 1, Attachment A, is assigned for payment under the OPPS, effective January 1, 2015.

2. New Device Pass-Through Categories

Section 1833(t)(6)(B) of the Social Security Act requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that we create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

We are establishing one new device pass-through category as of January 1, 2015. Table 2, Attachment A, provides a listing of new coding and payment information concerning the new device category for transitional pass-through payment.

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

We have determined that a portion of the APC payment amount associated with the cost of C2624 is reflected in APC 0080, Diagnostic Cardiac Catheterization. The C2624 device should always be billed with procedure code C9741 (Right heart catheterization with implantation of wireless pressure sensor in the pulmonary artery, including any type of measurement, angiography, imaging supervision, interpretation, and report), which is assigned to APC 0080 for CY 2015. The device offset from payment represents a deduction from pass-through payments for the device in category C2624. Therefore, we are establishing the offset

amount for C2624 to be that of APC 0080, $310.33, which will be deducted from pass-through payment.

3. Comprehensive APCs

For CY 2015, we are creating a new category of codes, called "Comprehensive APCs", for which we provide **a single claim payment**. Through OCE logic, the PRICER will automatically assign payment for a "Comprehensive APC" service reported on a claim. Both the OCE and the PRICER will implement these new policies without any coding change required on the part of hospitals.

Effective January 1, 2015, comprehensive APCs (Identified by a new Status Indicator, J1) 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. We are updating Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, by adding section 10.2.3 and revising section 10.4 to reflect comprehensive APC payment policies.

4. Billing for Corneal Tissue

We remind hospitals that according to Pub. 100-04, the Medicare Claims Processing Manual, Chapter 4, Section 200.1 - Billing for Corneal Tissue, the corneal tissue is paid on a cost basis and not under the OPPS. To receive cost based reimbursement for corneal tissue hospitals must bill charges for corneal tissue using HCPCS code V2785.

5. Billing for Mobile Cardiac Telemetry Monitoring Services

CPT code 93229 describes wearable mobile cardiovascular telemetry services. As instructed in the CY 2015 OPPS/ASC final rule, CPT code 93229 should be used to report continuous outpatient cardiovascular monitoring that includes **up to 30 consecutive days** of real-time cardiac monitoring. In particular, the 2015 CPT Code Book defines CPT code 93229 as:

"Mobile cardiovascular telemetry (MCT): continuously records the electrocardiographic rhythm from external electrodes placed on the patient's body. Segments of the ECG data are automatically (without patient intervention) transmitted to a remote surveillance location by cellular or landline telephone signal. The segments of the rhythm, selected for transmission, are triggered automatically (MCT device algorithm) by rapid and slow heart rates or by the patient during a symptomatic episode. There is continuous real time data analysis by preprogrammed algorithms in the device and attended surveillance of the transmitted rhythm segments by a surveillance center technician to evaluate any arrhythmias and to determine signal quality. The surveillance center technician reviews the data and notifies the physician or other qualified health care professional depending on the prescribed criteria." (2015 CPT Professional Edition; page 578).

We expect that hospitals will report CPT code 93229 on hospital claims only when they have provided the mobile telemetry service as described above.

For information on the APC assignment, OPPS status indicator, and payment rate for CPT code 93229 effective January 1, 2015, refer to Addendum B of the January 2015 OPPS Update that is posted on the CMS website.

6. Billing for "Sometimes Therapy" Services that May be Paid as Non-Therapy Services for Hospital Outpatients

Section 1834(k) of the Act, as added by Section 4541 of the BBA, allows payment at 80 percent of the lesser of the actual charge for the services or the applicable fee schedule amount for all outpatient therapy services; that is, physical therapy services, speech-language pathology services, and occupational therapy services. As provided under Section 1834(k)(5) of the Act, a therapy code list was created based on a uniform coding system (that is, the HCPCS) to identify and track these outpatient therapy services paid under the Medicare

Physician Fee Schedule (MPFS).

The list of therapy codes, along with their respective designation, can be found on the CMS Website, specifically at http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage. Two of the designations that are used for therapy services are: “always therapy” and “sometimes therapy.” An “always therapy” service must be performed by a qualified therapist under a certified therapy plan of care, and a “sometimes therapy” service may be performed by physician or a non-physician practitioner outside of a certified therapy plan of care.

Under the OPPS, separate payment is provided for certain services designated as “sometimes therapy” services if these services are furnished to hospital outpatients as a non-therapy service, that is, without a certified therapy plan of care. Specifically, to be paid under the OPPS for a non-therapy service, hospitals SHOULD NOT append the therapy modifier GP (physical therapy), GO (occupational therapy), or GN (speech language pathology), or report a therapy revenue code 042x, 043x, or 044x in association with the “sometimes therapy” codes listed in the table below.

To receive payment under the MPFS, when “sometimes therapy” services are performed by a qualified therapist under a certified therapy plan of care, providers should append the appropriate therapy modifier GP, GO, or GN, and report the charges under an appropriate therapy revenue code, specifically 042x, 043x, or 044x. This instruction does not apply to claims for “sometimes therapy” codes furnished as non-therapy services in the hospital outpatient department and paid under the OPPS.

Effective January 1, 2015, two HCPCS codes designated as “Sometimes Therapy” services, G0456 (Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters) and G0457 (Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters) would be terminated and replaced with two new CPT codes 97607 (Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters) and 97608 (Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters).

