DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

REVISED product from the Medicare Learning Network® (MLN)

- "Swing Bed Services", Fact sheet (ICN 006951)

MLN Matters® Number: MM8873 Revised **Related Change Request (CR) #: CR 8873**

Related CR Release Date: September 26, 2014 **Effective Date:** October 1, 2014

Related CR Transmittal #: R3080CP **Implementation Date:** October 6, 2014

October 2014 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Note: This article was revised on September 30, 2014, to reflect the revised CR8873 issued on September 26. In the article, the long descriptor for HCPCS code C9135 in Table 2 is revised and the APC code for HCPCS code J9171 in Table 7 has been revised. The CR release date, transmittal number, and the Web address for accessing the CR are also changed. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice (HH&H) MACs for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8873 describes changes to and billing instructions for various payment policies implemented in the October 2014 hospital Outpatient Prospective Payment System (OPPS) update. Make sure your billing staff are aware of these changes.

Background

The October 2014 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, Status Indicator (SI), and Revenue Code additions, changes, and deletions identified in CR8873.

The October 2014 revisions to I/OCE data files, instructions, and specifications are provided in the October 2014 I/OCE (CR8879). The MLN Matters® Article related to CR8879 will be available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8879.pdf** as soon as that CR is released.

Key changes to and billing instructions for various payment policies implemented in the October 2014 OPPS update are as follows:

Changes to Device Edits for October 2014

The most current list of device edits can be found under "Device and Procedure Edits" at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/** on the CMS website. Failure to pass these edits will result in the claim being returned to the provider.

New Services

The new service in Table 1 is assigned for payment under the OPPS, effective October 1, 2014.

Table 1 – New Service Effective October 1, 2014

HCPCS	Effective date	SI	APC	Short Descriptor	Long Descriptor	Payment	Minimum Unadjusted Copayment
C9741	10/01/2014	T	0319	Impl pressure sensor w/angio	Right heart catheterization with implantation of wireless pressure sensor in the pulmonary artery, including any type of measurement, angiography, imaging supervision, interpretation, and report, includes provision of patient home electronics unit	$15,509.99	$3,102.00

Billing for Drugs, Biologicals, and Radiopharmaceuticals

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective October 1, 2014

In the Calendar Year (CY) 2014 OPPS/ASC final rule with comment period, the Centers for Medicare & Medicaid Services (CMS) stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the October 2014 release of the OPPS Pricer. The updated payment rates, effective October 1, 2014 will be included in the October 2014 update of the OPPS Addendum A and Addendum B, which will be posted at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html** on the CMS website.

b. Drugs and Biologicals with OPPS Pass-Through Status Effective October 1, 2014

Four drugs and biologicals have been granted OPPS pass-through status effective October 1, 2014. These items, along with their descriptors and APC assignments, are identified in Table 2.

Table 2 – Drugs and Biologicals with OPPS Pass-Through Status Effective October 1, 2014

HCPCS Code	Long Descriptor	APC	Status Indicator
C9023	Injection, testosterone undecanoate, 1 mg	1487	G
C9025	Injection, ramucirumab, 5 mg	1488	G
C9026	Injection, vedolizumab, 1 mg	1489	G
C9135	Factor ix (antihemophilic factor, recombinant), Alprolix, per i.u.	1486	G

c. New HCPCS Codes Effective October 1, 2014 for Certain Drugs and Biologicals

Two new HCPCS codes have been created for reporting certain drugs and biologicals (other than new pass-through drugs and biological listed in Table 2) in the hospital outpatient setting for October 1, 2014. These codes are listed in Table 3, and are effective for services furnished on or after October 1, 2014.

Table 3 – New HCPCS Codes for Certain Drugs and Biologicals Effective October 1, 2014

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 10/1/14
Q9972	Injection, Epoetin Beta, 1 microgram, (For ESRD On Dialysis)	N/A	E
Q9973	Injection, Epoetin Beta, 1 microgram, (Non-ESRD use)	N/A	E

d. Revised Status Indicator for HCPCS Codes J9160 and J9300

Effective October 1, 2014, the status indicator for HCPCS codes J9160 (Injection, denileukin diftitox, 300 micrograms) and J9300 (Injection, gemtuzumab ozogamicin, 5 mg) will change from SI=K (Paid under OPPS; separate APC payment) to SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)). Table 4 includes the drugs and biologicals with revised Status Indicators.

Table 4 – Drugs and Biologicals with Revised Status Indicators

HCPCS Code	Long Descriptor	APC	Status Indicator	Effective Date
J9160	Injection, denileukin diftitox, 300 micrograms	N/A	E	10/1/2014
J9300	Injection, gemtuzumab ozogamicin, 5 mg	N/A	E	10/1/2014

e. Reassignment of One Skin Substitute Product that was New for CY 2014 from the Low Cost Group to the High Cost Group

In the CY 2014 OPPS/ASC final rule, CMS finalized a policy to package payment for skin substitute products into the associated skin substitute application procedure. For packaging purposes, CMS created two groups of application procedures: application procedures that use high cost skin substitute products (billed using CPT codes 15271-15278) and application procedures that use low cost skin substitute products (billed using HCPCS codes C5271-C5278).

