CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2718	**Date: June 7, 2013**
	Change Request 8338

SUBJECT: July 2013 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 July 2013 OPPS update. The July 2013 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). Instructions can be located in Chapter 4, Section 61.4 of the IOM."

The July 2013 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming July I/OCE CR.

EFFECTIVE DATE: July 1, 2013
IMPLEMENTATION DATE: July 1, 2013

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	4/61.4.1/Billing for Brachytherapy Sources - General
N	4/61.4.5/Payment for New Brachytherapy Sources

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: 2718	Date: June 7, 2013	Change Request: 8338

SUBJECT: July 2013 Update of the Hospital Outpatient Prospective Payment System (OPPS)

EFFECTIVE DATE: July 1, 2013
IMPLEMENTATION DATE: July 1, 2013

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the July 2013 OPPS update. The July 2013 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 July 2013 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming July I/OCE CR.

B. Policy:

1. Changes to Device Edits for July 2013

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

2. New Service

New service listed in table 1, Attachment A, is assigned for payment under the OPPS, effective July 1, 2013.

3. New Long Descriptor for C9734

Table 2, in Attachment A, reflects a new long descriptor for HCPCS code C9734, effective July 1, 2013. HCPCS code C9734 must be performed with magnetic resonance (MR) guidance.

4. Deletion of HCPCS code C1879 and Use of A4648

Consistent with our general policy of using permanent HCPCS codes rather than using temporary HCPCS codes under the OPPS in order to streamline coding, we are deleting HCPCS code C1879 (Tissue marker, implantable) on June 30, 2013 because it is described by HCPCS code A4648 (Tissue marker, implantable, any type). Therefore, effective July 1, 2013, when using implantable tissue markers with any services provided in the OPPS, providers should report the use and cost of the implantable tissue marker with HCPCS code A4648 only.

5. Category III CPT Codes

The AMA releases Category III CPT codes twice per year: in January, for implementation beginning the following July, and in July, for implementation beginning the following January. For the July 2013 update, CMS is implementing in the OPPS six Category III CPT codes that the AMA released in January 2013 for implementation on July 1, 2013. Of the six, four Category III CPT codes are separately payable under the hospital OPPS. The status indicators and APCs for these codes are shown in table 3, Attachment A. Payment rates for these services can be found in Addendum B of the July 2013 OPPS Update that is posted on the

CMS website.

6. Billing for Drugs, Biologicals, and Radiopharmaceuticals

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective July 1, 2013

In the CY 2013 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 July 2013 release of the OPPS Pricer. The updated payment rates, effective July 1, 2013 will be included in the July 2013 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 July 1, 2013

Two drugs and biologicals have been granted OPPS pass-through status effective July 1, 2013. These items, along with their descriptors and APC assignments, are identified in table 4, listed in Attachment A.

c.Flublok (Influenza virus vaccine)

Flublok (influenza virus vaccine) was approved by the FDA on January 16, 2013. For the July 2013 update, the HCPCS Workgroup established HCPCS code Q2033 to describe Flublok. We are assigning the OPPS status indicator "L" (Influenza Vaccine; Pneumococcal Pneumonia Vaccine) to HCPCS code Q2033 effective July 1, 2013. Prior to July 1, 2013, the appropriate code to report for Flublok would be an unlisted CPT/HCPCS vaccine code. Table 5, in Attachment A, provides the descriptors and OPPS status indicator for HCPCS code Q2033.

d. Fluarix Quadrivalent (Influenza virus vaccine)

Fluarix Quadrivalent (Influenza virus vaccine) was approved by the FDA on December 14, 2012 and is described by CPT code 90686. Because of the timing of the FDA approval, we were unable to assign CPT code 90686 to a separately payable status. For the July 2013 update, we are revising the OPPS status indicator for CPT code 90686 from "E" (Not Covered by Medicare) to "L" (Influenza Vaccine; Pneumococcal Pneumonia Vaccine) effective January 1, 2013. Prior to January 1, 2013, the appropriate code to report for Fluarix Quadrivalent would be an unlisted CPT/HCPCS vaccine code. Table 6, Attachment A, provides the descriptors and OPPS status indicator for CPT code 90686.

