CMS made relatively few changes in the April quarterly I/OCE update, introducing four new APCs, deleting one, and reclassifying several skin substitute codes.

“This is what I refer to as an ‘off quarter,’” says Dave Fee, MBA, product marketing manager at 3M Health Information Systems, in Murray, Utah. CMS’ extensive January changes are often followed by modest updates in the next quarter.

Skin substitute updates

The April update also brought changes to the packaging of skin substitutes that was introduced in the 2014 OPPS final rule.

In the final rule, CMS created two groups for packaging:

- High-cost skin substitutes having a weighted average cost greater than $32 per square cm
- Low-cost skin substitutes having a weighted average cost less than $32 per square cm

Liquid or powder skin substitutes that are per milliliter or per milligram are packaged into the surgical procedure in which they are used.

As part of the April update, CMS added three skin substitute products to the high-cost category, effective April 1:

- Q4121, TheraSkin
- Q4147, architect extracellular matrix, per square cm
- Q4148, Neox™ 1k, per sq. cm

Q4121 is a new code, and is assigned status indicator G, meaning that unlike the other codes added to the high-cost category, it has pass-through status and a separate payment may be provided with an off-set for applying it. Q4147 and Q4148 have been moved from the low-cost category.

CMS also updated the logic for edit 87, which included the procedure codes for both high- (CPT codes 15271, 15273, 15275, 15277) and low-cost (C5271, C5273, C5275, C5277) substitutes. Effective April 1, edit 87 now includes the add-on codes for applying these products:

- 15272, application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area, each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure 15273, application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children
• 15274, application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children, each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof

• 15276, application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area, each additional 25 sq cm wound surface area, or part thereof

• 15278, application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children, each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof

The edit also includes the similarly worded codes for low-cost substitutes (C5272, C5274, C5276, C5278).

New revenue codes

CMS added eight new revenue codes, effective January 1:

• 0690, pre-hospice/palliative care services, general
• 0691, pre-hospice/palliative care services, visit charge
• 0692, pre-hospice/palliative care services, hourly charge
• 0693, pre-hospice/palliative care services, evaluation
• 0694, pre-hospice/palliative care services, consultation and education
• 0695, pre-hospice/palliative care services, inpatient care
• 0696, pre-hospice/palliative care services, physician services
• 0699, pre-hospice/palliative care services, other

Providers will have to pay attention to their use of these codes depending on the bill type, according to Fee. They will hit edit 48 (revenue center requires HCPCS) for Medicare patients if using the following bill types:

• 12x without condition code 41
• 13x
• 14x without condition code 41
• 74x
• 75x
• 76x

For other bill types, CMS will return an APC of 0 if the HCPCS field is blank.
Laboratory services billing

CMS also continued to refine the process for reporting packaged laboratory tests in the April update before an anticipated new modifier is introduced July 1, 2014. In the 2014 OPPS final rule, CMS packaged clinical laboratory tests in specific instances for claims on a 13x bill type, which were previously paid under the Clinical Laboratory Fee Schedule (CLFS).

Most of those instances were clear, except:

*When the hospital provides a laboratory test (directly or under arrangement) during the same encounter as other hospital outpatient services that is clinically unrelated to the other hospital outpatient services, and the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services provided in the hospital outpatient setting.*

“This continues to be an area of great concern and difficulty for hospitals,” Fee says.

Providers have had difficulty proving that lab tests were “unrelated” to other services provided during the encounter, in order to receive payment under the CLFS by billing the labs separately on a 14x.

Subsequently, National Uniform Billing Committee (NUBC) Chairman George Arges sent a public letter to CMS in January to say the use of a 14x in this manner violated HIPAA standards. Arges wrote that the 14x should only be used for billing for lab services provided to “non-patients” by definition.

In March, CMS announced it would introduce a new modifier July 1 for use on 13x bills for the exceptions that allow providers to claim separate payment, according to *MLN Matters®* article SE1412.

Until July 1, CMS has stated that hospitals can choose whether to bill “unrelated” labs on the 14x or on the 13x. If billed on the 13x, labs will be packaged under OPPS packaging logic.

The April I/OCE update changes the status indicator for clinical labs billed on both the 12x and 14x from N to A (services paid under fee schedule or payment system other than OPPS), effective January 1. The exception is for 12x bills with condition code W2 present, in which case the labs will remain packaged.

**New APCs**

Two APCs were added with an effective date of January 1, 2014, and assigned status indicator K (nonpass-through drugs and nonimplantable biologicals, including therapeutic radiopharmaceuticals):

- 01477, injection, tbo-filgrastim, 5 mcg
- 01478, human fibrinogen concentrate injection

CMS also added two APCs with an effective date of April 1, 2014, with status indicator G (pass-through drugs and biologicals):

- 01476, injection, obinutuzumab
• 01479, TheraSkin®

CMS deleted APC 01645 (I131 tositumomab, rx) effective April 1, 2014.

The quarterly update added five new HCPCS Level II codes. Code G9361 (medical indication for induction) is effective retroactively to January 1, 2014, and was assigned status indicator M (items and services not billable to the fiscal intermediary/MAC).

CMS added the following codes to the I/OCE effective April 1, 2014:

• C9021 injection, obinutuzumab, status indicator G
• C9739, cystoscopy prostatic imp 1-3, status indicator T (significant procedure, multiple reduction applies)
• C9740, cystourethroscopy, with insertion of transprostatic implant; 4 or more implants, status indicator T
• Q2052, intravenous immunoglobulin demonstration, services/supplies, status indicator N (items and services packaged into APC rates)

CMS deleted four HCPCS codes, effective January 1, 2014:

• D0363, cone beam, three dimensional
• D3354, pulpal regeneration
• D5860, overdenture complete
• D5861, overdenture partial

In addition, CMS changed the status indicators or APCs for 12 codes and changed the descriptions for 921 codes.

Editor’s note: To review all of the code changes, as well as the full list of changes to skin substitute products and procedures, discounted devices, and more, see CMS Transmittal 2900 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/