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July 2017 Update of the Hospital Outpatient Prospective Payment System (OPPS)

MLN Matters Number: MM**10122**	Related Change Request (CR) Number: **10122**
Related CR Release Date: May 30, 2017	Effective Date: **July 1, 2017**
Related CR Transmittal Number: R3783CP	Implementation Date: **July 3, 2017**

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

This article is based on Change Request (CR) 10122 which describes changes to the OPPS to be implemented in the July 2017 update. Make sure your billing staffs are aware of these changes.

BACKGROUND

The July 2017 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 CR10115. The MLN Matters® Article related to CR10115 is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10115.pdf.

Key changes to and billing instructions for various payment policies implemented in the July 2017 Outpatient Prospective Payment System (OPPS) updates are as follows:

Category III CPT Codes Effective July 1, 2017

The American Medical Association (AMA) releases Category III Current Procedural Terminology (CPT) codes twice per year: in January, for implementation beginning the following July, and in July, for implementation beginning the following January.

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For the July 2017 update, the CMS is implementing 10 Category III CPT codes that the AMA released in January 2017 for implementation on July 1, 2017. The Status Indicators (SI) and APC assignments for these codes are shown below in Table 1. Payment rates for these services are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html.

Table 1 — Category III CPT Codes Effective July 1, 2017

CPT Code	Long Descriptor	July 2017 OPPS SI	July 2017 OPPS APC
0469T	Retinal polarization scan, ocular screening with on-site automated results, bilateral	E1	N/A
0470T	Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report; first lesion	M	N/A
0471T	Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report; each additional lesion (List separately in addition to code for primary procedure)	N	N/A
0472T	Device evaluation, interrogation, and initial programming of intra-ocular retinal electrode array (eg, retinal prosthesis), in person, with iterative adjustment of the implantable device to test functionality, select optimal permanent programmed values with analysis, including visual training, with review and report by a qualified health care professional	Q1	5743
0473T	Device evaluation and interrogation of intra-ocular retinal electrode array (eg, retinal prosthesis), in person, including reprogramming and visual training, when performed, with review and report by a qualified health care professional	Q1	5742

CPT Code	Long Descriptor	July 2017 OPPS SI	July 2017 OPPS APC
0474T*	Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space	J1	5492
0475T	Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording and storage, data scanning with signal extraction, technical analysis and result, as well as supervision, review, and interpretation of report by a physician or other qualified health care professional	M	N/A
0476T	Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording, data scanning, with raw electronic signal transfer of data and storage	Q1	5734
0477T	Recording of fetal magnetic cardiac signal using at least 3 channels; signal extraction, technical analysis, and result	Q1	5734
0478T	Recording of fetal magnetic cardiac signal using at least 3 channels; review, interpretation, report by physician or other qualified health care professional	M	N/A

***For the device offset amount associated with this CPT code, refer to the discussion on device offset.**

Proprietary Laboratory Analyses (PLA) CPT Codes Effective May 1, 2017

The AMA CPT Editorial Panel established two additional PLA CPT codes, specifically, CPT codes 0004U and 0005U effective May 1, 2017. The long descriptors for the codes are listed below in Table 2. Because the codes were effective May 1, 2017, they were not included in the April 2017 OPPS Update and are instead being including in the July Update with an effective date of May 1, 2017.

Under the hospital OPPS, CPT code 0004U is assigned to status indicator “A” and CPT code 0005U to status indicator “Q4” (Conditionally packaged laboratory tests). For more information

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on OPPS SI “A” and “Q4”, refer to OPPS Addendum D1 of the CY 2017 OPPS/ASC final rule for the latest definitions to the OPPS status indicators for CY 2017.

CPT codes 0004U and 0005U have been added to the July 2017 I/OCE with an effective date of May 1, 2017. These codes, along with their short descriptors and status indicators, are in the July 2017 Addendum B at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html.

Table 2 — Proprietary Laboratory Analyses (PLA) CPT Codes Effective May 1, 2017

CPT Code	Long Descriptor	OPPS SI
0004U	Infectious disease (bacterial), DNA, 27 resistance genes, PCR amplification and probe hybridization in microarray format (molecular detection and identification of AmpC, carbapenemase and ESBL coding genes), bacterial culture colonies, report of genes detected or not detected, per isolate	A
0005U	Oncology (prostate) gene expression profile by real-time RT-PCR of 3 genes (ERG, PCA3, and SPDEF), urine, algorithm reported as risk score	Q4

New Separately Payable Procedure Codes

Effective July 1, 2017, three new HCPCS codes, C9745, C9746, and C9747 have been created as described in the Table 3.

