CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4255	**Date: March 15, 2019**
	Change Request 11216

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

I. SUMMARY OF CHANGES: This recurring update notification describes changes to, and billing instructions for, various payment policies implemented in the April 2019 OPPS update. The April 2019 Integrated Outpatient Code Editor (I/OCE) will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this Change Request (CR). This recurring update notification applies to chapter 4, sections 10.2.3 and 20.6.18.

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

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

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	4/10.2.3/Comprehensive APCs
R	4/20.6.18/Use of HCPCS Modifier - ER

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

IV. ATTACHMENTS:

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 4255	Date: March 15, 2019	Change Request: 11216

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

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

I. GENERAL INFORMATION

A. Background: This recurring update notification describes changes to, and billing instructions for, various payment policies implemented in the April 2019 OPPS update. The April 2019 Integrated Outpatient Code Editor (I/OCE) will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this Change Request (CR). This recurring update notification applies to chapter 4, sections 10.2.3 and 20.6.18.

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

B. Policy: 1. Proprietary Laboratory Analyses (PLA) CPT Coding Changes Effective January 1, 2019

The American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel established four new PLA CPT codes, specifically, CPT codes 0080U through 0083U effective January 1, 2019. Because the codes were released on November 30, 2018, they were too late to include in the January 2019 OPPS update and are instead being included in the April 2019 update with an effective date of January 1, 2019.

Table 1, attachment A, lists the long descriptors and status indicators for CPT codes 0080U through 0083U. For more information on OPPS status indicators “A” and “Q4”, refer to OPPS Addendum D1 of the Calendar Year (CY) 2019 OPPS/ASC (Ambulatory Surgery Center) final rule for the latest definitions. CPT codes 0080U through 0083U have been added to the April 2019 I/OCE with an effective date of January 1, 2019. These codes, along with their short descriptors and status indicators, are also listed in the April 2019 OPPS Addendum B.

2. New Advanced Diagnostic Laboratory Test (ADLT) Under the Clinical Lab Fee Schedule (CLFS)

On December 21, 2018, effective January 1, 2019, the laboratory test described by CPT code 81538 (Oncology (lung), mass spectrometric 8-protein signature, including amyloid a, utilizing serum, prognostic and predictive algorithm reported as good versus poor overall survival), was approved as an ADLT. Based on the ADLT designation, we revised the OPPS status indicator for CPT code 81538 from "Q4" to "A" effective January 1, 2019. However, because the code's ADLT designation was made in December 2018, it was too late to include this change the January 2019 OPPS update, therefore, we are including this change in the April 2019 update with an effective date of January 1, 2019. The latest list of ADLT codes can be found on this CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/List-of-Approved-ADLTs.pdf

For more information on the OPPS status indicators “A” and “Q4”, refer to OPPS Addendum D1 of the CY 2019 OPPS/ASC final rule for the latest definitions. CPT code 81538 has been added to the April 2019 I/OCE with an effective date of January 1, 2019. CPT code 81538, along with its short descriptor and status

indicator, is also listed in the April 2019 OPPS Addendum B.

3. The Comprehensive APC (C-APC) Exclusion List

The Comprehensive APC (C-APC) exclusion list in section 10.2.3 of chapter 4, Medicare Claims Processing Manual, has been updated to match the list provided in Addendum J of the CY 2019 OPPS/ASC Final Rule. The additions to the list included brachytherapy sources, self-administered drugs, services assigned to status indicators F and L, certain part B inpatient services, and therapy services.

4. Drugs, Biologicals, and Radiopharmaceuticals

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

For CY 2019, seven 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 2, attachment A.

b. Separately Payable Drugs and Biologicals that Will Receive Pass-Through Status (Status Indicator "G") Effective April 1, 2019

Some separately payable drugs and biologicals will change from status indicator "K" to status indicator "G" effective April 1, 2019 as these drugs and biologicals have been given pass-through status. These drugs and biologicals are reported in Table 3, attachment A.

c. Drugs and Biologicals with Payments Based on Average Sales Price (ASP)

For CY 2019, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals that were not acquired through the 340B Program is made at a single rate of ASP + 6 percent (or ASP - 22.5 percent if acquired under the 340B Program), which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2019, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available.