Assignment of skin substitute products to the high cost or low cost groups depended upon a comparison of the July 2013 payment rate for the skin substitute product to $32, which is the weighted average payment per unit for all skin substitute products using the skin substitute utilization from the CY 2012 claims data and the July 2013 payment rate for each product. Skin substitute products with a July 2013 payment rate that was above $32 per square centimeter are paid through the high cost group and those with a July 2013 payment rate that was at or below $32 per square centimeter are paid through the low cost group for CY 2014.

CMS also finalized a policy that for any new skin substitute products approved for payment during CY 2014, and CMS will use the $32 per square centimeter threshold to determine mapping to the high or low cost skin substitute group. Any new skin substitute products without pricing information were assigned to the low cost category until pricing information becomes available. There is now pricing information available for three of the new skin substitute products. Table 5 shows the new products and the low/high cost status based on the comparison of the price per square centimeter for the products to the $32 square centimeter threshold for CY 2014.

Table 5 – Revised Low/High Cost Status for Certain Skin Substitute Codes

HCPCS Code	Long Descriptor	Status Indicator	Low/High Cost Status	Effective Date
Q4137	Amnioexcel or Biodexcel, Per Square Centimeter	N	High	07/01/2014
Q4138	BioDfence DryFlex, Per Square Centimeter	N	High	10/01/2014
Q4140	BioDfence, Per Square Centimeter	N	High	10/01/2014

f. Updated Payment Rate for HCPCS Code J9171, Effective January 1, 2014, through March 31, 2014

The payment rate for HCPCS code J9171 was incorrect in the January 2014 OPPS Pricer. The corrected payment rate is listed in Table 6, and has been installed in the October 2014 OPPS Pricer, effective for services furnished on January 1, 2014, through March 31, 2014. Your MAC will not automatically adjust claims already processed with the incorrect rate, but they will adjust such claims that you bring to the MAC's attention.

Table 6 – Updated Payment Rate for HCPCS Code J9171, Effective January 1, 2014, through March 31, 2014

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J9171	K	0823	Docetaxel injection	$4.63	$0.93

g. Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2014 through June 30, 2014

The payment rate for three HCPCS codes were incorrect in the April 2014 OPPS Pricer. The corrected payment rates are listed in Table 7, and have been installed in the October 2014 OPPS Pricer, effective for services furnished on April 1, 2014 through June 30, 2014. Your MAC will not automatically adjust claims already processed with the incorrect rates, but they will adjust such claims that you bring to the MAC's attention.

Table 7 – Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2014 through June 30, 2014

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J7335	K	9268	Capsaicin 8% patch	$25.49	$5.10

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J8700	K	1086	Temozolomide	$6.94	$1.39
J9171	K	0823	Docetaxel injection	$4.35	$0.87

h. Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2014 through September 30, 2014

The payment rate for two HCPCS codes were incorrect in the July 2014 OPPS Pricer. The corrected payment rates are listed in Table 8, and have been installed in the October 2014 OPPS Pricer, effective for services furnished on July 1, 2014, through September 30, 2014. Your MAC will not automatically adjust claims already processed with the incorrect rate, but they will adjust such claims that you bring to the MAC's attention.

Table 8 – Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2014, through September 30, 2014

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J9047	G	9295	Injection, carfilzomib, 1 mg	$29.67	$5.93
J9315	K	9265	Romidepsin injection	$270.24	$54.05

Incorrect National Unadjusted Copayment for APC 0066 (Level I Stereotactic Radiosurgery) in the CY 2014 OPPS Final Rule

CMS incorrectly calculated the National Unadjusted Copayment for APC 0066 (Level I Stereotactic Radiosurgery) in the CY 2014 OPPS final rule. The National Unadjusted Copayment for APC 0066 was set to an explicit value, but it should have been set to the Minimum Unadjusted Copayment equivalent to a coinsurance percentage of 20 percent. CMS corrected this error in the July 2014 Pricer, and CMS is making the change for the copayment associated with APC 0066 retroactive to January 1, 2014. The correct copayment is included in the July 2014 update of the OPPS Addendum A and Addendum B at **https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html** on the CMS website.

Providers should refer to the recent edition of the MLN Connects Provider eNews which instructs

1. contractors to reprocess claims, and
2. providers to reimburse beneficiaries for any overpayment of beneficiary copayment created by correcting the National Unadjusted Copayment associated with APC 0066.

You can subscribe to MLN Connects Provider eNews at **http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/index.html** on the CMS website, and you can find archived copies of the MLN Connects Provider eNews at **http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive.html** on the CMS website.

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. 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, CR8873 issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3080CP.pdf** on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.