Table 3 — New Separately Payable Procedure Codes Effective July 1, 2017

HCPCS Code	Short Descriptor	Long Descriptor	July 2017 OPPS SI	July 2017 OPPS APC	July 2017 ASC PI
C9745	Nasal endo balloon dil	Nasal endoscopy, surgical; balloon dilation of eustachian tube	J1	5165	J8

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HCPCS Code	Short Descriptor	Long Descriptor	July 2017 OPPS SI	July 2017 OPPS APC	July 2017 ASC PI
C9746	Trans imp balloon cont	Transperineal implantation of permanent adjustable balloon continence device, with cystourethroscopy, when performed and/or fluoroscopy, when performed	J1	5377	J8
C9747	Ablation, HIFU, prostate	Ablation of prostate, transrectal, high intensity focused ultrasound (HIFU)	J1	5376	J8

New Procedures Requiring the Insertion of a Device

As described in the CY 2017 OPPS/ASC final rule with comment period, effective January 1, 2017, all new procedures requiring the insertion of an implantable medical device will generally be assigned a default device offset percentage of 41 percent and assigned device intensive status, until claims data become available. In certain rare instances, CMS may temporarily assign a higher offset percentage if warranted by additional information. In accordance with this policy, the following new code(s) requiring the insertion of a device (listed Table 4) will be assigned device intensive status.

Table 4 — New Device Intensive Procedures Effective July 1, 2017

HCPCS Code	Long Descriptor	Effective Date	July 2017 OPPS SI	July 2017 OPPS APC	CY 2017 OPPS Payment Rate	CY 2017 Device Offset
0474T	Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space	7-01-2017	J1	5492	$3,418.76	$1,401.69

HCPCS Code	Long Descriptor	Effective Date	July 2017 OPPS SI	July 2017 OPPS APC	CY 2017 OPPS Payment Rate	CY 2017 Device Offset
C9745	Nasal endoscopy, surgical; balloon dilation of eustachian tube	7-01-2017	J1	5165	$4,130.94	$1,693.69
C9746	Transperineal implantation of permanent adjustable balloon continence device, with cystourethroscopy, when performed and/or fluoroscopy, when performed	7-01-2017	J1	5377	$14,363.61	$5,889.08

New HCPCS Code for Pathogen Testing for Blood Platelets

For the July 2017 update, the HCPCS Workgroup inactivated HCPCS P9072 for Medicare reporting and replaced the code with two new HCPCS codes effective July 1, 2017. Specifically, to report either of the services described by HCPCS P9072 based on the code descriptor in effect for January 1, 2017 – June 30, 2017, providers must instead report either HCPCS code Q9988 (Platelets, pathogen reduced, each unit) or Q9987 (Pathogen(s) test for platelets) effective July 1, 2017. CMS notes that HCPCS code Q9987 should be reported to describe the test used for the detection of bacterial contamination in platelets as well as any other test that may be used to detect pathogen contamination. The coding changes associated with these codes are available at https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update.html effective July 2017. The payment rates for HCPCS codes Q9987 and Q9988 are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html. Also, see Table 5 below.

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Table 5 – Blood Platelet Coding Changes Effective July 1, 2017

HCPCS Code	Short Descriptor	Long Descriptor	July 2017 OPPS SI	July 2017 OPPS APC
P9072	Plate path red/rapid bac tes	Platelets, pheresis, pathogen reduced or rapid bacterial tested, each unit	E1	N/A
Q9987	Pathogen test for platelets	Pathogen(s) test for platelets	S	1493
Q9988	Platelets, pathogen reduced	Platelets, pathogen reduced, each unit	R	9536

Drugs, Biologicals, and Radiopharmaceuticals

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective July 1, 2017

For CY 2017, payment for non-pass-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 2017, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective July 1, 2017 are available at http://www.cms.gov/HospitalOutpatientPPS/.

b. 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 at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html on the first date of the quarter. Providers may resubmit claims that were impacted by adjustments to previous quarter's payment files.

c. Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2017

Two drugs and biologicals have been granted OPPS pass-through status effective July 1, 2017. These items, along with their descriptors and APC assignments, are in Table 6 below.

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Table 6 — Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2017

HCPCS Code	Long Descriptor	APC	Status Indicator
C9489	Injection, nusinersen, 0.1 mg	9489	G
C9490	Injection, bezlotoxumab, 10 mg	9490	G

d. New Drug HCPCS Codes Effective July 1, 2017

Effective July 1, 2017, three 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 7.

