

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-04 Medicare Claims Processing</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 2174</b>	<b>Date: March 18, 2011</b>
	<b>Change Request 7342</b>

**SUBJECT: April 2011 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 2011 OPPS update that can be found in Chapter 4, section 10 of the IOM.

**EFFECTIVE DATE: April 1, 2011**

**IMPLEMENTATION DATE: April 4, 2011**

*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.

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
N/A	

**III. FUNDING:**

**For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:**

No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

**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:**

**Recurring Update Notification**

*\*Unless otherwise specified, the effective date is the date of service.*

# Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 2174	Date: March 18, 2011	Change Request: 7342
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**SUBJECT: April 2011 Update of the Hospital Outpatient Prospective Payment System (OPPS)**

**Effective Date: April 1, 2011**

**Implementation Date: April 4, 2011**

## **I. GENERAL INFORMATION**

**A. Background:** This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the April 2011 OPPS update. The April 2011 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this Change Request (CR).

The April 2011 revisions to I/OCE data files, instructions, and specifications are provided in CR 7344, "April 2011 Integrated Outpatient Code Editor (I/OCE) Specifications Version 12.1."

## **B. Policy:**

### **1. Billing for Drugs, Biologicals, and Radiopharmaceuticals**

Hospitals are strongly encouraged to report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately, or packaged, using the correct HCPCS codes for the items used. It is also of great importance that hospitals billing for these products make certain that the reported units of service of the reported HCPCS codes are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used in the care of the patient.

More complete data from hospitals on the drugs and biologicals provided during an encounter would help improve payment accuracy for separately payable drugs and biologicals in the future. CMS strongly encourages hospitals to report HCPCS codes for all drugs and biologicals furnished, if specific codes are available. CMS realizes that this may require hospitals to change longstanding reporting practices. Precise billing of drug and biological HCPCS codes and units, especially in the case of packaged drugs and biologicals for which the hospital receives no separate payment, is critical to the accuracy of the OPPS payment rates for drugs and biologicals each year.

CMS reminds hospitals that under the OPPS, if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used in the care of the patient. The mixing together of two or more products does not constitute a "new" drug as regulated by the Food and Drug Administration (FDA) under the New Drug Application (NDA) process. In these situations, hospitals are reminded that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, Unclassified drug or biological, is for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned.

Unless otherwise specified in the long description, HCPCS descriptions refer to the non-compounded, FDA-approved final product. If a product is compounded and a specific HCPCS code does not exist for the compounded product, the hospital should report an appropriate unlisted code such as J9999 or J3490.

**a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective April 1, 2011**

For CY 2011, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP+5 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2011, 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. CMS notes that for the second quarter of CY 2011, payment for drugs and biologicals with pass-through status is not made at the Part B Drug Competitive Acquisition Program (CAP) rate, as the CAP program was suspended beginning January 1, 2009. Should the Part B Drug CAP program be reinstated sometime during CY 2011, CMS would again use the Part B drug CAP rate for pass-through drugs and biologicals if they are a part of the Part B drug CAP program, as required by the statute.

In the CY 2011 OPPS/ASC final rule with comment period, 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 April 2011 release of the OPPS PRICER. The updated payment rates, effective April 1, 2011 will be included in the April 2011 update of the OPPS Addendum A and Addendum B, which will be posted on the CMS Web site.

**b. Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2011**

Three drugs and biologicals have been granted OPPS pass-through status effective April 1, 2011. These items, along with their descriptors and APC assignments, are identified in Table 1 below.

**Table 1: Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2011**

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 4/1/11
C9280*	Injection, eribulin mesylate, 1 mg	9280	G
C9281*	Injection, pegloticase, 1 mg	9281	G
C9282*	Injection, ceftaroline fosamil, 10 mg	9282	G

**NOTE:** The HCPCS codes identified with an “\*” indicate that these are new codes effective April 1, 2011.

**c. New HCPCS Codes Effective for Certain Drugs and Biologicals**

One new HCPCS code has been created for reporting drugs and biologicals in the hospital outpatient setting for April 1, 2011. This code is listed in Table 2 below and is effective for services furnished on or after April 1, 2011. HCPCS code Q2040 is replacing HCPCS code C9278 beginning on April 1, 2011.

