CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2531	**Date: August 24, 2012**
	Change Request 8031

SUBJECT: October 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 October 2012 OPPS update. The October 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 October 2012 revisions to I/OCE data files, instructions, and specifications are provided in CR8035, "October 2012 Integrated Outpatient Code Editor (I/OCE) Specifications Version 13.3."

EFFECTIVE DATE: October 1, 2012
IMPLEMENTATION DATE: October 1, 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 CY 2012
R	32/150.8/Fiscal Intermediary Billing Requirements

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; Contractors activities are to be carried out with 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 obliged 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

Manual Instruction

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

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 2531	Date: August 24, 2012	Change Request: 8031

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

EFFECTIVE DATE: October 1, 2012

IMPLEMENTATION DATE: October 1, 2012

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the October 2012 OPPS update. The October 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 October 2012 revisions to I/OCE data files, instructions, and specifications are provided in CR 8035, "October 2012 Integrated Outpatient Code Editor (I/OCE) Specifications Version 13.3."

B. Policy: 1. Outpatient Payment for Laparoscopic Bariatric Surgery

In Pub. 100-04, Medicare Claims Processing Manual, Chapter 32, section 150.8, a revision is being made to indicate that, effective January 1, 2012, laparoscopic bariatric surgery procedures described by CPT code 43770 (Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)) are payable when performed in hospital outpatient departments.

2. Billing for Drugs, Biologicals, and Radiopharmaceuticals

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

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 October 2012 release of the OPPS PRICER. The updated payment rates, effective October 1, 2012, will be included in the October 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 October 1, 2012

Two drugs and biologicals have been granted OPPS pass-through status effective October 1, 2012. These items, along with their descriptors and APC assignments, are identified in Table 1 in attachment A.

c. Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2012 through September 30, 2012

The payment rates for three HCPCS codes were incorrect in the July 2012 OPPS PRICER. The corrected payment rates are listed in Table 2 in attachment A and have been installed in the October 2012 OPPS PRICER, effective for services furnished on July 1, 2012, through implementation of the October 2012 update.

3. Update the Outpatient Provider Specific File (OPSF) for CY 2012 Transitional Outpatient Payments (TOPs)

Section 5105 of the Deficit Reduction Act of 2005 (DRA) extended hold harmless transitional outpatient payments (TOPs) through December 31, 2008, for rural hospitals having 100 or fewer beds that are not sole community hospitals (SCHs). Hospitals received 95 percent of the hold harmless amount for services furnished in CY 2006, 90 percent in CY 2007, and 85 percent in CY 2008. Section 147 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) extended the hold harmless provision for small rural hospitals with 100 or fewer beds through December 31, 2009, at 85 percent of the hold harmless amount. Section 147 also provided 85 percent of the hold harmless amount from January 1, 2009 through December 31, 2009, to SCHs with 100 or fewer beds, per CR 6320, Transmittal 1657.

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 through December 31, 2010. **(Note:**EACHs are considered SCHs for purposes of the TOPs adjustment.) Cancer and children's hospitals are permanently held harmless under section 1833(t)(7)(D)(ii) of the Social Security Act.

Section 108 of the Medicare and Medicaid Extenders Act of 2010 (MEA) extends the Outpatient Hold Harmless provision from January 1, 2011 through December 31, 2011 for rural hospitals with 100 or fewer beds at 85 percent of the hold harmless amount, and to all SCHs and EACHs regardless of bed size at 85 percent of the hold harmless amount from January 1, 2011 through December 31, 2011.

Section 308 of the Temporary Payroll Tax Cut Continuation Act of CY 2011 as amended by section 3002 of the Middle Class Tax Relief and Jobs Creation Act, extended through December 31, 2012, the hold harmless provision for a rural hospital with 100 or fewer beds at 85 percent of the hold harmless amount. Section 308 of the Temporary Payroll Tax Cut Continuation Act of CY 2011 also extended through February 29, 2012 the hold harmless provision to SCH and EACHs, without the bed size limitation at 85 percent of the hold harmless amount. Section 3002 of the Middle Class Tax Relief and Jobs Creation Act extended through December 31, 2012 the hold harmless provision to SCHs and EACHs that have no more than 100 beds at 85 percent of the hold harmless amount.