Effective April 1, 2019, payment rates for some drugs and biologicals have changed from the values published in the January 2019 update of the OPPS Addendum A and Addendum B found on the CMS website. CMS is not publishing the updated payment rates in this CR implementing the April 2019 update of the OPPS. However, the updated payment rates effective April 1, 2019 can be found in the April 2019 update of the OPPS Addendum A and Addendum B on the CMS website at http://www.cms.gov/HospitalOutpatientPPS/.

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

Some drugs and biologicals based on ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the CMS website on the first date of the quarter at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html. Providers may resubmit claims that were impacted by adjustments to previous quarter's payment files.

5. Reassignment of Skin Substitute Products from the Low Cost Group to the High Cost Group

Four skin substitute products, HCPCS codes Q4183, Q4184, Q4194, and Q4203 have been reassigned from the low cost skin substitute group to the high cost skin substitute group based on updated pricing information. The products are listed in Table 4, attachment A.

6. Chimeric Antigen Receptor (CAR) T- Cell Therapy

(CAR) T-cell therapy is a cell-based gene therapy in which T-cells are collected and genetically engineered to express a chimeric antigen receptor that will bind to a certain protein on a patient's cancerous cells. The CAR T-cells are then administered to the patient to attack certain cancerous cells and the individual is observed for potential serious side effects that would require medical intervention.

As stated in the CY 2019 OPPS/ASC final rule, CMS is continuing OPPS pass-through payment status for CAR T HCPCS codes Q2041 (Yescarta) and Q2042 (Kymriah) (see long descriptors in Table 5, Attachment A). The OPPS pass-through payment rate is determined following the standard ASP methodology, updated on a quarterly basis if applicable information indicates that adjustments to the payment rates are necessary.

As shown in Table 5, the HCPCS Q-code for each currently approved CAR T-cell therapy includes leukapheresis and dose preparation procedures. The procedures described by CPT codes 0537T, 0538T, and 0539T describe various steps required to collect and prepare the genetically modified T-cells, and Medicare does not generally pay separately for each step used to manufacture a drug or biological. Therefore, in the CY 2019 OPPS/ASC final rule, CPT codes 0537T, 0538T, and 0539T were assigned to status indicator "B" (Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x). However, as noted in the OPPS final rule, it will be possible for Medicare to track utilization and cost data from hospitals reporting these services, even for HCPCS codes reported for services in which no separate payment is made under the OPPS. The CAR T-cell related revenue codes and value code established by the National Uniform Billing Committee (NUBC) will be reportable on Hospital Outpatient Department (HOPD) claims, and will be available for tracking utilization and cost data, effective for claims received on or after April 1, 2019.

Accordingly, effective April 1, 2019, hospitals may report CPT codes 0537T, 0538T, and 0539T, as non-covered items/services to allow for Medicare to track these services when furnished in the outpatient setting. In addition, hospitals may report the CAR T-cell related revenue codes 087X (Cell/Gene Therapy) and 089X (Pharmacy) as well as new value code 86 (Invoice Cost) established by the NUBC will be reportable on HOPD claims.

Hospitals are reminded that the administration of CAR T-cells in the hospital outpatient setting is paid separately under CPT code 0540T, which is assigned status indicator "S".

Below is further clarification on billing of CAR-T related items and services should be reported in various clinical scenarios.

- **Scenario 1: CAR-T Dosing and Preparation Services and Viable T-cells Administered in Hospital Outpatient Setting**: In those instances when the CAR-T drug is administered in the hospital outpatient setting, report CPT code 0540T for the administration and HCPCS Q-code Q2041 or Q2042 for the drug/biological. As stated in the CY 2019 OPPS/ASC final rule, the procedures described by CPT codes 0537T (collection/handling), 0538T (preparation for transport), and 0539T (receipt and preparation) represent the various steps required to collect the cells and prepare the genetically modified T-cells are not separately payable. However, these services may be reported as non-covered charges on the outpatient claim.

- **Scenario 2: CAR-T Dosing and Preparation Services Administered in Hospital Outpatient Setting, but Viable T-cells not Administered:** In those instances when the CAR-T drug is not ultimately administered to the patient, but the CAR-T preparation services are initiated or performed in the HOPD facility, hospital outpatient departments may report CPT codes 0537T, 0538T, and

0539T (as appropriate) and the charges associated with each code under the appropriate revenue code on the HOPD claim as non-covered charges.

