CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3280	**Date: June 5, 2015**
	Change Request 9205

SUBJECT: July 2015 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 2015 OPPS update. The July 2015 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). This Recurring Update Notification applies to Chapter 4, section 20.6.11.

The July 2015 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming July 2015 I/OCE CR.

EFFECTIVE DATE: July 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2015

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	4/20.6.11/Use of HCPCS Modifier - PO

III. FUNDING:
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

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 3280	Date: June 5, 2015	Change Request: 9205

SUBJECT: July 2015 Update of the Hospital Outpatient Prospective Payment System (OPPS)

EFFECTIVE DATE: July 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2015

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the July 2015 OPPS update. The July 2015 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). This Recurring Update Notification applies to Chapter 4, section 20.6.11.

The July 2015 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming July 2015 I/OCE CR.

B. Policy:

1. 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 July 1, 2015. Table 1, 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. We have determined that a portion of the APC payment amount associated with the cost of C2613 is reflected in APC 0005. The C2613 device should always be billed with CPT Code 32405 (Biopsy, lung or mediastinum, percutaneous needle) which is assigned to APC 0005 for CY 2015. The device offset from payment represents a deduction from pass-through payments for the device in category C2613.

b. Application of Offset to C2623: On April 1, 2015, we determined that an offset would apply to C2623 because APCs 0083, APC 0229, and APC 0319 already contain costs associated with the device described by C2623. The device offset is a deduction from pass-through payments for C2623. After further review, we have determined that the costs associated with C2623 are not already reflected in APCs 0083, APC 0229 or APC 0319. Therefore, we are not applying an offset to C2623. This determination to not apply the device offset from payment will be retroactive to April 1, 2015. See 68 FR 63438-9 for further discussion about the device offset policy.

2. Category III CPT Codes

The American Medical Association (AMA) releases Category III Current Procedural Terminology (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 2015 update, CMS is implementing in the OPPS two Category III CPT codes that the AMA released in January 2015 for implementation on July 1, 2015. Both Category III CPT codes are separately payable under the hospital OPPS. The status indicators and APCs for these codes are shown in Table 2, attachment A. Payment rates for these services can be found in Addendum B of the July 2015 OPPS Update that is posted on the CMS website.

3. LINX Reflux Management System

In January 2014, CMS established HCPCS code C9737 to describe the laparoscopic implantation of a magnetic esophageal ring for the treatment of gastroesophageal reflux disease (GERD), which is the procedure associated with the LINX Reflux Management System. For the July 2015 update, the CPT Editorial Panel established CPT code 0392T to describe the LINX Reflux Management System. With the establishment of the CPT code, CMS is deleting HCPCS code C9737 effective June 30, 2015. Therefore, effective July 1, 2015, HOPDs must report CPT code 0392T to report the implantation of a magnetic esophageal ring associated with the LINX Reflux Management System procedure.

Table 3, attachment A, lists the long descriptors for HCPCS C9737 and CPT code 0392T. To view the July 2015 OPPS payment rate for CPT code 0392T, refer to the July 2015 OPPS Addendum B (which is available via the Internet on the CMS Web site).

4. Use of HCPCS Modifier - PO

Effective January 1, 2015, the definition of modifier -PO is "**Services, procedures, and/or surgeries furnished at off-campus provider-based outpatient departments.**" This modifier is to be reported with every HCPCS code for all outpatient hospital items and services furnished in an off-campus provider-based department of a hospital. See 42 CFR 413.65(a)(2) for a definition of "campus".

This modifier should not be reported for remote locations of a hospital (defined at 42 CFR 413.65(a)(2)), satellite facilities of a hospital (defined at 42 CFR 412.22(h)), or for services furnished in an emergency department.

Reporting of this modifier is voluntary for CY 2015; reporting of this modifier is required beginning January 1, 2016.

5. Drugs, Biologicals, and Radiopharmaceuticals

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective July 1, 2015

For CY 2015, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP+6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2015, 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. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective July 1, 2015 and drug price restatements can be found in the July 2015 update of the OPPS Addendum A and Addendum B on the CMS Web site at http://www.cms.gov/HospitalOutpatientPPS/.

b. Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates

Some drugs and biologicals paid based on the ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the CMS Web site on the first date of the quarter at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-

Payment/HospitalOutpatientPPS/index.html?redirect=/HospitalOutpatientPPS/01_overview.asp

Providers may resubmit claims that were impacted by adjustments to previous quarter's payment files.

c. Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2015

Three drugs and biologicals have been granted OPPS pass-through status effective July 1, 2015. These items, along with their descriptors and APC assignments, are identified in Table 4, attachment A.

d. New HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Biosimilar Biological Products

Effective July 1, 2015 two new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. These new codes are listed in Table 5, attachment A.