e. New HCPCS Codes Effective July 1, 2013 for Certain Drugs and Biologicals

Two new HCPCS codes have been created for reporting certain drugs and biologicals (other than new pass-through drugs and biological listed in Table 4) in the hospital outpatient setting for July 1, 2013. These codes are listed in table 7, in Attachment A, and are effective for services furnished on or after July 1, 2013.

f. Revised Status Indicator for HCPCS Codes Q4126 and Q4134 Effective July 1, 2013

Effective July 1, 2013, the status indicators for HCPCS code Q4126 (Memoderm, dermaspan, tranzgraft or integuply, per square centimeter) and HCPCS code Q4134 (Hmatrix, per square centimeter) will change from SI=E (not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=K (paid under OPPS; separate APC payment). For the remainder of CY 2013, HCPCS code Q4126 and HCPCS code Q4134 will be separately paid and the prices for these codes will be updated on a quarterly basis. These codes are listed in table 8, in Attachment A, and are effective for services furnished on or after July 1, 2013

g. Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2013 through June 30, 2013

The payment rates for two HCPCS codes were incorrect in the April 2013 OPPS Pricer. The corrected payment rates are listed in table 9, in Attachment A, and have been installed in the July 2013 OPPS Pricer, effective for services furnished on April 1, 2013 through June 30, 2013.

h. Updated Guidance: Billing and Payment for New Drugs, Biologicals, or Radiopharmaceuticals Approved by the FDA but Before Assignment of a Product-Specific HCPCS Code

Hospital outpatient departments are allowed to bill for new drugs, biologicals, and therapeutic radiopharmaceuticals that are approved by the FDA on or after January 1, 2004 for which pass-through status has not been approved and a C-code and APC payment have not been assigned using the "unclassified" drug/biological HCPCS code C9399 (Unclassified drugs or biological). Drugs, biologicals, and therapeutic radiopharmaceuticals that are assigned to HCPCS code C9399 are contractor priced at 95 percent of AWP.

Diagnostic radiopharmaceuticals and contrast agents are policy packaged under the OPPS unless they have been granted pass-through status. Therefore, new diagnostic radiopharmaceuticals and contrast agents are an exception to the above policy and should not be billed with C9399 prior to the approval of pass-through status but, instead, should be billed with the appropriate "A" NOC code as follows:

1. Diagnostic Radiopharmaceuticals – All new diagnostic radiopharmaceuticals are assigned HCPCS code A4641 (Radiopharmaceutical, diagnostic, not otherwise classified). HCPCS code A4641 should be used to bill a new diagnostic radiopharmaceutical until the new diagnostic radiopharmaceutical has been granted pass-through status and a C-code has been assigned. HCPCS code A4641 is assigned status indicator "N" and, therefore, the payment for a diagnostic radiopharmaceutical assigned to HCPCS code A4641 is packaged into the payment for the associated service.

2. Contrast Agents – All new contrast agents are assigned HCPCS code A9698 (Non-radioactive contrast imaging material, not otherwise classified, per study) or A9700 (Supply of injectable contrast material for use in echocardiography, per study). HCPCS code A9698 or A9700 should be used to bill a new contrast agent until the new contrast agent has been granted pass-through status and a C-code has been assigned. HCPCS code A9698 is assigned status indicator "N" and, therefore, the payment for a drug assigned to HCPCS code A9698 is packaged into the payment for the associated service. The status indicator for A9700 will change from SI=B (Not paid under OPPS) to SI=N (Payment is packaged into payment for other services) and, therefore, the payment for a drug assigned to HCPCS code A9700 is packaged into the payment for the associated service.