The list of HCPCS codes designated as “sometimes therapy” services that may be paid as non-therapy services when furnished to hospital outpatients is displayed in the table 3, Attachment A.

7. New Laboratory HCPCS G-codes Effective January 1, 2015

For the CY 2015 update, the CPT Editorial Panel deleted several laboratory services on December 31, 2014 and replaced them with new CPT codes effective January 1, 2015. Because the laboratory services described by the 2014 CPT codes (which are being deleted) will continue to be paid under the Clinical Lab Fee Schedule (CLFS) in 2015, Medicare has established the following HCPCS G-codes to replace the deleted CPT codes for these laboratory services. Under the hospital OPPS, the HCPCS G-codes are assigned to status indicator “N” (packaged) effective January 1, 2015. In addition, the new laboratory CY 2015 CPT codes that replaced the deleted laboratory CY 2014 CPT codes have been assigned to status indicator “B” to indicate that another code should be reported under the hospital OPPS. The list of the new HCPCS G-codes and their predecessor CPT codes can be found in table 4, Attachment A.

8. Coding Guidance for Intraocular or Periocular Injections of Combinations of Anti-Inflammatory Drugs and Antibiotics

Intraocular or periocular injections of combinations of anti-inflammatory drugs and antibiotics are being used with increased frequency in ocular surgery (primarily cataract surgery). One example of combined or compounded drugs includes triamcinolone and moxifloxacin with or without vancomycin. Such combinations may be administered as separate injections or as a single combined injection. Because such injections may obviate the need for post-operative anti-inflammatory and antibiotic eye drops, some have referred to cataract surgery with such injections as "dropless cataract surgery."

As stated in Chapter VIII, section D, item 20 of the CY 2015 NCCI Policy Manual, injection of a drug during a cataract extraction procedure or other ophthalmic procedure is not separately reportable. Specifically, no separate procedure code may be reported for any type of injection during surgery or in the perioperative period. Injections are a part of the ocular surgery and are included as a part of the ocular surgery and the HCPCS code used to report the surgical procedure.

According to Pub.100-04, the Medicare Claims Processing Manual, Chapter 17, section 90.2, the compounded drug combinations described above and similar drug combinations should be reported with HCPCS code J3490 (Unclassified drugs), regardless of the site of service of the surgery, and are packaged as surgical supplies in both the HOPD and the ASC. Although these drugs are a covered part of the ocular surgery, no separate payment will be made. In addition, these drugs and drug combinations may not be reported with HCPCS code C9399. According to the Medicare Claims Processing Manual, Chapter 30, section 40.3.6, physicians or facilities should not give Advance Beneficiary Notices (ABNs) to beneficiaries for either these drugs or for injection of these drugs because they are fully covered by Medicare. Physicians or facilities are not permitted to charge the patient an extra amount (beyond the standard copayment for the surgical procedure) for these injections or the drugs used in these injections because they are a covered part of the surgical procedure. Also, physicians or facilities cannot circumvent packaged payment in the HOPD or ASC for these drugs by instructing beneficiaries to purchase and bring these drugs to the facility for administration.

9. Drugs, Biologicals, and Radiopharmaceuticals

a. New CY 2015 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

For CY 2015, 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 5, Attachment A.

b. Other Changes to CY 2015 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 2015. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2014 and replaced with permanent HCPCS codes in CY 2015. 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 2015 HCPCS and CPT codes.

Table 6, 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 2014 HCPCS/CPT code and long descriptor are noted in the two left hand columns and the CY 2015 HCPCS/CPT code and long descriptor are noted in the adjacent right hand columns.

c. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective January 1, 2015

For CY 2015, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2015, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Effective January 1, 2015, payment rates for many drugs and biologicals have changed from the values published in the CY 2015 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 2014. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2015 release of the OPPS Pricer. CMS is not publishing the updated payment rates in this Change Request implementing the January 2015 update of the OPPS. However, the updated payment rates effective January 1, 2015 can be found in the January 2015 update of the OPPS Addendum A and Addendum B on the CMS Web site at http://www.cms.gov/HospitalOutpatientPPS/.

d. 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 7, Attachment A, lists the skin substitute products and their assignment as either a high cost or a low cost skin substitute product, when applicable. CMS will implement an OPPS edit that requires hospitals to report all high-cost skin substitute products in combination with one of the skin application procedures described by CPT codes 15271-15278 and to report all low-cost skin substitute products in combination with one of the skin application procedures described by HCPCS codes C5271-C5278.All pass-through skin substitute products are to be reported in combination with one of the skin application procedures described by CPT codes 15271-15278.

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

Some drugs and biologicals based on ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the CMS Web site on the first date of the quarter at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html?redirect=/HospitalOutpatientPPS/01_overview.asp

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

11. 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 2015. 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, 2015. 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 2014 inpatient deductible.

c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2015. 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 decreases in CY 2015 relative to CY 2014. The estimated cost of a service must be greater than the APC payment amount plus $2,775 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 2015. This threshold of 3.4 is multiplied by the total line-item APC payment for APC 0173 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 0173 payment x 3.4))/2.

f. Effective October 1, 2013, and continuing for CY 2015, C1841 (Retinal prosthesis, includes all internal and external components is eligible for pass-through payment in the OPPS Pricer logic and has an offset amount of $0, because CMS is not able to identify portions of the APC payment amounts associated with the cost of the device in APC 0673, Level III, Intraocular Procedures. For outlier purposes, when C1841 is billed with CPT code 0100T, which is assigned to APC 0673, it will be eligible for outlier calculation and payment.

