CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2775	**Date: August 23, 2013**
	Change Request 8428

SUBJECT: October 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 October 2013 OPPS update. The October 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 October 2013 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming October I/OCE CR.

EFFECTIVE DATE: October 1, 2013
IMPLEMENTATION DATE: October 7, 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
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
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
**Unless otherwise specified, the effective date is the date of service.*

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 2775	Date: August 23, 2013	Change Request: 8428

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

EFFECTIVE DATE: October 1, 2013
IMPLEMENTATION DATE: October 7, 2013

I. GENERAL INFORMATION

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

B. Policy: 1. Changes to Device Edits for October 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 Device Pass-Through Categories

Section 1833(t)(6)(B) of the Social Security Act requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that we create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

We are establishing one new device pass-through category as of October 1, 2013. Table 1, in Attachment A, provides a listing of new coding and payment information concerning the new device category for transitional pass-through payment.

a. Device Offset from Payment: Section 1833(t)(6)(D)(ii) of the Act requires that we deduct from pass-through payments for devices an amount that reflects the portion of the APC payment amount that we determine is associated with the cost of the device (70 FR 68627-8).

We have determined that we are not able to identify a portion of the APC payment amount associated with the cost of C1841 (Retinal prosthesis, includes all internal and external components) in APC 0672, Level III, Posterior segment eye procedures. The device offset from payment represents a deduction from pass-through payments for devices associated with the device in category C1841, which we believe there are none. Therefore, we are establishing an offset amount for C1841 of $0 and will not make any offset deduction from pass-through payment.

3. Billing for Drugs, Biologicals, and Radiopharmaceuticals

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective October 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 October 2013 release of the OPPS Pricer. The updated payment rates, effective October 1, 2013 will be included in the October 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 October 1, 2013

Two drugs and biologicals have been granted OPPS pass-through status effective October 1, 2013. These items, along with their descriptors and APC assignments, are identified in Table 2, in Attachment A.

c. Fluzone (Influenza virus vaccine)

CPT code 90685 was effective January 1, 2013, however, the flu vaccine associated with this code was not approved by the FDA until recently. Specifically, Fluzone (Influenza virus vaccine) was approved by the FDA on June 7, 2013. Because of this recent FDA approval, we are revising the status indicator for CPT code 90685 from “E” (Not paid by Medicare) to “L” (Influenza Vaccine; Pneumococcal Pneumonia Vaccine) effective June 7, 2013. Table 3, in Attachment A, provides the descriptors and OPPS status indicator for HCPCS code 90685.

d. Revised Status Indicator for HCPCS Codes Q4135 and Q4136 Effective October 1, 2013

Effective October 1, 2013, the status indicators for HCPCS code Q4135 (Mediskin, per square centimeter) and HCPCS code Q4136 (Ez-derm, 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 Q4135 and HCPCS code Q4136 will be separately paid and the prices for these codes will be updated on a quarterly basis. These codes are listed in Table 4, in Attachment A, and are effective for services furnished on or after October 1, 2013.

e. Updated Payment Rate for HCPCS code J1566 Effective July 1, 2013 through September 30, 2013

The payment rate for J1566 was incorrect in the July 2013 OPPS Pricer. The corrected payment rate is listed in Table 5, in Attachment A, and has been installed in the October 2013 OPPS Pricer, effective for services furnished on July 1, 2013 through September 30, 2013.

4. 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	
8428.1	Medicare contractors shall install the October 2013 OPPS Pricer.	X				X		X	X				COBC
8428.2	Medicare contactors shall manually add the following HCPCS codes to their systems: 1. HCPCS codes listed in tables 1 and 2, effective October 1, 2013; and 2. G9187 listed in the October I/OCE CR, effective October 1, 2013. **Note:** These HCPCS codes will be included with the October 2013 I/OCE update. Status and payment indicators for these HCPCS codes will be listed in the October 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	X				COBC
8428.3	Medicare contractors shall adjust, as appropriate, claims brought to their attention that: 1. Have dates of service that fall on or after July 1, 2013, but prior to October 1, 2013; and 2. Contain HCPCS code J1566; and 3. Were originally processed prior to the installation of the October 2013 OPPS Pricer	X				X		X					COBC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
8428.4	MLN Article : A provider education article related to this instruction will be available at	X				X		X	

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
	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.								

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

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

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

Attachment A. − Tables Related to the Policy Section

Table 1 − New Device Pass-Through Code

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Device Offset from Payment
C1841	10-01-13	H	1841	Retinal prosth int/ext comp	Retinal prosthesis, includes all internal and external components	$0

Table 2 – Drugs and Biologicals with OPPS Pass-Through Status Effective October 1, 2013

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 10/1/13
C1204*	Technetium Tc 99m tilmanocept, diagnostic, up to 0.5 millicuries	1463	G
C9132*	Prothrombin complex concentrate (human), Kcentra, per i.u. of Factor IX activity	9132	G

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

Table 3 – Fluzone Influenza Vaccine OPPS Status Indicator

HCPCS Code	Short Descriptor	Long Descriptor	APC	Status Indicator
90685	Flu vac no prsv 4 val 6-35 m	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use	N/A	L

Table 4 – Drugs and Biologicals with Revised Status Indicators Effective October 1, 2013

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 10/1/13
Q4135	Mediskin, per square centimeter	1461	K
Q4136	Ez-derm, per square centimeter	1462	K

Table 5 – Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2013 through September 30, 2013

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J1566	K	2731	Immune globulin, powder	$30.66	$6.13