DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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MLN Matters® Number: MM9014 | **Related Change Request (CR) #: CR 9014**

Related CR Release Date: December 22, 2014 | **Effective Date:** January 1, 2015

Related CR Transmittal #: R3156CP | **Implementation Date:** January 5, 2015

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

Note: This article was revised on December 23, 2014, based on a revised Change Request (CR) that corrected some values in Table 8, which addressed changes to the Outpatient Provider Specific File. That Table is in Attachment A of the CR, but was not included in this article. The CR Release Date, transmittal number and link to the CR was 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) for services provided to Medicare beneficiaries and paid under the Outpatient Prospective Payment System (OPPS).

Provider Action Needed

Change Request (CR) 9014 describes changes to and billing instructions for various payment policies implemented in the January 2015 OPPS update. Make sure your billing staffs are aware of these changes.

Background

CR9014 describes changes to and billing instructions for various payment policies implemented in the January 2015 Outpatient Prospective Payment System (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, Status Indicators (SIs)and Revenue Code additions, changes, and deletions identified in CR 9014.

The January 2015 revisions to I/OCE data files, instructions, and specifications are provided in CR9005. The MLN Matters® Article related to CR9005 is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9005.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

Key changes to and billing instructions for various payment policies implemented in the January 2015, OPPS update are as follows:

New Service

The new service listed in Table 1 is assigned for payment under the OPPS, effective January 1, 2015.

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

New Device Pass-Through Categories

The Social Security Act (Section 1833(t)(6)(B); see **http://www.ssa.gov/OP_Home/ssact/title18/1833.htm**) 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 Social Security Act (the Act) requires that CMS create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

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

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

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

CMS has 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, CMS is establishing the offset amount for C2624 to be that of APC 0080, $310.33, which will be deducted from pass-through payment.

Comprehensive APCs

For CY 2015, CMS is creating a new category of codes, called “Comprehensive APCs,” for which CMS provides **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.

CMS is updating the "Medicare Claims Processing Manual," (Chapter 4,, by adding Section 10.2.3 and revising Section 10.4 to reflect comprehensive APC payment policies. The added Section 10.2.3 (Comprehensive APCs) and revised Section 10.4 (Packaging) are included in CR9014. The added Section 10.2.3 states the following:

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); and
- 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; and
- 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 modifier -73 or -74).

Billing for Corneal Tissue

CMS reminds hospitals that according to the "Medicare Claims Processing Manual" (Chapter 4, Section 200.1 at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf**), 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.

Billing for Mobile Cardiac Telemetry Monitoring Services

Current Procedural Terminology (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).

CMS expects 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 at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html** on the CMS website.

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

The Social Security Act (Section 1834(k); see **http://www.ssa.gov/OP_Home/ssact/title18/1834.htm**, as added by Section 4541 of the Balanced Budget Act (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 at **http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage** on the CMS website. 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 Table 3 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, (for example, 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, (for example, 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 Table 3.

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 (for example, 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 (for example,, 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 (for example,, 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 (for example,, 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 (for example,, 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, (for example, 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, (for example, 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

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 are in Table 4.

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

CY 2014 CPT Code	CY 2014 CPT Long Descriptor	CY 2015 HCPCS 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
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

CY 2014 CPT Code	CY 2014 CPT Long Descriptor	CY 2015 HCPCS code	CY 2015 HCPCS G-code Long Descriptor	CY 2015 OPPS SI
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

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 “National Correct Coding Initiative (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 the“ Medicare Claims Processing Manual” (Chapter 17, Section 90.2; see **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf**), 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 ; **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf** on the CMS website) 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.

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.

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	

CY 2015 HCPCS Code	CY 2015 Long Descriptor	CY 2015 SI	CY 2015 APC
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	

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 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 below notes those drugs, biologicals, and radiopharmaceuticals that have 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.

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**	Factor ix (antihemophilic factor, recombinant), Rixubis, per i.u.
C9134	Factor XIII (antihemophilic factor, recombinant), Tretten, per i.u.	**J7181**	Factor XIII (antihemophilic factor, recombinant), Tretten, per i.u.
C9135	Factor ix (antihemophilic factor, recombinant), Alprolix, per i.u.	**J7201**	Factor ix (antihemophilic factor, recombinant), Alprolix, per i.u.
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 (preservative-free sterile solution), per 10 mg	**J2274**	Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10mg

CY 2014 HCPCS/ CPT code	CY 2014 Long Descriptor	CY 2015 HCPCS/ CPT Code	CY 2015 Long Descriptor
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

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 at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html** on the CMS website.

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 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.

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
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

CY 2015 HCPCS Code	CY 2015 Short Descriptor	CY 2015 SI	Low/High Cost Skin Substitute
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
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

CY 2015 HCPCS Code	CY 2015 Short Descriptor	CY 2015 SI	Low/High Cost Skin Substitute
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.

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 first date of the quarter at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html?redirect=/HospitalOutpatientPPS/01_overview.asp** on the CMS website. Providers may resubmit claims that were impacted by adjustments to previous quarter's payment files.

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 Social Security 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, one device is eligible for pass-through payment in the OPPS Pricer logic. Category C1841 (Retinal prosthesis, includes all internal and external components), 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 0672, Level III, Posterior segment eye procedures. For outlier purposes, when C1841 is billed with CPT code 0100T, assigned to APC 0672, 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 radiopharmaceutical 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 website.

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-Inpatient Prospective Payment System (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.

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, CR 9014 issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3156CP.pdf** on the CMS website.

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

Seasonal Flu Vaccinations - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information on coverage and billing of the influenza vaccine and its administration, please visit MLN Matters® Article #MM8890, "Influenza Vaccine Payment Allowances - Annual Update for 2014-2015 Season" and MLN Matters® Article #SE1431, "2014-2015 Influenza (Flu) Resources for Health Care Professionals."

While some providers may offer flu vaccines, those that don't can help their patients locate flu vaccines within their local community. The HealthMap Vaccine Finder is a free online service where users can search for locations offering flu and other adult vaccines. If you provide vaccination services and would like to be included in the HealthMap Vaccine Finder database, register for an account to submit your information in the database. Also, visit the CDC Influenza (Flu) web page for the latest information on flu including the CDC 2014-2015 recommendations for the prevention and control of influenza.