g. C2624 (Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components), is effective January 1, 2015, device offset is $310.33, assigned to APC 2624. The procedure this should be billed with is C9741 (Right heart catheterization with implantation of wireless pressure sensor in the pulmonary artery, including any type of measurement, angiography, imaging supervision, interpretation, and report), and the procedure maps to APC 0080 (which has the offset of $310.33).

h. Effective January 1, 2015, 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.

i. Effective January 1, 2015, there will be two diagnostic radiopharmaceuticals receiving pass-through payment in the OPPS Pricer logic. For APCs containing nuclear medicine procedures, Pricer will reduce the amount of the pass-through diagnostic radiopharmaceutical payment by the wage-adjusted offset for the APC with the highest offset amount when the radiopharmaceutical with pass-through appears on a claim with a nuclear procedure. The offset will cease to apply when the diagnostic radiopharmaceutical expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals are the "policy-packaged" portions of the CY 2014 APC payments for nuclear medicine procedures and may be found on the CMS Web site.

j. Effective January 1, 2015, there will be four skin substitute products receiving pass-through payment in the OPPS Pricer logic. For skin substitute application procedure codes that are assigned to APC 0328 (Level III Skin Repair) or APC 0329 (Level IV Skin Repair), Pricer will reduce the payment amount for the pass-through skin substitute product by the wage-adjusted offset for the APC when the pass-through skin substitute product appears on a claim with a skin substitute application procedure that maps to APC 0328 or APC 0329. The offset amounts for skin substitute products are the "policy-packaged" portions of the CY 2014 payments for APC 0328 and APC 0329.

k. Pricer will update the payment rates for drugs, biologicals, therapeutic radiopharmaceuticals, and diagnostic radiopharmaceuticals with pass-through status when those payment rates are based on ASP on a quarterly basis.

l. Effective January 1, 2015, CMS is adopting the FY 2015 IPPS post-reclassification wage index values with application of out-commuting adjustment authorized by Section 505 of the MMA to non-IPPS hospitals discussed below.

m. Effective January 1, 2015, for claims with APCs, which require implantable devices and have significant device offsets (greater than 40%), a device offset cap will be applied based on the credit amount listed in the "FD" (Credit Received from the Manufacturer for a Replaced Medical Device) value code. The credit

amount in value code “FD” which reduces the APC payment for the applicable procedure, will be capped by the device offset amount for that APC. The offset amounts for the above referenced APCs are available on the CMS website.

n. Effective January 1, 2015, CMS is adopting the FY 2014 IPPS post-reclassification wage index values with application of out-commuting adjustment authorized by Section 505 of the MMA to non-IPPS hospitals discussed below.

12. Update the Outpatient Provider Specific File (OPSF)

For January 1, 2015, contractors shall maintain the accuracy of the provider records in the Outpatient Provider Specific File (OPSF) as changes occur in data element values.

Update the OPSF for New Core-Based Statistical Area (CBSA) and Wage Indices for Non-IPPS Hospitals Eligible for the Out-Commuting Adjustment Authorized by Section 505 of the MMA

This includes updating the CBSA in the provider records, as well as updating the “special wage index” value for those providers who qualify for the Section 505 adjustment as annotated in Table 8, Attachment A. As always, the OPPS applies the IPPS fiscal year 2015 post-reclassification wage index values to all hospitals and community mental health centers participating in the OPPS for the 2015 calendar year.

Contractors shall do the following to update the OPSF (effective January 1, 2015):

1. Update the CBSA value for each provider in Table 8;

2. For non-IPPS providers who qualify for the 505 adjustment in CY 2015 (Table 8);

a) Create a new provider record, effective January 1, 2015 and

b) Enter a value of “1” in the Special Payment Indicator field on the OPSF; and

c) Enter the final wage index value (given for the provider in Table 8.) in the Special Wage Index field in the OPSF.

3. For non-IPPS providers who received a special wage index in CY 2014, but no longer receive it in CY 2015;

a) Create a new provider record, effective January 1, 2015 and

b) Enter a blank in the Special Payment Indicator field; and

c) Enter zeroes in the special wage index field.

NOTE: Although the Section 505 adjustment is static for each qualifying county for 3 years, the special wage index will need to be updated (using the final wage index in Table 8) because the post-reclassification CBSA wage index has changed.

NOTE: Payment for Distinct Part Units (DPUs) located in an acute care hospital is based on the wage index for the labor market area where the hospital is located, even if the hospital has a reclassified wage index. If the DPU falls in a CBSA eligible to receive the section 505 out-commuting adjustment, the DPU’s final wage index should consist of the geographic wage index plus the appropriate out-commuting adjustment.

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

Cancer and children's hospitals are permanently held harmless under section 1833(t)(7)(D)(ii) of the Social Security Act and continue to receive hold harmless TOPs permanently. For CY 2015, cancer hospitals will continue to receive an additional payment adjustment.

b) Updating the OPSF for the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) 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 HOP QDRP 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, 2015, 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 HOP QDRP requirements. Once this list is released, FIs/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 HOP QDRP requirements, FIs/MACs shall update the OPSF. For greater detail regarding updating the OPSF for the HOP QDRP requirements, see Transmittal 368, CR 6072, issued on August 15, 2008.

c) Updating the OPSF for the Outpatient Cost to Charge Ratio (CCR)

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

d) Updating the OPSF for Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals Under §412.103

An urban hospital that reclassifies as a rural hospital under §412.103 is considered rural. In order to ensure correct payment under the OPPS, the rural CBSA (2-digit State code) in the Wage Index Location CBSA and the special payment indicator field must be updated.