**Table 2- New HCPCS Codes Effective for Certain Drugs and Biologicals Effective April 1, 2011**

HCPCS	Long Descriptor	Status Indicator
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Code		APC	Effective 4/1/11
Q2040	Injection, incobotulinumtoxin A, 1 unit	9278	G

**d. Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2010 through December 31, 2010**

The payment rates for several HCPCS codes were incorrect in the October 2010 OPPS PRICER. The corrected payment rate is listed in Table 3 below and has been installed in the April 2011 OPPS PRICER, effective for services furnished on October 1, 2010, through implementation of the January 2011 update.

**Table 3-Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2010 through December 31, 2010**

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J0833	K	0835	Cosyntropin injection NOS	\$51.32	\$10.26
J1451	K	1689	Fomepizole, 15 mg	\$7.14	\$1.43
J3030	K	3030	Sumatriptan succinate / 6 MG	\$45.71	\$9.14
J7502	K	1292	Cyclosporine oral 100 mg	\$3.04	\$0.61
J7507	K	0891	Tacrolimus oral per 1 MG	\$3.18	\$0.64
J9185	K	0842	Fludarabine phosphate inj	\$162.67	\$32.53
J9206	K	0830	Irinotecan injection	\$7.45	\$1.49
J9218	K	0861	Leuprolide acetate injection	\$4.50	\$0.90
J9263	K	1738	Oxaliplatin	\$4.52	\$0.90

**e. Updated Payment Rate for HCPCS Code Q4118 Effective January 1, 2011 through March 31, 2011**

The payment rate for HCPCS code Q4118 was incorrect in the January 2011 OPPS PRICER. The corrected payment rate is listed in Table 4 below and has been installed in the April 2011 OPPS PRICER, effective for services furnished on January 1, 2011, through implementation of the April 2011 update.

**Table 4-Updated Payment Rates for HCPCS Code Q4118 Effective January 1, 2011 through March 31, 2011**

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
Q4118	K	1342	Matristem micromatrix	\$3.19	\$0.64

**f. Adjustment to Status Indicator for HCPCS code Q4119 Effective January 1, 2011**

In the CY 2011 OPPS/ASC Final Rule with comment period, CMS assigned HCPCS code Q4119, Matristem wound matrix, per square centimeter, a status indicator of "E" for services billed on or after January 1, 2011, indicating that the service is not paid by Medicare when submitted on outpatient claims. For services furnished on or after January 1, 2011, CMS is changing the status indicator for HCPCS code Q4119 to "K" to indicate that separate payment may be made for this product. HCPCS

code Q4119 is assigned to APC 1351 (Matristem wound matrix, per square centimeter) with a payment rate of \$5.62 and a minimum unadjusted copayment rate of \$1.12 for the first quarter of CY 2011. The January 2011 price for HCPCS code Q4119 will be incorporated into the April 2011 OPSS Pricer.

#### **g. Category I H1N1 Vaccine Codes**

As stated in the July 2010 update of the hospital OPSS that was published in Transmittal 1980, dated June 4, 2010, CMS assigned status indicator “E” to CPT codes 90663 and 90470. As of December 31, 2010, the AMA discontinued the use of these codes. Therefore, effective January 1, 2011, CPT codes 90663 and 90470 are being assigned a status indicator of “D” under the OPSS, to indicate that these codes are discontinued and are no longer paid under the OPSS or any other Medicare payment system.

#### **h. Correct Reporting of Biologicals When Used As Implantable Devices**

When billing for biologicals where the HCPCS code describes a product that is solely surgically implanted or inserted, whether the HCPCS code is identified as having pass-through status or not, hospitals are to report the appropriate HCPCS code for the product. Units should be reported in multiples of the units included in the HCPCS descriptor. Providers and hospitals should not bill the units based on the way the implantable biological is packaged, stored, or stocked. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the implantable biological. Therefore, before submitting Medicare claims for biologicals that are used as implantable devices, it is extremely important to review the complete long descriptors for the applicable HCPCS codes. In circumstances where the implanted biological has pass-through status, either as a biological or a device, a separate payment for the biological or device is made. In circumstances where the implanted biological does not have pass-through status, the OPSS payment for the biological is packaged into the payment for the associated procedure.

When billing for biologicals where the HCPCS code describes a product that may either be surgically implanted or inserted or otherwise applied in the care of a patient, hospitals should not separately report the biological HCPCS codes, with the exception of biologicals with pass-through status, when using these items as implantable devices (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures. Under the OPSS, hospitals are provided a packaged APC payment for surgical procedures that includes the cost of supportive items, including implantable devices without pass-through status. When using biologicals during surgical procedures as implantable devices, hospitals may include the charges for these items in their charge for the procedure, report the charge on an uncoded revenue center line, or report the charge under a device HCPCS code (if one exists) so these costs would appropriately contribute to the future median setting for the associated surgical procedure.