- **Scenario 3: CAR-T Dosing and Preparation Services Administered in Hospital Outpatient Setting, but Viable T-cells Administered in the Hospital Inpatient Setting:** When CAR T-cell preparation services are initiated and furnished in the hospital outpatient setting, but the CAR T-cells are administered in the inpatient setting following inpatient admission to the hospital more than 3-days after the related outpatient services are furnished , the hospital may not report the drug Q-code (which only applies when the T-cells are administered in the HOPD setting). However, the charges associated with the CAR T-cell dosing and preparation services as described by CPT codes 0537T, 0538T, and 0539T may be reported on the inpatient claim (bill type 11x) using revenue code 0891 – Special Processed Drugs – FDA (Food and Drug Administration) Approved Cell Therapy - Charges for Modified cell therapy.

Providers who have additional questions not covered by this transmittal should consult their Medicare Administrative Contractors (MACs) for additional guidance on billing for these services.

7. Modifier "ER"

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

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

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

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

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

This policy change can be found in section 20.6.18 of chapter 4 of the Medicare Claims Processing Manual.

8. Coverage Determinations

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

payment.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
11216.1	Medicare contactors shall manually add to their systems: • All CPT codes listed in table 1, attachment A, effective January 1, 2019; and • All HCPCS codes listed in table 2, attachment A, effective April 1, 2019; and • C9042 listed in the upcoming April 2019 I/OCE CR, effective April 1, 2019; and • G2001-G2009 and G2013-G2015 listed in the upcoming April 2019 I/OCE CR, effective January 1, 2019. **Note:** These HCPCS codes will be included in the April 2019 I/OCE update. Status and payment indicators for these HCPCS codes will be listed in the April 2019 update of the OPPS Addendum A and Addendum B on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html	X		X						
11216.2	Medicare contractors shall adjust, as appropriate, claims brought to their attention with any retroactive changes that were received prior to implementation of April 2019 OPPS I/OCE.	X		X						
11216.3	Contractors shall accept and allow as covered revenue code series 087X (Cell/Gene Therapy) and new covered revenue code series 089X (Pharmacy), established by the NUBC, effective April 1, 2019 based on the date of receipt - not the date of service. The covered subcategories for 087X are as follows: 4 – Modified Cell Infusion, and 5 – Modified Cell	X								

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
	Injection. Contractors shall accept and allow as covered the subcategory for 089X as follows: 1 – Special Processed Drugs – FDA Approved Cell Therapy - Charges for Modified cell therapy. All other subcategories shall remain noncovered.									
11216.4	Contractors shall ensure that the revenue code table information for the covered revenue codes in business requirement 3 is coded to allow for Type of Bills (TOB) 11x, 12x, and 13x, uses date of service date January 1, 2018 (if needed), units are required, HCPCS are required for TOB 12x, and 13x, and that the revenue code table is coded with any other valid information as the revenue code table requires.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
11216.5	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the “MLN Matters” listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X		X		

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

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

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

VI. FUNDING

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

ATTACHMENTS: 1

Attachment A − Tables for the Policy Section

Table 1. ─ Proprietary Laboratory Analyses (PLA) CPT Coding Changes Effective January 1, 2019

CPT Code	Long Descriptor	OPPS SI	OPPS APC
0080U	Oncology (lung), mass spectrometric analysis of galectin-3-binding protein and scavenger receptor cysteine-rich type 1 protein M130, with five clinical risk factors (age, smoking status, nodule diameter, nodule-spiculation status and nodule location), utilizing plasma, algorithm reported as a categorical probability of malignancy	Q4	N/A
0081U	Oncology (uveal melanoma), mRNA, gene-expression profiling by real-time RT-PCR of 15 genes (12 content and 3 housekeeping genes), utilizing fine needle aspirate or formalin-fixed paraffin-embedded tissue, algorithm reported as risk of metastasis	A	N/A
0082U	Drug test(s), definitive, 90 or more drugs or substances, definitive chromatography with mass spectrometry, and presumptive, any number of drug classes, by instrument chemistry analyzer (utilizing immunoassay), urine, report of presence or absence of each drug, drug metabolite or substance with description and severity of significant interactions per date of service	Q4	N/A
0083U	Oncology, response to chemotherapy drugs using motility contrast tomography, fresh or frozen tissue, reported as likelihood of sensitivity or resistance to drugs or drug combinations	Q4	N/A

Table 2. ─ New HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals Effective April 1, 2019