The first biosimilar, Zarxio® listed in table 6, attachment A, was approved by the FDA on March 6, 2015. As the biosimilar is currently not being marketed, pricing information is not available for Zarxio for the July OPPS quarterly release. Once Zarxio is marketed we will make pricing information available at the soonest possible date on the OPPS payment files and payment for Zarxio will be retroactive to the date the product is first marketed.

e. Revised Descriptor for HCPCS Code C9349

Effective July 1, 2015, the descriptor for HCPCS code C9349 will change from FortaDerm, and FortaDerm Antimicrobial, any type, per square centimeter to PuraPly, and PuraPly Antimicrobial, any type, per square centimeter. See table 7, attachment A.

f. Revised Status Indicators for HCPCS Codes J0365, 90620, and 90621

Effective April 1, 2015, the status indicator for HCPCS code J0365 (Injection, aprotonin, 10,000 kiu) will change from SI=K (Paid under OPPS; separate APC payment) to SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)).

Effective February 1, 2015, the status indicators for HCPCS codes 90620 (Menb pr w/omv vaccine im) and 90621 (Menb rlp vaccine im) 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).

These codes are listed in Table 8, attachment A, along with the effective date for the revised status indicator.

g. Other Changes to CY 2015 HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals

Effective July 1, 2015, HCPCS code Q9978 Netupitant Palonosetron oral will replace HCPCS code C9448 Netupitant Palonosetron oral. The status indicator will remain G, "Pass-Through Drugs and Biologicals".

Table 9, attachment A, describes the HCPCS code change and effective date.

6. Hyperbaric Oxygen Therapy

Effective January 1, 2015, HCPCS code C1300, *Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval* has been discontinued. Hospitals providing hyperbaric oxygen (HBO) therapy should report this service using HCPCS code G0277, *Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval* that is effective January 1, 2015. The following may be included in calculating the total number of 30-minute intervals billable under G0277: (1) time spent by the patient under 100% oxygen; (2)

descent; (3) airbreaks; and (4) ascent.

NOTE: A physician order for a 90-minute HBO treatment typically means that the physician desires that the patient be placed under 100% oxygen for 90 minutes. In order to safely achieve 100% oxygen for 90 minutes, additional time may be needed to provide for the descent, airbreaks, and ascent. Therefore, the total number of billable 30-minute intervals would not be based solely on the amount of time noted on the physician order. In calculating how many 30-minute intervals to report, hospitals should take into consideration the time spent under pressure during descent, airbreaks, and ascent. Additional units may be billed for sessions requiring at least 16 minutes of the next 30-minute interval. For example, 2 units of HCPCS code G0277 should be billed for a session in duration of between 46 and 75 minutes, while 3 units should be billed for a session in duration of between 76 and 105 minutes. Furthermore, 4 units of HCPCS code G0277 should be billed for a session in duration of between 106 and 135 minutes. HBO is typically prescribed for an average of 90 minutes, which hospitals should report using appropriate units of HCPCS code G0277 in order to properly bill for full body HBO therapy. In general, we do not expect that a physician order for 90 minutes of HBO therapy would exceed 4 billed units of HCPCS code G0277.

EXAMPLE:

Physician orders and patient receives 90 minutes of therapeutic HBO;

Patient requires and receives 10 minutes of descent time;

Patient requires and receives 10 minutes of air breaks;

Patient requires and receives 10 minutes of ascent time.

The above example would be billed correctly by reporting 4 units of HCPCS code G0277, reflecting the sum of the 90 minutes of therapeutic HBO, 10 minutes for descent, 10 minutes for air breaks, and 10 minutes for ascent.

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. Medicare Administrative Contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, 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			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9205.1	Medicare contractors shall install the July 2015 OPPS Pricer.	X		X		X				BCRC
9205.2	Medicare contactors shall manually add the following	X		X						BCRC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	HCPCS codes to their systems: • HCPCS codes listed in tables 1, 2, and 4 of Attachment A, effective July 1, 2015; and • HCPCS codes Q9976 and Q9977 listed in table 5 of Attachment A, effective July 1, 2015; and • HCPCS code Q5101 listed in table 6 of Attachment A, effective March 6, 2015; and • HCPCS code Q9978 listed in table 9 of Attachment A, effective July 1. 2015; and • CPT codes 0009M – 0010M listed in the upcoming July I/OCE CR, effective July 1, 2015. **Note:** These HCPCS codes will be included with the July 2015 I/OCE update. Status and payment indicators for these HCPCS codes will be listed in the July 2015 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									
9205.3	Medicare contactors shall add the termination date of June 30, 2015, to the following HCPCS codes in their systems: • HCPCS code C9737 listed in table 3 of Attachment A; and • HCPCS code C9448 listed in table 9 of Attachment A. **Note:** The deletions of these codes will be reflected in the July 2015 I/OCE update and in the July 2015 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						BCRC
9205.4	Medicare contractors shall adjust, as appropriate, claims brought to their attention with any retroactive	X		X						BCRC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	changes that were received prior to implementation of July 2015 OPPS Pricer.									
9205.5	Medicare contractors shall adjust, as appropriate, claims brought to their attention that: 1. Contain HCPCS code C2623, listed in table 1 of Attachment A in CR9097; and 2. Have dates of service that fall on or after April 1, 2015 through July 1, 2015; and 3. Were originally processed prior to the installation of the July 2015 OPPS Pricer.	X		X						BCRC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9205.6	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 5 business days after receipt of the notification from CMS announcing the availability of the 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		