MACs shall do the following to update the OPSF (effective January 1, 2015):

a. Create a new provider record, effective January 1, 2015, and

b. Enter a value of "Y" in the Special Payment Indicator field on the OPSF; and

c. Enter the rural CBSA (2-digit State code) in the Wage Index Location CBSA field for each provider found in Table 9C of the FY 2015 IPPS Final rule.

13. Coverage Determinations

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

whether it is excluded from payment.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9014.1	Medicare contractors shall install the January 2015 OPPS Pricer.	X				X				BCRC
9014.2	As specified in chapter 4, section 50.1, Medicare contractors shall maintain the accuracy of the data and update the OPSF file as changes occur in data element values.	X		X						BCRC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9014.3	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X		

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Marina Kushnirova, marina.kushnirova@cms.hhs.gov

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

VI. FUNDING

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

ATTACHMENTS: 1

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

Table of Contents
(Rev.3156, 12-22-14)

10.2.3 - Comprehensive APCs

(Rev.3156*, Issued: 12-22-14, Effective: 01-01-15, Implementation: 01-05-15*)

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.

HCPCS codes assigned to comprehensive APCs are designated with status indicator J1, See Addendum B at www.cms.hhs.gov/HospitalOutpatientPPS/ for the list of HCPCS codes designated with status indicator J1.

Claims reporting at least one J1 procedure code will package the following items and services that are not typically packaged under the OPPS:

- *major OPPS procedure codes (status indicators P, S, T, V)*
- *lower ranked comprehensive procedure codes (status indicator J1)*
- *non-pass-through drugs and biologicals (status indicator K)*
- *blood products (status indicator R)*
- *DME (status indicator Y)*
- *therapy services (HCPCS codes with status indicator A reported on therapy revenue centers)*

The following services are excluded from comprehensive APC packaging:

- *brachytherapy sources (status indicator U)*
- *pass-through drugs, biologicals and devices (status indicators G or H)*
- *corneal tissue, CRNA services, and Hepatitis B vaccinations (status indicator F)*
- *influenza and pneumococcal pneumonia vaccine services (status indicator L)*
- *ambulance services*
- *mammography*
- *certain preventive services*

The single payment for a comprehensive claim is based on the rate associated with the J1 service. When multiple J1 services are reported on the same claim, the single payment is based on the rate associated with the highest ranking J1 service. When certain pairs of J1 services (or in certain cases a J1 service and an add-on code) are reported on the same claim, the claim is eligible for a complexity adjustment, which provides a single payment for the claim based on the rate of the next higher comprehensive APC within the same clinical family. Note that complexity adjustments will not be applied to discontinued services (reported with mod -73 or -74).

10.4 - Packaging

(Rev.3156*, Issued: 12-22-14, Effective: 01-01-15, Implementation: 01-05-15*)

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

A. Packaging for Claims Resulting in APC Payments

If a claim contains services that result in an APC payment but also contains packaged services, separate payment for the packaged services is not made since payment is included in the APC. However, charges related to the packaged services are used for outlier and Transitional Corridor Payments (TOPs) as well as for future rate setting.

Therefore, it is extremely important that hospitals report all HCPCS codes consistent with their descriptors; CPT and/or CMS instructions and correct coding principles, and all charges for all services they furnish, whether payment for the services is made separately paid or is packaged.

B. Packaging for Claims Resulting in No APC Payments

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

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

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

C. Packaging Types Under the OPPS

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

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

3. T-packaged services are services for which separate payment is made only if there is no service with status indicator T reported with the same date of service on the same claim. When there is a claim

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

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

5. *J1 services are assigned to comprehensive APCs. Payment for all adjunctive services reported on the same claim as a J1 service is packaged into payment for the primary J1 service. See the discussion of comprehensive APCs in section 10.2.2.*

200.9 Billing for "Sometimes Therapy" Services that May be Paid as Non-Therapy Services for Hospital Outpatients

(Rev.3156,* Issued: 12-22-14, Effective: 01-01-15, Implementation: 01-05-15*)

Section 1834(k) of the Act, as added by Section 4541 of the BBA, allows payment at 80 percent of the lesser of the actual charge for the services or the applicable fee schedule amount for all outpatient therapy services; that is, physical therapy services, speech-language pathology services, and occupational therapy services. As provided under Section 1834(k)(5) of the Act, a therapy code list was created based on a uniform coding system (that is, the HCPCS) to identify and track these outpatient therapy services paid under the Medicare Physician Fee Schedule (MPFS).

The list of therapy codes, along with their respective designation, can be found on the CMS Website, specifically at http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage. Two of the designations that are used for therapy services are: "always therapy" and "sometimes therapy." An "always therapy" service must be performed by a qualified therapist under a certified therapy plan of care, and a "sometimes therapy" service may be performed by *physician or a non-physician practitioner* outside of a certified therapy plan of care.

Under the OPPS, separate payment is provided for certain services designated as "sometimes therapy" services if these services are furnished to hospital outpatients as a non-therapy service, that is, without a certified therapy plan of care. Specifically, to be paid under the OPPS for a non-therapy service, hospitals SHOULD NOT append the therapy modifier GP (physical therapy), GO (occupational therapy), or GN (speech language pathology), or report a therapy revenue code 042x, 043x, or 044x in association with the "sometimes therapy" codes listed in the table below.