#### **i. Correct Reporting of Units for Drugs**

Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor. For example, if the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be 1. As another example, if the description for the drug code is 50 mg, but 200 mg of the drug was administered to the patient, the units billed should be 4. Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, hospitals should bill 10 units, even though only 1 vial was administered. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete

description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

As discussed in Pub.100-04, Medicare Claims Processing Manual, Chapter 17, section 40, CMS encourages hospitals to use drugs efficiently and in a clinically appropriate manner. However, CMS also recognizes that hospitals may discard some drug and biological product when administering from a single use vial or package. In that circumstance, Medicare pays for the amount of drug or biological discarded *as well as* the *dose* administered, up to the amount of the drug or biological as indicated on the vial or package label. Multi-use vials are not subject to payment for discarded amounts of drug or biological.

#### **j. Reporting of Outpatient Diagnostic Nuclear Medicine Procedures**

With the specific exception of HCPCS code C9898 (Radiolabeled product provided during a hospital inpatient stay), to be reported by hospitals on outpatient claims for nuclear medicine procedures to indicate that a radiolabeled product that provides the radioactivity necessary for the reported diagnostic nuclear medicine procedure was provided during a hospital inpatient stay, hospitals should only report HCPCS codes for products they provide in the hospital outpatient department and should not report a HCPCS code and charge for a radiolabeled product on the nuclear medicine procedure-to-radiolabeled product edit list solely for the purpose of bypassing those edits present in the I/OCE.

As CMS stated in the October 2009 OPSS update, in the rare instance when a diagnostic radiopharmaceutical may be administered to a beneficiary in a given calendar year prior to a hospital furnishing an associated nuclear medicine procedure in the subsequent calendar year, hospitals are instructed to report the date the radiolabeled product is furnished to the beneficiary as the same date that the nuclear medicine procedure is performed. CMS believes that this situation is extremely rare and expects that the majority of hospitals will not encounter this situation.

Where a hospital or a nonhospital location, administers a diagnostic radiopharmaceutical product for a different hospital providing the nuclear medicine scan, hospitals should comply with the OPSS policy that requires that radiolabeled products be reported and billed with the nuclear medicine scan. In these cases, the first hospital or nonhospital location may enter into an arrangement under section 1861(w)(1) of the Act, and as discussed in 42 CFR 410.28(a)(1) and defined in 42 CFR 409.3, where the second hospital that administers the nuclear medicine scan both bills Medicare for the administration of the nuclear medicine scan with diagnostic radiopharmaceutical and pays the first hospital or nonhospital location that administers the diagnostic radiopharmaceutical some amount for administration of the diagnostic radiopharmaceutical. CMS notes that it considers the radiolabeled product and the nuclear medicine scan to be part of one procedure and would expect both services to be performed together.

#### **k. Use of HCPCS Code C9399**

As stated in Pub. 100-04, Medicare Claims Processing Manual, Chapter 17, section 90.3, hospitals are to report HCPCS code C9399, Unclassified drug or biological, solely for new outpatient drugs or biologicals that are approved by the FDA on or after January 1, 2004 and that are furnished as part of covered outpatient department services for which a product-specific HCPCS code has not been assigned. It is not appropriate to report HCPCS code C9399 for drugs and biologicals that are defined as usually self-administered drugs by the patient as defined in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, section 50.2.

## **2. Procedure and Device Edits**

Procedure-to-device edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code. Failure to pass these edits will result in the claim being returned to the provider. Procedures for which both a Device A and a Device B are specified require that at least one each of Device A and Device B be present on the claim (i.e., there must be some combination of a Device A with a Device B in order to pass the edit). Device B can be reported with any Device A for the same procedural HCPCS code.

Device-to-procedure edits require that a claim that contains one of a specified set of device codes be returned to the provider if it fails to contain an appropriate procedure code. The updated lists of both types of edits can be found under "Device, Radiolabeled Product, and Procedure Edits" at <http://www.cms.gov/HospitalOutpatientPPS/>.

