CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2418	**Date: March 2, 2012**
	Change Request 7748

SUBJECT: April 2012 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 2012 OPPS update. The April 2012 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).

EFFECTIVE DATE: April 1, 2012
IMPLEMENTATION DATE: April 2, 2012

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/Table of Contents
R	4/70.7/Transitional Outpatient Payments (TOPs) for CY 2010 through February 29, 2012

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
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:
Manual Instruction
Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 2418	Date: March 2, 2012	Change Request: 7748

SUBJECT: April 2012 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Effective Date: April 1, 2012
Implementation Date: April 2, 2012

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the April 2012 OPPS update. The April 2012 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 2012 revisions to I/OCE data files, instructions, and specifications are provided in CR 7751, "April 2012 Integrated Outpatient Code Editor (I/OCE) Specifications Version 13.1."

B. Policy:

1. Changes to Device Edits for April 2012

Claims for OPPS services must pass two types of device edits to be accepted for processing: procedure-to-device edits and device-to-procedure edits. Procedure-to-device edits, which have been in place for many procedures since 2005, continue to be in place. These edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code. Procedures for which both a Device A and Device B are specified require that at least one each of a 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.

Since January 1, 2007, CMS also has required 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. CMS has determined that the devices contained in this list cannot be correctly reported without one of the specified procedure codes also being reported on the same claim. Where these devices were billed without an appropriate procedure code prior to January 1, 2007, the cost of the device was being packaged into the median cost for an incorrect procedure code and therefore inflated the payment for the incorrect procedure code. In addition, hospitals billing devices without the appropriate procedure code were being incorrectly paid. The device-to-procedure edits are designed to ensure that the costs of these devices are assigned to the appropriate APC in OPPS ratesetting.

The most current edits for both types of device edits can be found under "Device, Radiolabeled Product, and Procedure Edits" at http://www.cms.gov/HospitalOutpatientPPS/. Failure to pass these edits will result in the claim being returned to the provider.

Effective for services furnished on or after January 1, 2012, the AMA changed the descriptor for CPT code 33249 to read "Insertion or replacement of permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber." This has necessitated the removal of HCPCS code C1882 (Cardioverter-defibrillator, other than single or dual chamber (implantable)) from the list of those device codes required to be billed with CPT code 33249 on the procedure-to-device edit list, since this link is no longer clinically appropriate. We are making this change retroactive to January 1, 2012.

2. New Service (Fluorescent Vascular Angiography)

The following new service is assigned for payment under the OPPS, effective April 1, 2012:

Table 1 – Fluorescent Vascular Angiography

HCPCS	Effective date	SI	APC	Short Descriptor	Long descriptor	Payment	Minimum Unadjusted Copayment
C9733	4/01/2012	Q2	0397	Non-ophthalmic FVA	Non-ophthalmic fluorescent vascular angiography	$154.87	$30.98

HCPCS code C9733 is assigned to APC 0397 (Vascular Imaging) and should be used to report fluorescent vascular angiography. C9733 describes SPY® Fluorescence Vascular Angiography and other types of non-ophthalmic fluorescent vascular angiography.

3. Billing for Drugs, Biologicals, and Radiopharmaceuticals

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective April 1, 2012

For CY 2012, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 4 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2012, 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.

In the CY 2012 OPPS/ASC final rule with comment period, we 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, we will incorporate changes to the payment rates in the April 2012 release of the OPPS Pricer. The updated payment rates, effective April 1, 2012 will be included in the April 2012 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, 2012

Four drugs and biologicals have been granted OPPS pass-through status effective April 1, 2012. These items, along with their descriptors and APC assignments, are identified in Table 2 below.

Table 2 – Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2012

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 4/1/12

C9288*	Injection, centruroides (scorpion) immune f(ab)2 (equine), 1 vial	9288	G
C9289*	Injection, asparaginase erwinia chrysanthemi, 1,000 international units (I.U.)	9289	G
C9290*	Injection, bupivicaine liposome, 1 mg	9290	G
C9291*	Injection, aflibercept, 2 mg vial	9291	G

NOTE: The HCPCS codes identified with an "*" indicate that these are new codes effective April 1, 2012.