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).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 1

Policy Section Tables

Table 1 − New Device Pass-Through Code

HCPCS	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Device Offset from Payment
C2613	07-01-15	H	2613	Lung bx plug w/del sys	Lung biopsy plug with delivery system	$24.83

Table 2 -- Category III CPT Codes Implemented as of July 1, 2015

CY 2015 CPT Code	CY 2015 Long Descriptor	July 2015 OPPS Status Indicator	July 2015 OPPS APC
0392T	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band)	T	0174
0393T	Removal of esophageal sphincter augmentation device	Q2	0130

Table 3 – The Long Descriptors for HCPCS C9737 and CPT Code 0392T

CPT / HCPCS Code	Long Descriptor	Add Date	Termination Date	July 2015 OPPS SI	July 2015 OPPS APC
C9737	Laparoscopy, surgical, esophageal sphincter augmentation with device (eg, magnetic band)	1/1/2014	6/30/2015	T	0174
0392T	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band)	7/1/2015		T	0174

Table 4 – Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2015

HCPCS Code	Long Descriptor	Status Indicator	APC
C9453	Injection, nivolumab, 1 mg	G	9453
C9454	Injection, pasireotide long acting, 1 mg	G	9454
C9455	Injection, siltuximab, 10 mg	G	9455

Table 5 – New HCPCS Codes Effective July 1, 2015, for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2015 HCPCS Code	CY 2015 Long Descriptor	CY 2015 SI
Q9976	Injection, Ferric Pyrophosphate Citrate Solution, 0.01 mg of iron	E
Q9977	Compounded Drug, Not Otherwise Classified	N

Table 6 – New HCPCS Code Effective March 6, 2015, for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2015 HCPCS Code	CY 2015 Long Descriptor	CY 2015 SI
Q5101	Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram	E

Table 7 – Revised Descriptor for HCPCS Code C9349

HCPCS Code	Previous 2015 Short Descriptor	Previous 2015 Long Descriptor	Revised July 2015 Short Descriptor	Revised July 2015 Long Descriptor
C9349	FortaDerm, FortaDerm Antimic	FortaDerm , and FortaDerm Antimicrobial, any type, per square centimeter	PuraPly, PuraPly Antimic	PuraPly, and PuraPly Antimicrobial, any type, per square centimeter

Table 8 – Drug and Biological with Revised Status Indicator

HCPCS Code	Long Descriptor	APC	Status Indicator	Effective Date
J0365	Injection, aprotonin, 10,000 kiu		E	4/1/2015
90620	Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B, 2 dose schedule, for intramuscular use	1807	K	2/1/2015
90621	Meningococcal recombinant lipoprotein vaccine, serogroup B, 3 dose schedule, for intramuscular use	1808	K	2/1/2015

Table 9 – New HCPCS Codes for Certain Drugs and Biologicals Effective July 1, 2015

HCPCS Code	Short Descriptor	Long Descriptor	Status Indicator	APC	Added Date	Termination Date
C9448	Netupitant	Netupitant 300 mg and Palonosetron	G	9448	04/01/2015	06/30/2015

	Palonosetron oral	0.5 mg, oral				
Q9978	Netupitant Palonosetron oral	Netupitant 300 mg and Palonosetron 0.5 mg, oral	G	9448	07/01/2015	

20.6.11 - Use of HCPCS Modifier - PO

(Rev.3280, Issued: 06-05-15, Effective: 07-01-15, Implementation: 07-06-15)

Effective January 1, 2015, the definition of modifier -PO is "**Services, procedures, and/or surgeries furnished at off-campus provider-based outpatient departments.**" This modifier is to be reported with every HCPCS code for *all* outpatient hospital *items and* services furnished in an off-campus provider-based department of a hospital. See 42 CFR 413.65(a)(2) for a definition of "campus".

This modifier should not be reported for remote locations of a hospital (defined at 42 CFR 41*3*.65*(a)(2)*), satellite facilities of a hospital (defined at 42 CFR 412.22(h)), or for services furnished in an emergency department.

Reporting of this modifier is voluntary for CY 2015; reporting of this modifier is required beginning January 1, 2016.