7. 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

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

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

		A	B	HHH	MAC		RIER	I	FISS	MCS	VMS	CWF	
8338.1	Medicare contractors shall install the July 2013 OPPS Pricer.	X				X		X	X				COBC
8338.2	Medicare contractors shall manually add the following HCPCS codes to their system: -HCPCS code in table 1, effective July 1, 2013; and -CPT codes listed in table 3, effective July 1, 2013; and -C9131 in table 4, effective July 1, 2013; and -Q2033 in table 5, effective January 16, 2013 ; and -HCPCS codes listed in table 7, effective July 1, 2013; and -G0460 listed in the July I/OCE CR, effective August 2, 2012; and -K0008, K0013, K0900 and Q0090 listed in the July I/OCE CR, effective July 1, 2013. Note: These HCPCS codes will be included with the July 2013 I/OCE update. Status and payment indicators for these HCPCS codes will be listed in the July 2013 update of te OPPS Addendum A and Addendum B on CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/HospitalOutpatientPPS/AddendumA-and-Addendum-B-Updates.html.	X				X		X	X				COBC
8338.3	Medicare contactors shall manually delete C1879 from their systems effective June 30, 2013. **Note:** This deletion will be reflected in the July 2013 I/OCE update and in the July 2013 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					COBC
8338.4	Medicare contractors shall adjust, as appropriate, claims brought to their attention that: 1. Have dates of service that fall on or after April 1, 2013, but prior to July 1, 2013; and	X				X		X					COBC

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	2. Contain HCPCS codes listed in table 9; and 3. Were originally processed prior to the installation of the July 2013 OPPS Pricer.												

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
8338.5	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

X-Ref Requirement Number	Recommendations or other supporting information:
	None

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. − Tables Related to the Policy Section

Table 1 – New service payable under OPPS effective July 1, 2013

HCPCS	Effective date	SI	APC	Short Descriptor	Long descriptor	Payment	Minimum Unadjusted Copayment
C9736	7/1/2013	T	0131	Lap ablate uteri fibroid rf	Laparoscopy, surgical, radiofrequency ablation of uterine fibroid(s), including intraoperative guidance and monitoring, when performed	$3,487.15	$1,001.89

Table 2 – New long descriptor for C9734 effective July 1, 2013

HCPCS	Effective date	SI	APC	Short Descriptor	Long descriptor	Payment	Minimum Unadjusted Copayment
C9734	4/01/2013	S	0067	U/S trtmt, not leiomyomata	Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with magnetic resonance (MR) guidance	$3,300.64	$660.13

Table 3 -- Category III CPT Codes Implemented as of July 1, 2013

CPT Code	Long Descriptor	SI	APC
0329T	Monitoring of intraocular pressure for 24 hours or longer, unilateral or bilateral, with interpretation and report	E	N/A
0330T	Tear film imaging, unilateral or bilateral, with interpretation and report	S	0230
0331T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment;	S	0398
0332T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT	S	0398
0333T	Visual evoked potential, screening of visual acuity, automated	E	N/A
0334T	Sacroiliac joint stabilization for arthrodesis, percutaneous or minimally invasive (indirect visualization), includes obtaining and applying autograft or allograft (structural or morselized), when performed, includes image guidance when performed (eg, CT or fluoroscopic)	T	0208

Table 4 – Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2013

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 7/1/13
C9131*	Injection, ado-trastuzumab emtansine, 1 mg	9131	G
Q4122	Dermacell, per square centimeter	1419	G

Note: The HCPCS codes identified with an "*" indicate that these are new codes effective July 1, 2013.