Additional Information on HCPCS Code C9291 (Injection, aflibercept, 2 mg vial)

Eylea (aflibercept) is packaged in a sterile, 3 mL single use vial containing a 0.278 mL fill of 40 mg/mL Eylea (NDC 61755-0005-02). As approved by the FDA, the recommended dose for Eylea is 2 mg every 4 weeks, followed by 2 mg every 8 weeks. Payment for HCPCS code C9291 is for the entire contents of the single-use vial, which is labeled as providing a 2 mg dose of aflibercept. As indicated in 42 CFR § 414.904, CMS calculates an average sales price (ASP) payment limit based on the amount of product included in a vial or other container as reflected on the FDA-approved label, and any additional product contained in the vial or other container does not represent a cost to providers and is not incorporated into the ASP payment limit. In addition, no payment is made for amounts of product in excess of that reflected on the FDA-approved label.

c. Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2011 through September 30, 2011

The payment rates for several HCPCS codes were incorrect in the July 2011 OPPS Pricer. The corrected payment rates are listed in Table 3 below and have been installed in the April 2012 OPPS Pricer, effective for services furnished on July 1, 2011, through implementation of the October 2011 update.

Table 3 – Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2011 through September 30, 2011

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J0735	K	0935	Clonidine hydrochloride	$35.67	$7.13
J1212	K	1221	Dimethyl sulfoxide 50% 50 ML	$84.55	$16.91
J1756	K	9046	Iron sucrose injection	$0.34	$0.07
J9245	K	0840	Inj melphalan hydrochl 50 MG	$1,308.97	$261.79

d. Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2011 through December 31, 2011

The payment rates for several HCPCS codes were incorrect in the October 2011 OPPS Pricer. The corrected payment rates are listed in Table 4 below and have been installed in the April 2012 OPPS Pricer, effective for services furnished on October 1, 2011, through implementation of the January 2012 update.

Table 4 – Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2011 through December 31, 2011

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J0735	K	0935	Clonidine hydrochloride	$30.54	$6.11
J1212	K	1221	Dimethyl sulfoxide 50% 50 ML	$84.86	$16.97
J1742	K	9044	Ibutilide fumarate injection	$126.92	$25.38
J9245	K	0840	Inj melphalan hydrochl 50 MG	$1,280.08	$256.02

e. Correct Reporting of Biologicals When Used As Implantable Devices

When billing for products that are used as either a surgically implanted or inserted biological or as a skin substitute, hospitals should report the appropriate HCPCS code for the product. Implantable biologicals with pass-through status receive separate payment, but for those that do not have pass-through status, the OPPS payment for the implanted biological is packaged into the payment for the associated procedure. Products that can be used as either a skin substitute or as an implantable biological will only be separately paid when billed with a skin substitute application procedure (see below for further details on payment for skin substitutes). 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, if different from the HCPCS descriptor. 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.

f. I/OCE Logic Changes for Skin Substitutes

Hospitals are reminded that HCPCS codes describing products that can be used as skin substitutes, as listed in Table 5 below, will be separately paid only when used with one of the CPT codes describing the application of a skin substitute (15271-15278). Effective April 1, 2012, CMS is implementing logic changes to the I/OCE to ensure that separate payment is made for skin substitutes only when they are billed with a skin substitute application procedure.

Table 5 – Payable Skin Substitute HCPCS Codes for CY 2012*

HCPCS Code	APC	Short Descriptor	Status Indicator
C9358	9358	SurgiMend, fetal	K
C9360	9360	SurgiMend, neonatal	K
C9363	9363	Integra Meshed Bil Wound Mat	K
C9366	9366	EpiFix wound cover	G
C9367	9367	Endoform Dermal Template	G
Q4100	N/A	Skin substitute, NOS	N
Q4101	1240	Apligraf	K
Q4102	1241	Oasis wound matrix	K
Q4103	1242	Oasis burn matrix	K
Q4104	1243	Integra BMWD	K
Q4105	1244	Integra DRT	K
Q4106	1245	Dermagraft	K

HCPCS Code	APC	Short Descriptor	Status Indicator
Q4107	1246	Graftjacket	K
Q4108	1247	Integra matrix	K
Q4110	1248	Primatrix	K
Q4111	1252	Gammagraft	K
Q4112	1249	Cymetra injectable	K
Q4113	1250	Graftjacket xpress	K
Q4114	1251	Integra flowable wound matri	K
Q4115	1287	Alloskin	K
Q4116	1270	Alloderm	K
Q4118	1342	Matristem micromatrix	K
Q4119	1351	Matristem wound matrix	K
Q4121	1345	Theraskin	K
Q4122	1419	Dermacell	K
Q4124	9365	Oasis Ultra Tri-Layer Matrix	G
Q4130	N/A	Strattice TM	N

4. Update to Section 308 of the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA)

The Medicare Claims Processing Manual, Pub. 100-04, Chapter 4, Section 70.7, is revised to include Section 308 of the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA) which extends the Outpatient Hold-Harmless provision, effective for dates of service on or after January 1, 2012, through February 29, 2012, to rural hospitals with 100 or fewer beds and to all SCHs and EACHs regardless of bed size.