To receive payment under the MPFS, when "sometimes therapy" services are performed by a qualified therapist under a certified therapy plan of care, providers should append the appropriate therapy modifier GP, GO, or GN, and report the charges under an appropriate therapy revenue code, specifically 042x, 043x, or 044x. This instruction does not apply to claims for "sometimes therapy" codes furnished as *non*-therapy services in the hospital outpatient department and paid under the OPPS.

Effective January 1, 2015, two HCPCS codes designated as "Sometimes Therapy" services, G0456 (Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters) and G0457 (Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters) would be terminated and replaced with two new CPT codes 97607 (Negative pressure wound therapy, (eg, vacuum

assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters) and 97608 (Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters).

The list of HCPCS codes designated as "sometimes therapy" services that may be paid as non-therapy services when furnished to hospital outpatients is displayed in the table below.

Services Designated as "Sometimes Therapy" that May be Paid as Non-Therapy Services for Hospital Outpatients

HCPCS Code	Long Descriptor
92520	Laryngeal function studies (i.e., aerodynamic testing and acoustic testing)
97597	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters
97598	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area greater than 20 square centimeters
97602	Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (e.g., wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session
97605	Negative pressure wound therapy (e.g., vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters
97606	Negative pressure wound therapy (e.g., vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters
97607	*Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters*
97608	*Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters*
97610	Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day

Attachment A − Tables for the Policy Section

Table 1 – New Service Assigned for Payment under OPPS, Effective January 1, 2015

HCPCS	Effective date	SI	APC	Short Descriptor	Long descriptor	Payment	Minimum Unadjusted Copayment
C9742	01/01/2015	T	0073	Laryngoscopy with injection	Laryngoscopy, flexible fiberoptic, with injection into vocal cord(s), therapeutic, including diagnostic laryngoscopy, if performed	$1259.06	$251.82

Table 2 – New Device Pass-Through Code

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Device Offset from Payment
C2624	01/01/15	H	2624	Wireless pressure sensor	Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components	$310.33

Table 3 – Services Designated as "Sometimes Therapy" that May be Paid as Non-Therapy Services for Hospital Outpatients

HCPCS Code	Long Descriptor
92520	Laryngeal function studies (i.e., aerodynamic testing and acoustic testing)
97597	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square

HCPCS Code	Long Descriptor
	centimeters
97598	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area greater than 20 square centimeters
97602	Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (e.g., wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session
97605	Negative pressure wound therapy (e.g., vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters
97606	Negative pressure wound therapy (e.g., vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters
97607	Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters
97608	Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters
97610	Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day

Table 4—New HCPCS G-codes and their Predecessor CPT codes

CY 2014 CPT Code	CY 2014 CPT Long Descriptor	CY 2015 HCPCS G-code	CY 2015 HCPCS G-code Long Descriptor	CY 2015 OPPS SI
80102	Drug confirmation, each procedure	**G6058**	Drug confirmation, each procedure	N
80152	Amitriptyline	**G6030**	Amitriptyline	N
80154	Benzodiazepines	**G6031**	Benzodiazepines	N
80160	Desipramine	**G6032**	Desipramine	N
80166	Doxepin	**G6034**	Doxepin	N
80172	Gold	**G6035**	Gold	N

CY 2014 CPT Code	CY 2014 CPT Long Descriptor	CY 2015 HCPCS G-code	CY 2015 HCPCS G-code Long Descriptor	CY 2015 OPPS SI
80174	Imipramine	**G6036**	Imipramine	N
80182	Nortriptyline	**G6037**	Nortriptyline	N
80196	Salicylate	**G6038**	Salicylate	N
82003	Acetaminophen	**G6039**	Acetaminophen	N
82055	Alcohol (ethanol); any specimen except breath	**G6040**	Alcohol (ethanol); any specimen except breath	N
82101	Alkaloids, urine, quantitative	**G6041**	Alkaloids, urine, quantitative	N
82145	Amphetamine or methamphetamine	**G6042**	Amphetamine or methamphetamine	N
82205	Barbiturates, not elsewhere specified	**G6043**	Barbiturates, not elsewhere specified	N
82520	Cocaine or metabolite	**G6044**	Cocaine or metabolite	N
82646	Dihydrocodeinone	**G6045**	Dihydrocodeinone	N
82649	Dihydromorphinone	**G6046**	Dihydromorphinone	N
82651	Dihydrotestosterone (DHT)	**G6047**	Dihydrotestosterone (DHT)	N
82654	Dimethadione	**G6048**	Dimethadione	N
82666	Epiandrosterone	**G6049**	Epiandrosterone	N
82690	Ethchlorvynol	**G6050**	Ethchlorvynol	N
82742	Flurazepam	**G6051**	Flurazepam	N
83805	Meprobamate	**G6052**	Meprobamate	N
83840	Methadone	**G6053**	Methadone	N
83858	Methsuximide	**G6054**	Methsuximide	N
83887	Nicotine	**G6055**	Nicotine	N
83925	Opiate(s), drug and metabolites, each procedure	**G6056**	Opiate(s), drug and metabolites, each procedure	N
84022	Phenothiazine	**G6057**	Phenothiazine	N