HCPCS Code	Long Descriptor	SI	APC
C9040	Injection, fremanezumab-vfrm, 1mg	G	9197
C9041	Injection, coagulation factor Xa (recombinant), inactivated (andexxa), 10mg	G	9198
C9141	Injection, factor viii, (antihemophilic factor, recombinant), pegylated-aucl (jivi) 1 i.u.	G	9299
C9043	Injection, levoleucovorin, 1 mg	G	9303
C9044	Injection, cemiplimab-rwlc, 1 mg	G	9304
C9045	Injection, moxetumomab pasudotox-tdfk, 0.01 mg	G	9305
C9046	Cocaine hydrochloride nasal solution for topical administration, 1 mg	G	9307

Table 3. ─ Other CY 2019 HCPCS and CPT Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals Effective April 1, 2019

HCPCS Code	Long Descriptor	Old SI	New SI	APC
Q5108	Injection, pegfilgrastim-jmdb, biosimilar, (fulphila), 0.5 mg	K	G	9173
J3245	Injection, tildrakizumab, 1 mg	E2	G	9306
Q5110	Injection, filgrastim-aafi, biosimilar, (nivestym), 1 microgram	K	G	9193
Q5111	Injection, Pegfilgrastim-cbqv, biosimilar, (udenyca), 0.5 mg	K	G	9195

Table 4. – Reassignment of Skin Substitute Product from the Low Cost Group to the High Cost Group Effective April 1, 2019

CY 2019 HCPCS Code	CY 2019 Short Descriptor	CY 2019 SI	Low/High Cost Skin Substitute
Q4183	Surgigraft, 1 sq cm	N	High
Q4184	Cellesta, 1 sq cm	N	High
Q4194	Novachor 1 sq cm	N	High
Q4203	Derma-gide, 1 sq cm	N	High

Table 5. – CAR T-cell Therapy Codes

HCPCS Code	Long Descriptors	SI	APC
Q2041	Axicabtagene ciloleucel, up to 200 million autologous anticd 19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	G	9035
Q2042	Tisagenlecleucel, up to 600 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	G	9194
0537T	Chimeric antigen receptor t-cell (car-t) therapy; harvesting of blood-derived t lymphocytes for development of genetically modified autologous car-t cells, per day	B	N/A
0538T	Chimeric antigen receptor t-cell (car-t) therapy; preparation of blood-derived t lymphocytes for transportation (eg, cryopreservation, storage)	B	N/A
0539T	Chimeric antigen receptor t-cell (car-t) therapy; receipt and preparation of car-t cells for administration	B	N/A
0540T	Chimeric antigen receptor t-cell (car-t) therapy; car-t cell administration, autologous	S	5694

10.2.3 - Comprehensive APCs

(Rev.4255, Issued: 03-15-19, Effective: 04-01-19, Implementation: 04-01-19)

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:

- ambulance services
- brachytherapy sources (status indicator U)
- *diagnostic and mammography screenings*
- *physical therapy, speech-language pathology and occupational therapy services reported on a separate facility claim for recurring services*
- pass-through drugs, biologicals, and devices (status indicators G or H)
- *preventive services defined in 42 CFR410.2*
- *self-administered drugs (SADs) - drugs that are usually self-administered and do not function as supplies in the provision of the comprehensive service*
- *services assigned to OPPS status indicator F (certain CRNA services, Hepatitis B vaccines and corneal tissue acquisition)*
- *services assigned to OPPS status indicator L (influenza and pneumococcal pneumonia vaccines)*
- *certain Part B inpatient services – Ancillary Part B inpatient services payable under Part B when the primary J1 service for the claim is not a payable Medicare Part B inpatient service (for example, exhausted Medicare Part A benefits, beneficiaries with Part B only)*
- *services assigned to a New Technology APC*

The single payment for a comprehensive claim is based on the rate associated with either the J1 service or the specific combination of J2 services. 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. When a J1 service and a J2 service are reported on the same claim, the single payment is based on the rate associated with the J1 service, and the combination of the J1 and J2 services on the claim does not make the claim eligible for a complexity adjustment. Note that complexity adjustments will not be applied to discontinued services (reported with mod -73 or -74).

20.6.18 - Use of HCPCS Modifier - ER

(Rev.4255, Issued: 03-15-19, Effective: 04-01-19, Implementation: 04-01-19)

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

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