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October 2018 Update of the Hospital Outpatient Prospective Payment System (OPPS)

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Related CR Transmittal Number: R4123CP
Implementation Date: October 1, 2018

PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for providers and suppliers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR10923 describes changes to and billing instructions for various payment policies implemented in the October 2018 Outpatient Prospective Payment System (OPPS) update. The October 2018 Integrated Outpatient Code Editor (I/OCE) will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR10923. Make sure your billing staffs are aware of these updates.

BACKGROUND

CR 10923 informs you of the following changes to billing instructions for various payment policies implemented in the October 2018 OPPS update.

Key changes are as follows:

1. New Separately Payable Procedure Code

Effective October 1, 2018, HCPCS code C9750 is created, as described in Table 1, and assigned to APC 5223 (Level 3 Pacemaker and Similar Procedures) with a payment rate of $9,747.99. This procedure was previously described by Category III Current Procedural Terminology (CPT) code 0302T, which was deleted December 31, 2017.

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Table 1 – New Separately Payable Procedure Code, Effective October 1, 2018

HCPCS Code	Short Descriptor	Long Descriptor	SI	APC	Payment Rate
C9750	Ins/rem-replace compl iims	Insertion or removal and replacement of intracardiac ischemia monitoring system including imaging supervision and interpretation and peri-operative interrogation and programming; complete system (includes device and electrode)	J1	5223	$9,747.99

2. Drugs, Biologicals, and Radiopharmaceuticals

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective October 1, 2018

For Calendar (CY) 2018, payment for separately payable, non-pass-through drugs, biologicals and therapeutic radiopharmaceuticals that were not acquired through the 340B Program is made at a single rate of ASP + 6 percent (or ASP - 22.5 percent if acquired under the 340B Program), which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2018, 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 October 1, 2018, and drug price restatements are in the October 2018 update of the OPPS Addendum A and Addendum B on the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.gov/HospitalOutpatientPPS/.

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

Some drugs and biologicals based on 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 first date of the quarter at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html.

c. Drugs and Biologicals with OPPS Pass-Through Status Effective October 1, 2018

Eight drugs and biologicals have been granted OPPS pass-through status, effective October 1, 2018. These drugs and biologicals are described in Section 2b and 2c of this article and are in Tables 2 and 3.

Four drugs and biologicals have been granted new OPPS pass-through status, effective October 1, 2018. CMS received a completed pass-through application for these drugs, which

passed both the newness and cost criteria to receive pass-through payment. These items, along with their descriptors and APC assignments, are identified in Table 2.

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

Table 2 – Drugs and Biologicals with OPPS Pass-Through Status Effective October 1, 2018

HCPCS Code	Long Descriptor	SI	APC
C9033	Injection, fosnetupitant 235 mg and palonosetron 0.25 mg	G	9099
C9034	Injection, dexamethasone 9%, intraocular, 1 mcg	G	9172
Q5105	Injection, epoetin alfa, biosimilar, (Retacrit) (for esrd on dialysis), 100 units	G	9096
Q5106	Injection, epoetin alfa, biosimilar, (Retacrit) (for non-esrd use), 1000 units	G	9097

Table 3 – Drugs and Biologicals Receiving Pass-Through Status in Accordance with Public Law 115-141 Effective October 1, 2018

HCPCS Code	Long Descriptor	SI	APC
A9586	Florbetapir f18, diagnostic, per study dose, up to 10 millicuries	G	9084
C9447	Injection, phenylephrine and ketorolac, 4 ml vial	G	9083
Q4172	PuraPly, and PuraPly Antimicrobial, any type, per square centimeter	G	9082
Q9950	Injection, sulfur hexafluoride lipid microsphere, per ml	G	9085

d. Proposed Drugs, Biologicals, and Radiopharmaceuticals with Pass-Through Status as a Result of Section 1301 of the Consolidated Appropriations Act of 2018 (Public Law 115-141)

Section 1301(a)(1) of the Consolidated Appropriations Act of 2018 (Pub. L. 115-141) amended section 1833(t)(6) of the Social Security Act and added a new section 1833(t)(6)(G), which provides that, for drugs or biologicals whose period of pass-through payment status ended on December 31, 2017, and for which payment was packaged into a covered hospital outpatient

service furnished beginning January 1, 2018, such pass-through payment status shall be extended for a 2-year period beginning on October 1, 2018, through September 30, 2020. There are four products whose period of drug and biological pass-through payment status ended on December 31, 2017; these four drugs and biologicals will have pass-through status reinstated effective October 1, 2018. These products are listed in Table 3.

Beginning in CY 2019, CMS proposed to continue pass-through payment status for these drugs and biologicals (83 FR 37114).