Table 5 – New CY 2015 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2015 HCPCS Code	CY 2015 Long Descriptor	CY 2015 SI	CY 2015 APC
A9606	Radium ra-223 dichloride, therapeutic, per microcurie	K	1745
C9027	Injection, pembrolizumab, 1 mg	G	1490
C9136	Injection, factor viii, fc fusion protein, (recombinant), per i.u.	G	1656
C9349	FortaDerm, and FortaDerm Antimicrobial, any type, per square centimeter	G	1657
C9442	Injection, belinostat, 10 mg	G	1658
C9443	Injection, dalbavancin, 10 mg	G	1659
C9444	Injection, oritavancin, 10 mg	G	1660
C9446	Injection, tedizolid phosphate, 1 mg	G	1662
C9447	Injection, phenylephrine and ketorolac, 4 ml vial	G	1663
J0571	Buprenorphine, oral, 1 mg	E	
J0572	Buprenorphine/naloxone, oral, less than or equal to 3 mg	E	
J0573	Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg	E	
J0574	Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg	E	
J0575	Buprenorphine/naloxone, oral, greater than 10 mg	E	
J1826	Injection, interferon beta-1a, 30 mcg	E	
J2704	Injection, Propofol, 10mg	N	
J7182	Factor viii, (antihemophilic factor, recombinant), (novoeight), per iu	E	
J7301	Levonorgestrel-releasing intrauterine contraceptive system, 13.5mg	E	
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg	E	
J7327	Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose	K	1747
J8565	Gefitinib, oral, 250 mg	E	
Q4150	Allowrap dds or dry, per square centimeter	N	
Q4151	Amnioband or guardian, per square centimeter	N	
Q4152	Dermapure, per square centimeter	N	
Q4153	Dermavest, per square centimeter	N	
Q4154	Biovance, per square centimeter	N	
Q4155	Neoxflo or Clarixflo, 1 mg	N	
Q4156	Neox 100, per square centimeter	N	
Q4157	Revitalon, per square centimeter	N	
Q4158	Marigen, per square centimeter	N	
Q4159	Affinity, per square centimeter	N	
Q4160	Nushield, per square centimeter	N	

Table 6 – Other CY 2015 HCPCS and CPT Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2014 HCPCS /CPT code	CY 2014 Long Descriptor	CY 2015 HCPCS /CPT Code	CY 2015 Long Descriptor
J7195	Factor ix (antihemophilic factor, recombinant) per i.u.	J7195	Injection, Factor ix (antihemophilic factor, recombinant) per iu, not otherwise specified
J7301	Levonorgestrel-releasing intrauterine contraceptive system (Skyla), 13.5mg	J7301	Levonorgestrel-releasing intrauterine contraceptive system, 13.5mg
Q4119	Matristem wound matrix, psmx, rs, or psm,-per square centimeter	Q4119	Matristem wound matrix, per square centimeter
Q4147	Architect, extracellular matrix, per square centimeter	Q4147	Architect, architect px, or architect fx, extracellular matrix, per square centimeter
C9021	Injection, obinutuzumab, 10 mg	J9301	Injection, obinutuzumab, 10 mg
C9022	Injection, elosulfase alfa, 1mg	J1322	Injection, elosulfase alfa, 1mg
C9023	Injection, testosterone undecanoate, 1 mg	J3145	Injection, testosterone undecanoate, 1 mg
C9133	Factor ix (antihemophilic factor, recombinant), Rixubis, per i.u.	J7200	Injection, factor ix,(antihemophilic factor, recombinant), Rixubis, per i.u.
C9134	Factor XIII (antihemophilic factor, recombinant), Tretten, per i.u.	J7181	Injection, factor xiii a-subunit, (recombinant), per iu
C9135	Factor ix (antihemophilic factor, recombinant), Alprolix, per i.u.	J7201	Injection, factor ix, fc fusion protein (recombinant), per iu
J0150	Injection, adenosine for therapeutic use, 6 mg (not to be used to report any adenosine phosphate compounds, instead use a9270)	J0153	Injection, adenosine for therapeutic use, 6 mg (not to be used to report any adenosine phosphate compounds, instead use a9270)
J0151	Injection, adenosine for diagnostic use, 1 mg (not to be used to report any adenosine phosphate compounds, instead use a9270)	J0153	Injection, adenosine for diagnostic use, 1 mg (not to be used to report any adenosine phosphate compounds, instead use a9270)
J1070	Injection, testosterone cypionate, up to 100 mg	J1071	Injection, testosterone cypionate, 1mg
J1080	Injection, testosterone cypionate, 1 cc, 200 mg	J1071	Injection, testosterone cypionate, 1mg
J2271	Injection, morphine sulfate, 100mg	J2274	Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10mg
J2275	Injection, morphine sulfate	J2274	Injection, morphine sulfate,

CY 2014 HCPCS /CPT code	CY 2014 Long Descriptor	CY 2015 HCPCS /CPT Code	CY 2015 Long Descriptor
	(preservative-free sterile solution), per 10 mg		preservative-free for epidural or intrathecal use, 10mg
J3120	Injection, testosterone enanthate, up to 100 mg	J3121	Injection, testosterone enanthate, 1mg
J3130	Injection, testosterone enanthate, up to 200 mg	J3121	Injection, testosterone enanthate, 1mg
J7335	Capsaicin 8% patch, per 10 square centimeters	J7336	Capsaicin 8% patch, per square centimeter
J9265	Injection, paclitaxel, 30 mg	J9267	Injection, paclitaxel, 1 mg
Q9970	Injection, ferric carboxymaltose, 1mg	J1439	Injection, ferric carboxymaltose, 1 mg
Q9972	Injection, epoetin beta, 1 microgram, (For ESRD On Dialysis)	J0887	Injection, epoetin beta, 1 microgram, (for esrd on dialysis)
Q9973	Injection, Epoetin Beta, 1 microgram, (Non-ESRD use)	J0888	Injection, epoetin beta, 1 microgram, (for non esrd use)
Q9974	Injection, morphine sulfate (preservative-free sterile solution), per 10 mg	J2274	Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10mg
S0144	Injection, Propofol, 10mg	J2704	Injection, Propofol, 10mg