Table 5– Flublok Influenza Vaccine OPPS Status Indicator

HCPCS Code	Short Descriptor	Long Descriptor	APC	Status Indicator Effective 07/01/13
Q2033	Influenza Vaccine, (Flublok)	Influenza Vaccine, Recombinant Himagglutinin Antigens, for Intramuscular Use (Flublok)	N/A	L

Table 6– Fluarix Quadrivalent (Influenza virus vaccine) Effective January 1, 2013

HCPCS Code	Short Descriptor	Long Descriptor	APC	Status Indicator Effective 01/01/13
90686	Flu vac no prsv 4 val 3 yrs+	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use	N/A	L

Table 7 – New HCPCS Codes for Certain Drugs and Biologicals Effective July 1, 2013

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 7/1/13
Q2050*	Injection, Doxorubicin Hydrochloride, Liposomal, Not Otherwise Specified, 10 mg	7046	K
Q2051**	Injection, Zoledronic Acid, Not Otherwise Specified, 1 mg	1356	K

*HCPCS code J9002 (Injection, Doxorubicin Hydrochloride, Liposomal, Doxil, 10 mg) will be replaced with HCPCS code Q2050 effective July 1, 2013. The status indicator for HCPCS code J9002 will change to E, "Not Payable by Medicare", effective July 1, 2013.

** HCPCS code J3487 (Injection, Zoledronic Acid (Zometa), 1 mg) and HCPCS code J3488 (Injection, Zoledronic Acid (Reclast), 1 mg) will be replaced with HCPCS code Q2051 effective July 1, 2013. The status indicators for HCPCS codes J3487 and J3488 will change to E, "Not Payable by Medicare", effective July 1, 2013.

Table 8 – Drugs and Biologicals with Revised Status Indicators Effective July 1, 2013

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 7/1/13
Q4126	Memoderm, dermaspan, tranzgraft or integuply, per square centimeter	1452	K
Q4134	Hmatrix, per square centimeter	1453	K

Table 9 – Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2013 through June 30, 2013

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9297	G	9297	Omacetaxine mepesuccinate	$2.53	$0.51
C9298	G	9298	Injection, ocriplasmin	$1,046.75	$209.35

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

Table of Contents
(Rev.2718, Issued: 06-07-13)

Transmittals for Chapter 4

61.4.1 - Billing for Brachytherapy Sources - General

(Rev.2718, Issued: 06-07-13, Effective: 07-01-13, Implementation: 07-01-13)

Brachytherapy sources (e.g., brachytherapy devices or seeds, solutions) are paid separately from the services to administer and deliver brachytherapy in the OPPS, per section 1833(t)(2)(H) of the Act, reflecting the number, isotope, and radioactive intensity of devices furnished, as well as stranded versus non-stranded configurations of sources. Therefore, providers must bill for brachytherapy sources in addition to the brachytherapy services with which the sources are applied, in order to receive payment for the sources. The separately payable sources *are* found in Addendum B of the most recent OPPS annual update published *on the CMS web site*. New sources meeting the OPPS definition of a brachytherapy source may be added for payment beginning any quarter, and the new source codes and descriptors are announced in recurring update notifications.
Each unit of a billable source is identified by the unit measurement in the respective source's long descriptor. Seed-like sources are generally billed and paid "per source" based on the number of units of the source HCPCS code reported, including the billing of the number of sources within a stranded configuration of sources. Providers therefore must bill the number of units of a source used with the brachytherapy service rendered.

61.4.5 - Payment for New Brachytherapy Sources

Rev.2718, Issued: 06-07-13, Effective: 07-01-13, Implementation: 07-01-13)

Not otherwise specified (NOS) brachytherapy source codes are available for payment of new brachytherapy sources for which source codes have not yet been established: C2698 (Brachytherapy source, stranded, not otherwise specified, per source), and C2699 (Brachytherapy source, non-stranded, not otherwise specified, per source). The payment rates for these NOS codes are based on a rate equal to the lowest stranded or non-stranded payment rate for such sources, respectively, on a per source basis (as opposed, for example, to per mCi). Once CMS establishes a new HCPCS code for a new source, the new code will be assigned to its own APC, with the payment rate set based on consideration of external data and other relevant information, until claims data are available for the standard OPPS rate making methodology.