For CY 2012, small rural hospitals with 100 or fewer beds and sole community hospitals (and essential access community hospitals) with 100 or fewer beds remain eligible for a TOPS adjustment, so the TOPS indicator for these hospitals must be set to ‘Y’. From January 1, 2012 through February 29, 2012 SCHs (and EACHs) with more than 100 beds remain eligible for TOPS, so the TOPS indicator for these hospitals must be set to ‘Y’. Cancer and children's hospitals continue to receive hold harmless TOPs permanently.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility						
		A/B MAC	D M E	F I	C A R	R H H	Shared-System Maintainers	Other

		Part A	Part B	MAC		RIER	I	FISS	MCS	VMS	CWF	
8031.1	Medicare contractors shall install the October 2012 OPPS Pricer.	X			X		X	X				COBC
8031.2	Medicare contactors shall manually add the following HCPCS codes to their systems: • HCPCS codes listed in table 1, effective October 1, 2012; and • G9157 listed in CR 8035, effective October 1, 2012; **Note:**These HCPCS codes will be included with the October 2012 IOCE update. Status and payment indicators for these HCPCS codes will be listed in the October 2012 update of the OPPS Addendum A and Addendum B on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html.	X			X		X	X				COBC
8031.3	Effective 01/01/2012, the contractor shall pay for laparoscopic bariatric surgery procedures described by CPT code 43770 when the service is submitted on an outpatient Type of Bill (TOB) 13X and 85X.	X			X			X				COBC
8031.4	Medicare contractors shall adjust, as appropriate, claims brought to their attention that: 1. Have dates of service that fall on or after July 1, 2012, but prior to October 1, 2012; 2. Contain HCPCS codes listed in Table 2; and 3. Were originally processed prior to the installation of the October 2012 OPPS Pricer.	X			X		X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
8031.5	MLN Article : 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 sites 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 the contractor's 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	

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
Use "Should" to denote 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) 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; Contractors activities are to be carried out with 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 do 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.

Attachment (1)

Attachment A

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

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 10/1/12
C9292*	Injection, pertuzumab, 10 mg	9292	G
C9293*	Injection, glucarpidase, 10 units	9293	G

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

Table 2 – Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2012 through September 30, 2012

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9368	G	9368	Grafix core	$160.66	$31.53
C9369	G	9369	Grafix prime	$51.84	$10.17
Q2045	K	1414	Human fibrinogen conc inj	$0.89	$0.18

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

Table of Contents
(Rev.2531, Issued: 08-24-12)

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

(Rev.2531, 08-24-12, Effective:10-01-12, Implementation:10-01-12)

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) *as amended by section 3002 of the Middle Class Tax Relief and Jobs Creation Act,* extends the Outpatient Hold-Harmless provision, effective for dates of service on or after January 1, 2012, through *December 31*, 2012, to rural hospitals with 100 or fewer beds.

Section 308 of the Temporary Payroll Tax Cut Continuation Act of 2011 also extended through February 29, 2012 the hold harmless provision for SCHs (and EACHs) without the bed size limitation. However, section 3002 of the Middle Class Tax Relief and Jobs Creation Act extended through December 31, 2012, the hold harmless provision for SCHs (and EACHs) that have no more than 100 beds.

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 *by SCH (and EACHs) with more than 100 beds* between January 1, 2010 and February 29, 2012. *This calculation is effective for services provided by rural hospitals with 100 or fewer beds and SCHs (and EACHs) with 100 or fewer beds between January 1, 2010 and December 31, 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 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.

Medicare Claims Processing Manual

Chapter 32 – Billing Requirements for Special Services

150.8 - Fiscal Intermediary Billing Requirements

(Rev. .2531, 08-24-12, Effective: 10-01-12, Implementation: 10-01-12)

The FI/MAC will pay for bariatric surgery when the services are submitted on the following type of bill (TOB): 11X. *Laparoscopic bariatric surgery described by CPT code 43770 also may be paid when submitted on an outpatient TOB 13X and 85X.*

Type of facility and setting determines the basis of payment:

- For services performed in IHS inpatient hospitals, TOB 11X under IPPS payment is based on the DRG.
- For services performed in inpatient hospitals, TOB 11X under IPPS payment is based on the DRG.
- For services performed in IHS critical access hospitals, TOB 11X, payment is based on 101% facility specific per diem rate.
- For services performed in CAH inpatient hospitals, TOB 11X, payment is based on 101% of reasonable cost.
- For services performed in outpatient hospitals, TOB 13X under OPPS payment is based on the APC.
- For services performed in CAH outpatient hospitals, TOB 85X, payment is based on 101% of reasonable cost.