Table 7 – Skin Substitute Product Assignment to High Cost/Low Cost Status for CY 2015

CY 2015 HCPCS Code	CY 2015 Short Descriptor	CY 2015 SI	Low/High Cost Skin Substitute
C9349	Fortaderm, fortaderm antimic	G	High
C9358	SurgiMend, fetal	N	Low
C9360	SurgiMend, neonatal	N	Low
C9363	Integra Meshed Bil Wound Mat	N	High
Q4100	Skin substitute, NOS	N	Low
Q4101	Apligraf	N	High
Q4102	Oasis wound matrix	N	Low
Q4103	Oasis burn matrix	N	Low
Q4104	Integra BMWD	N	High
Q4105	Integra DRT	N	High

CY 2015 HCPCS Code	CY 2015 Short Descriptor	CY 2015 SI	Low/High Cost Skin Substitute
Q4106	Dermagraft	N	High
Q4107	Graftjacket	N	High
Q4108	Integra Matrix	N	High
Q4110	Primatrix	N	High
Q4111	Gammagraft	N	Low
Q4112	Cymetra injectable	N	N/A
Q4113	GraftJacket Xpress	N	N/A
Q4114	Integra Flowable Wound Matrix	N	N/A
Q4115	Alloskin	N	Low
Q4116	Alloderm	N	High
Q4117	Hyalomatrix	N	Low
Q4118	Matristem Micromatrix	N	N/A
Q4119	Matristem Wound Matrix	N	Low
Q4120	Matristem Burn Matrix	N	Low
Q4121	Theraskin	G	High
Q4122	Dermacell	G	High
Q4123	Alloskin	N	High
Q4124	Oasis Tri-layer Wound Matrix	N	Low
Q4125	Arthroflex	N	High
Q4126	Memoderm/derma/tranz/integup	N	High
Q4127	Talymed	G	High
Q4128	Flexhd/Allopatchhd/matrixhd	N	High
Q4129	Unite Biomatrix	N	High
Q4131	Epifix	N	High
Q4132	Grafix core	N	High
Q4133	Grafix prime	N	High
Q4134	HMatrix	N	High
Q4135	Mediskin	N	Low
Q4136	EZderm	N	Low
Q4137	Amnioexcel or Biodexcel, 1cm	N	High
Q4138	BioDfence DryFlex, 1cm	N	High
Q4139	Amniomatrix or Biodmatrix, 1cc	N	N/A
Q4140	Biodfence 1cm	N	High
Q4141	Alloskin ac, 1 cm	N	Low

CY 2015 HCPCS Code	CY 2015 Short Descriptor	CY 2015 SI	Low/High Cost Skin Substitute
Q4142	Xcm biologic tiss matrix 1cm	N	Low
Q4143	Repriza, 1cm	N	Low
Q4145	Epifix, 1mg	N	N/A
Q4146	Tensix, 1cm	N	Low
Q4147	Architect ecm px fx 1 sq cm	N	High
Q4148	Neox 1k, 1cm	N	High
Q4149	Excellagen, 0.1 cc	N	N/A
Q4150	Allowrap DS or Dry 1 sq cm	N	Low
Q4151	AmnioBand, Guardian 1 sq cm	N	Low
Q4152*	Dermapure 1 square cm	N	High
Q4153	Dermavest 1 square cm	N	Low
Q4154	Biovance 1 square cm	N	High
Q4155	NeoxFlo or ClarixFlo 1 mg	N	N/A
Q4156	Neox 100 1 square cm	N	High
Q4157	Revitalon 1 square cm	N	Low
Q4158	MariGen 1 square cm	N	Low
Q4159	Affinity 1 square cm	N	High
Q4160	NuShield 1 square cm	N	High

*HCPCS code Q4152 was assigned to the low cost group in the CY 2015 OPPS/ASC final rule with comment period. Upon submission of updated pricing information, Q4152 is assigned to the high cost group for CY 2015.

Table 8 – Wage Index by CBSA for Non-IPPS Hospitals that are Eligible for the Section 505 Out-Commuting Adjustment

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2015
012011	11500	YES	0.7393
013027	19300	YES	0.7385
014009	19460	YES	0.7112
014016	01	YES	0.7084
014017	19300	YES	0.7385
042007	38220	YES	0.8146
042011	04	YES	0.7558

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2015
052034	36084	YES	1.6501
053301	36084	YES	1.6501
054074	46700	YES	1.6278
054110	36084	YES	1.6501
054122	34900	YES	1.5887
054141	46700	YES	1.6278
054146	36084	YES	1.6501
062017	22660	YES	0.9454
064007	14500	YES	0.9721
074003	25540	YES	1.1908
074007	25540	YES	1.1908
082000	48864	YES	1.0552
083300	48864	YES	1.0552
084001	48864	YES	1.0552
084002	48864	YES	1.0552
084003	48864	YES	1.0552
102028	45540	YES	0.8808
114018	11	YES	0.7703
132001	17660	YES	0.9499
133027	17660	YES	0.9499
144037	20994	YES	1.0217
153040	15	YES	0.8447
154014	15	YES	0.8439
154035	15	YES	0.8373
154047	15	YES	0.8447
154058	15	YES	0.8447
183028	21060	YES	0.7910
184012	21060	YES	0.7910
192022	19	YES	0.7523
192026	43340	YES	0.8501
192034	19	YES	0.7587
192036	25220	YES	0.9526
192040	25220	YES	0.9526
192050	29180	YES	0.7902
193036	19	YES	0.7587
193044	25220	YES	0.9526
193047	29180	YES	0.7864
193049	29180	YES	0.7864