Section 1301(a)(1) of Pub. L. 115-141 also added a new subparagraph (H) to section 1833(t)(6) to the Act, which provides for a temporary payment rule for drugs and biologicals whose period of pass-through payment ended on December 31, 2017. Under this provision, the payment amount for such drugs or biologicals furnished during the period beginning on October 1, 2018 and ending on March 31, 2019, shall be the greater of the payment amount that would otherwise apply under subparagraph (D)(i) for such drug or biological or the payment amount that applied under subparagraph (D)(i) for such drug or biological on December 31, 2017. In addition, section 1301(a)(1) of Pub. L. 115-141 added a new subparagraph (I) to section 1833(t)(6) to require that, for any drug or biological whose period of pass-through payment ended on December 31, 2017, and for which payment under this subsection is packaged into a payment amount for a covered hospital Outpatient Department (OPD) service (or group of services) furnished during the period beginning on October 1, 2018, and ending on December 31, 2018, the Secretary shall remove the packaged costs of such drug or biological from the payment amount for the covered OPD service with which it is packaged. Finally, section 1301(a)(3) of Pub. L. 115-141 permits the Secretary to implement the amendments made by section 1301(a)(1) and (2) by program instruction or otherwise. CR10923 implements the requirement in section 1833(t)(6)(I)(i) to remove the packaged costs of the drugs or biologicals listed in Table 3 from the payment amounts for the covered OPD services (or groups of services) with which they are packaged.

As explained above, these drugs and biologicals will be receiving separate payment under the OPPS instead of having their costs packaged into the payment amount for associated procedures for the period beginning October 1, 2018 through December 31, 2018. Therefore, CMS updated the CY 2018 payment rates to reflect the separate payment for the drugs and biologicals listed in Table 3 and found the payment rates for the 10 APCs listed in Table 4 were affected by the separate payment for these drugs and biologicals, and therefore, CMS removed the costs of the drugs and biologicals from the payment amounts for these APCs. The updated payment rates for these APCS, which are effective October 1, 2018 through December 31, 2018, are in the October 2018 update of the OPPS Addendum A and Addendum B at http://www.cms.gov/HospitalOutpatientPPS/.

Table 4 – APCs with New Payment Rates because of the Separate Payment for Certain Drugs and Biologicals Receiving Pass-Through Status in Accordance with Public Law 115-141 Effective October 1, 2018, through December 31, 2018

Long Descriptor	SI	APC
Level 5 Intraocular Procedures	J1	5495
Level 1 Intraocular Procedures	J1	5491
Level 3 Imaging with Contrast	S	5573
Level 4 Nuclear Medicine and Related Services	S	5594
Level 3 Intraocular Procedures	J1	5493
Level 2 Intraocular Procedures	J1	5492
Level 3 ENT Procedures	T	5163
Level 2 Imaging with Contrast	S	5572
Pulmonary Treatment	S	5791
Level 4 Extraocular, Repair, and Plastic Eye Procedures	J1	5504

e. New Biosimilar HCPCS Code

HCPCS code Q5108, listed in table 5, is a biosimilar with the trade name Fulphila that will be paid separately in the OPPS. The code will be included in the OPPS with an effective date retroactive to July 12, 2018, per CR10834, which states that HCPCS code is payable for Medicare for claims with a date of service on or after July 12, 2018.

Table 5 — New Biosimilar HCPCS Code Effective July 12, 2018

HCPCS Code	Long Descriptor	SI	APC	Effective Date
Q5108	Injection, pegfilgrastim-jmdb, biosimilar, (fulphila), 0.5 mg	K	9173	07/12/2018

3. Reassignment of Skin Substitute Product from the Low-Cost Group to the High-Cost Group

One skin substitute product, HCPCS code Q4181, is reassigned from the low-cost skin substitute group to the high-cost skin substitute group based on updated pricing information. The product is listed in Table 6.

Table 6 – Reassignment of Skin Substitute Product from the Low Cost Group to the High Cost Group Effective October 1, 2018

HCPCS Code	Short Descriptor	SI	Low/High Cost Skin Substitute
Q4181	Amnio wound, per square cm	N	High

4. Changes to OPPS Pricer Logic

a. New OPPS payment rates and copayment amounts will be effective October 1, 2018. All copayment amounts will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the CY 2018 inpatient deductible of $1,340. For most OPPS services, copayments are set at 20 percent of the APC payment rate.

b. Effective October 1, 2018, there will be one contrast agent, Q9950, receiving pass-through payment in the OPPS Pricer logic. For APCs containing nuclear medicine procedures, the I/OCE will send the off-set amount of the pass-through for the contrast agent, then Pricer will reduce the amount of the pass-through contrast agent payment by the wage-adjusted offset for the APC with the highest offset amount when the contrast agent with pass-through appears on a claim with a nuclear procedure. The offset will cease to apply when the contrast agent expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals are the "policy-packaged" portions of the CY 2018 APC payments for nuclear medicine procedures and are on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html.

5. Coverage Determinations

As a reminder, 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.

ADDITIONAL INFORMATION

The official instruction, CR10923, issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4123CP.pdf.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
August 27, 2018	Initial article released.