5. 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. Fiscal Intermediaries (FIs)/Medicare Administrative Contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, FIs/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

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)

		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7748.1	Medicare contractors shall install the April 2012 OPPS Pricer.	X		X		X	X				COBC
7748.2	Medicare contactors shall manually add the following HCPCS codes to their systems: • All HCPCS codes listed in table 1, and 2 effective April 1, 2012; and • G8675, G8676, G8677, G8678, G8679, and G8680 effective January 1, 2011 because these codes were deleted in error; and • G9148, G9149, G9150, G9151, G9152, G9153 effective July 1, 2011. **Note:** These HCPCS codes will be included with the April 2012 IOCE update. Status and payment indicators for these HCPCS codes will be listed in the April 2012 update of the OPPS Addendum A and Addendum B on the CMS Web site. https://www.cms.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage	X		X		X	X				COBC
7748.3	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service that fall on or after July 1, 2011, but prior to October 1, 2011; 2) Contain HCPCS codes listed in Table 3; and 3) Were originally processed prior to the installation of the April 2012 OPPS Pricer.	X		X		X					COBC
7748.4	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service that fall on or after October 1, 2011, but prior to January 1, 2012; 2) Contain HCPCS codes listed in Table 4; and 3) Were originally processed prior to the installation of the April 2012 OPPS Pricer.	X		X		X					COBC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7748.5	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. 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.	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:
	None

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

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

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)*:

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)*****:**

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.

Medicare Claims Processing Manual

Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

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(Rev.2418, Issued: 03-02-12)

70.7 - Transitional Outpatient Payments (TOPs) for CY 2010 *through February 29, 2012*

(Rev. 2418, Issued: 03-02-12, Effective: 04-01-12, Implementation: 04-02-12)

Hold harmless transitional outpatient payments (TOPs) to small rural hospitals and rural sole community hospitals were scheduled to expire December 31, 2009. Section 3121 of the Affordable Care Act extended the hold harmless provision for small rural hospitals with 100 or fewer beds through December 31, 2010, at 85 percent of the hold harmless amount. Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs) are no longer limited to those with 100 or fewer beds effective January 1, 2010 through December 31, 2010 and these providers will receive TOPs payments at 85 percent of the hold harmless amount until December 31, 2010. Section 108 of the Medicare and Medicaid Extenders Act of 2010 (MEA) further extended the hold harmless provision for rural hospitals with 100 or fewer beds and to all SCHs (and EACHs) regardless of bed size through December 31, 2011 at 85 percent of the hold harmless amount.

Section 308 of the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA) extends the Outpatient Hold-Harmless provision, effective for dates of service on or after January 1, 2012, through February 29, 2012, to rural hospitals with 100 or fewer beds and to all SCHs and EACHs regardless of bed size.

Cancer and children's hospitals are permanently held harmless under section 1833(t)(7)(D)(ii) of the Social Security Act.

Monthly TOPs calculations that contractors are required to calculate are described below. This calculation is effective for services provided between January 1, 2010 and *February 29, 2012.*

Step 1 – Compute the pre-BBA amount for each month by first multiplying the total charges for covered services for all OPPS services on claims paid during the month and reduce the total charges to cost by multiplying them by the outpatient cost-to-charge ratio and then multiplying this amount by the provider-specific payment-to-cost ratio (PSPCR).

Step 2 – Add together the total Medicare program payments, unreduced coinsurance and deductible applied for all APCs, as well as all outlier payments (including reconciled outlier payments and the time value of money) and transitional pass-through payments for drugs, biologicals and/or devices for those same claims paid during the month as those used in Step 1. If the result is greater than the result of step 1, go to step 4. No transitional payment is due this month.

Step 3 - If the hospital is a children’s hospital, a cancer hospital, a rural hospital with 100 or fewer beds, or a sole community hospital (including EACHs), subtract the result of step 2 from the result of step 1 and pay .85 times this amount. If the hospital is not one of the hospital types listed above, no payment is made.

Step 4 - When the result of step 2 is greater than the result of step 1 for the final month of a provider’s cost report period, do nothing more. When the result of step 2 is greater than the result of step 1 for any other month, store all step 1 and step 2 totals and include these totals with the totals for the next month’s TOP calculation.