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2015
193055	19	YES	0.7607
193063	25220	YES	0.9526
193067	19	YES	0.7539
193068	25220	YES	0.9526
193069	19	YES	0.7537
193073	19	YES	0.7587
193079	25220	YES	0.9526
193081	29180	YES	0.7902
193088	29180	YES	0.7902
193091	29180	YES	0.7809
194047	43340	YES	0.8501
194074	19	YES	0.7523
194075	19	YES	0.7539
194077	19	YES	0.7523
194081	19	YES	0.7509
194082	19	YES	0.7539
194083	19	YES	0.7537
194085	29180	YES	0.7902
194087	19	YES	0.7523
194091	25220	YES	0.9526
194092	19	YES	0.7507
194095	19	YES	0.7587
194097	29180	YES	0.7902
194111	19	YES	0.7587
212002	25180	YES	0.9175
214001	12580	YES	0.9819
214003	25180	YES	0.9175
232019	19804	YES	0.9341
232025	35660	YES	0.8857
232027	19804	YES	0.9341
232028	12980	YES	0.9906
232031	19804	YES	0.9341
232032	19804	YES	0.9341
232035	12980	YES	0.9906
232036	27100	YES	0.9631
232038	19804	YES	0.9341
233025	12980	YES	0.9906
233027	19804	YES	0.9341

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2015
233300	19804	YES	0.9341
234028	19804	YES	0.9341
234034	19804	YES	0.9341
234035	19804	YES	0.9341
234038	19804	YES	0.9341
234040	19804	YES	0.9341
252011	25	YES	0.7959
264005	26	YES	0.8113
303026	40484	YES	1.1852
304001	40484	YES	1.1852
312018	35614	YES	1.3075
312020	35084	YES	1.1386
312024	35084	YES	1.1477
313025	35084	YES	1.1477
313027	45940	YES	1.1346
313300	35614	YES	1.3075
314010	35084	YES	1.1477
314011	35614	YES	1.3075
314013	45940	YES	1.1346
314016	35084	YES	1.1386
314018	15804	YES	1.1145
314020	35084	YES	1.1477
314025	45940	YES	1.1346
334017	35614	YES	1.3307
334049	10580	YES	0.8458
334061	35614	YES	1.3307
342019	34	YES	0.8132
344001	39580	YES	0.9013
344011	39580	YES	0.9013
344014	39580	YES	0.9013
344029	34	YES	0.8167
362016	15940	YES	0.8375
362032	15940	YES	0.8375
364031	15940	YES	0.8375
364040	44220	YES	0.8768
364042	36	YES	0.8388
364043	36	YES	0.8417
364047	36	YES	0.8417

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2015
372017	37	YES	0.7841
372019	37	YES	0.8118
373032	37	YES	0.7841
392031	27780	YES	0.8770
392034	10900	YES	0.9431
392040	29540	YES	0.9536
392048	33874	YES	1.0555
393025	33874	YES	1.0555
393026	39740	YES	0.8834
393032	33874	YES	1.0821
393037	49620	YES	0.9689
393050	10900	YES	1.1334
393052	33874	YES	1.0555
393054	29540	YES	0.9536
394001	33874	YES	1.0821
394006	33874	YES	1.0821
394014	39740	YES	0.8834
394020	30140	YES	0.9020
394031	33874	YES	1.0821
394033	33874	YES	1.0821
394034	33874	YES	1.0821
394049	33874	YES	1.0821
394052	39740	YES	0.8834
422004	43900	YES	0.8381
423029	24860	YES	0.9087
423031	43900	YES	0.8381
424011	24860	YES	0.9087
424013	42	YES	0.8352
424014	16740	YES	0.8957
442016	28700	YES	0.7363
443027	28700	YES	0.7363
444008	44	YES	0.7671
444019	17300	YES	0.8006
452018	23104	YES	0.9317
452019	23104	YES	0.9317
452028	23104	YES	0.9317
452088	23104	YES	0.9317
452099	23104	YES	0.9317

Provider	CBSA	Section 505 Out Commuting Adjustment	Final Wage Index for Calendar Year 2015
452110	23104	YES	0.9317
453040	23104	YES	0.9317
453041	23104	YES	0.9317
453042	23104	YES	0.9317
453089	45	YES	0.8019
453094	23104	YES	0.9317
453300	23104	YES	0.9317
454009	45	YES	0.8083
454012	23104	YES	0.9317
454101	45	YES	0.8086
454113	23104	YES	0.9317
454124	23104	YES	0.9317
462005	39340	YES	0.9336
464014	39340	YES	0.9336
522005	39540	YES	0.9715
523302	36780	YES	0.9532
524002	36780	YES	0.9532
524025	22540	YES	0.9123
673035	23104	YES	0.9317
673044	23104	YES	0.9317
673048	23104	YES	0.9317