Table 7 — New Drug HCPCS Codes Effective July 1, 2017

HCPCS Code	Long Descriptor	Status Indicator	APC
Q9984	Levonorgestrel-releasing intrauterine contraceptive system (Kyleena), 19.5 mg	E1	N/A
Q9985	Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg	N	N/A
Q9986	Injection, hydroxyprogesterone caproate (Makena), 10 mg	K	9074

e. Changes to Status Indicator for CPT Code 90682

The influenza vaccine associated with CPT code 90682 (Influenza virus vaccine, quadrivalent (riv4), derived from recombinant DNA, hemagglutinin (ha) protein only, preservative and antibiotic free, for intramuscular use) is approved for use in the 2017-2018 flu season. (This is per CR9876; see related MLN Matters Article MM9876 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9876.pdf.) CPT code 90682 was added to the January 2017 I/OCE with an effective date of January 1, 2017 and assigned status indicator "L" (Not paid under OPPS. Paid at reasonable cost; not subject to deductible or coinsurance). Because this code is not payable until the start of the 2017 flu season, the status indicator will be retroactively corrected from SI=L to SI=E1 (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type]) effective January 1, 2017, through June 30, 2017. Effective July 1, 2017, CPT code 90682 is assigned SI=L. Table 8, below, describes the status indicator change and effective date.

Table 8 — Changes to Status Indicator for HCPCS Code 90682

CPT Code	Long Descriptor	Status Indicator	Effective Date
90682	(Influenza virus vaccine, quadrivalent (riv4), derived from recombinant dna, hemagglutinin (ha) protein only, preservative and antibiotic free, for intramuscular use)	E1	January 1, 2017 – June 30, 2017
90682	(Influenza virus vaccine, quadrivalent (riv4), derived from recombinant dna, hemagglutinin (ha) protein only, preservative and antibiotic free, for intramuscular use)	L	July 1, 2017

f. Revised Status Indicator for HCPCS Code J1725

For the July 2017 update, the HCPCS Workgroup inactivated HCPCS code J1725 for Medicare reporting and replaced it with HCPCS code Q9986. Therefore, effective July 1, 2017, the status indicator for HCPCS code J1725 (Injection, hydroxyprogesterone caproate, 1 mg) will change from SI=K (Paid under OPPS; separate APC payment) to SI=E1 (Not paid by Medicare when submitted on outpatient claims [any outpatient bill type]). Table 9, below, describes the status indicator change and effective date for HCPCS code J1725. The payment rates for HCPCS codes Q9986 are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html.

Table 9 — Revised Status Indicator for HCPCS Code J1725

HCPCS	Long Descriptor	Status Indicator	Effective Date	Termination Date
J1725	Injection, hydroxyprogesterone caproate, 1 mg	K	01/01/2012	06/30/2017
J1725	Injection, hydroxyprogesterone caproate, 1 mg	E1	07/01/2017	

g. Other Changes to CY 2017 HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals

Effective July 1, 2017, HCPCS code Q9989 (Ustekinumab, for Intravenous Injection, 1 mg) will replace HCPCS code C9487 (Ustekinumab, for Intravenous Injection, 1 mg). The status

indicator will remain G, “Pass-Through Drugs and Biologicals”. Table 10 describes the HCPCS code change and effective date.

Table 10 — Other Changes to CY 2017 HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals Effective July 1, 2017

HCPCS Code	Long Descriptor	Status Indicator	APC	Effective Date	Termination Date
C9487	Ustekinumab, for Intravenous Injection, 1 mg	G	9487	04/01/2017	06/30/2017
Q9989	Ustekinumab, for Intravenous Injection, 1 mg	G	9487	07/01/2017	

Application of Co-insurance and Deductible for HCPCS Code G0404

For CY 2017 HCPCS code G0404 (Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the Initial Preventive Physical Examination (IPPE)) was inadvertently assigned a waiver of coinsurance and deductible. Beginning July 1, 2017, CMS will apply coinsurance and deductible to HCPCS code G0404. This change will be retroactive back to January 1, 2017.

Changes to OPPS Pricer Logic

a. Effective January 1, 2017, for outliers for Community Mental Health Centers (CMHCs) (bill type 76x), updated logic to cap CMHC claims' outlier payments at 8% of payments based on the current claim’s OPPS Pricer calculations.

b. Effective January 1, 2017, added Payment Method Flag (PMF) ‘9’ to valid list to bypass the outlier cap logic.

c. Effective for CY’s 2016 and 2017, changed the location of the device credit selection logic to ensure that providers with a special payment indicator of ‘1’ or ‘2’ in the Outpatient Provider Specific File receive the device credit.

d. Effective July 1, 2017, added line item Denial/Rejection (D/R) Flag ‘3’ to valid list for FISS informational use.

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.

ADDITIONAL INFORMATION

The official instruction, CR10122, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3783CP.pdf.

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

DOCUMENT HISTORY

Date of Change	Description
May 30, 2017	Initial Article Released

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