Outpatient Facility Coding Alert

Reimbursement: Don't Miss These New Opportunities for Procedure Payments

Check out these OPPS and ASC changes that could affect your reporting.

Having procedures added to the OPPS or ASC payment lists is always good news for providers, so update your systems to reflect new data for these services and medications, effective April 1, 2013.

Add New Services and Pass-Through Status

Two services were added to the OPPS payment list:

- C9734 (Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with or without magnetic resonance [MR] guidance): MRgFUS (MR guidance focused ultrasound) provides high intensity focused ultrasound waves to treat leiomyomatomas located other than the uterus, says **Sarah Goodman, MBA, CHCAF, CPC-H, CCP, FCS,** president of the consulting firm SLG, Inc., in Raleigh, N.C. Generally performed under moderate sedation, this is a non-invasive procedure which minimizes complications and allows for faster patient recovery. MRgFUS for ablation of uterine leiomyomata may be reported with Category III codes 0071T (Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue) and 0072T (... total leiomyomata volume greater or equal to 200 cc of tissue).
- C9735 (Anoscopy; with directed submucosal injection[s], any substance): This procedure, a treatment for fecal incontinence, involves the administration of four 1-ml injections into the anal canal of Solesta™ which is separately reported with HCPCS L8605 (Injection bulking agent dextranomer/hyaluronic acid copolymer implant, anal canal, 1 ml, includes shipping and necessary supplies).

Five drugs and biologicals saw pass-through status changes with the April announcement. Each now has a pass-through status indicator of "G" (Pass-through drugs and biological).

Explanation: Drugs that are granted "pass through" payment status are required by law to be reimbursed at either the amount paid under the physician fee schedule, or, if the drug is included in the Part B drug competitive acquisition program (CAP), at the Part B drug CAP rate. Drugs that have pass-through status may have coinsurance amounts that are less than 20 percent of the OPPS payment amount. This is because pass-through payment amounts, by law, are not subject to coinsurance. CMS considers the amount of the pass-through drug payment rate that exceeds the otherwise applicable OPPS payment rate to be the pass-through payment amount. (Source: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf):

- C9130 □ Injection, immune globulin (Bivigam), 500 mg
- C9297 □ Injection, omacetaxine mepesuccinate, 0.01 mg
- C9298 □ Injection, ocriplasmin, 0.125 mg
- J7315 □ Mitomycin, opthalmic, 0. 2 mg
- Q4127 □ Talymed, per square centimeter.

Four of the affected codes (C9130, C9297, C9298, and J7315) are new for 2013. "It's very common for new codes to not

all have the correct information when they're first introduced," Goodman says. "Often, the guidance comes later from CMS or can be found on the manufacturer's website."

Correct Payment Rates for Existing Services

The April 1 changes also introduced payment rates for two procedures and corrected ASC payment rates for two HCPCS codes.

- The payment rate for 77371 (Radiation treatment delivery, stereotactic radiosurgery [SRS], complete course of treatment of cranial lesion[s] consisting of 1 session; multi-source Cobalt 60 based) is now $7,911 for rural hospitals and other eligible hospitals, and $3,301 for all other hospitals. The APC (ambulatory payment classification) is 0127 (Level IV stereotactic radiosurgery, MRgFUS, and MEG).
- The new payment rate for G0173 (Linear accelerator based stereotactic radiosurgery, complete course of therapy in one session) is $3,301. The APC is 0067 (Level III stereotactic radiosurgery, MRgFUS, and MEG).

Payment rates for two HCPCS medications and supplies were incorrectly published in January 2013. The April report published corrected rates:

- J9263 (Injection, Oxaliplatin, 0.5 mg) The corrected payment rate is $3.95, with an ASC payment indicator of K2 (Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate) and an OPPS APC of 1738 (Nonpass-through drugs biological).
- Q4106 (Dermagraft, per square centimeter) The corrected payment rate is $42.55. This code also carries an ASC payment indicator of K2. Its OPPS APC is 1245 (Dermagraft skin sub).

Retroactive: The corrected payment rates are retroactive to January 1, 2013. If your facility received incorrect payment for either J9263 or Q4106 between January 1, 2013 and March 31, 2013, request an adjustment to the previously processed claims.