### 3. New Service

The following new service is assigned for payment under the OPSS:

HCPCS	Short Descriptor	Long Descriptor	SI	APC	Payment Rate	Minimum Unadjusted Copayment	Effective Date
C9729	Percut lumbar lami	Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with ligamentous resection, discectomy, facetectomy and/or foraminotomy, when performed) any method under indirect image guidance, with the use of an endoscope when performed, single or multiple levels, unilateral or bilateral; lumbar	T	0208	\$3,535.92	\$707.19	4/1/2011

### 4. Adjustment to Status Indicator for HCPCS Code G0010 Effective January 1, 2011

HCPCS code G0010 (Administration of hepatitis B vaccine) was erroneously assigned status indicator "B" effective January 1, 2011 in the January 2011 update issued in CR 7271. Therefore, retroactively effective January 1, 2011, the status indicator for HCPCS code G0010 will change from status indicator "B" (Codes that are not recognized by OPSS when submitted on an outpatient hospital Part B bill type (12x and 13x)) to status indicator "S" (Significant Procedure, Not Discounted When Multiple). Beginning January 1, 2011, HCPCS code G0010 will be assigned to APC 0436.

In order to ensure correct waiver of coinsurance and deductible for the administration of hepatitis B vaccines, providers should report HCPCS G0010 for billing under the OPSS rather than CPT code 90471 (Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)) or CPT code 90472 (Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure)) for services performed beginning January 1, 2011.

## 5. HCPCS Code Q1003 Deleted Effective April 1, 2011

HCPCS code Q1003 (New technology intraocular lens category 3) is currently packaged under the OPPS and is being deleted for dates of service effective April 1, 2011. For more information on the deletion of this HCPCS code, refer to the January 2011 ASC Update (Transmittal 2128, Change Request 7275, dated December 29, 2010).

## II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B  M A C	D M E  M A C	F I  M A C	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
						F I S S	M C S	V M S	C W F		
7342.1	Medicare contractors shall install the April 2011 OPPS Pricer.	X		X		X	X				COBC
7342.2	Medicare contractors shall manually add the following HCPCS codes to their systems: C9280, C9281, C9282, C9729 and Q2040  Status and payment indicators for these HCPCS codes will be listed in the April 2011 update of the OPPS Addendum A and Addendum B on the CMS Web site.	X		X		X	X			X	COBC
7342.3	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service that fall on or after October 1, 2010, but prior to December 31, 2010; 2) Contain HCPCS codes listed in Table 3; and 3) Were originally processed prior to the installation of the April 2011 OPPS Pricer.	X		X		X					COBC
7342.4	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service that fall on or after January 1, 2011, but prior to March 31, 2011; 2) Contain the HCPCS code listed in Table 4; and 3) Were originally processed prior to the installation of the April 2011 OPPS Pricer.	X		X		X					COBC
7342.5	Medicare contractors shall adjust as appropriate claims brought to their attention that: 4) Have dates of service that fall on or after January 1, 2011, but prior to March 31, 2011; 5) Contain the HCPCS code Q4119; and 6) Were originally processed prior to the installation	X		X		X					COBC

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B  M A C	D M E  M A C	F I    	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	of the April 2011 OPSS Pricer.										

### III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B  M A C	D M E  M A C	F I    	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
7342.6	<p>A provider education article related to this instruction will be available at <a href="http://www.cms.hhs.gov/MLNMattersArticles/">http://www.cms.hhs.gov/MLNMattersArticles/</a> shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.</p> <p>Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.</p>	X		X		X					COBC

### IV. SUPPORTING INFORMATION

**Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A**

*Use "Should" to denote a recommendation.*

X-Ref Requirement Number	Recommendations or other supporting information:

**Section B: For all other recommendations and supporting information, use this space:**

Refer to CR 7111 “October 2010 Integrated Outpatient Code Editor (I/OCE) Specifications Version 11.3” for supporting information.

**V. CONTACTS**

**Pre-Implementation Contact(s):** OPPS Payment Policy: Chuck Braver at [chuck.braver@cms.hhs.gov](mailto:chuck.braver@cms.hhs.gov) or 410-786-6719. FI/ AB MAC Claims Processing Issues: Fred Rooke at [fred.rooke@cms.hhs.gov](mailto:fred.rooke@cms.hhs.gov) or 410-786-6987.

**Post-Implementation Contact(s):** Contact your Contracting Officer’s Technical Representative (COTR) or Contractor Manager, as applicable.

**VI. FUNDING**

**Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:**

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

**Section B: For Medicare Administrative Contractors (MACs), include the following statement:**

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.