

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



News Flash – The Centers for Medicare & Medicaid Services (CMS) has made changes to the Medicare Overpayment Notification Process. If an outstanding balance has not been resolved, providers previously received three notification letters regarding Medicare Overpayments, an Initial Demand Letter (1st Letter), a Follow-up-Letter (2nd Letter), and an Intent to Refer Letter (3rd Letter). CMS would send the second demand letter to providers 30 days after the initial notification of an overpayment. Recent review has determined that the majority of providers respond to the initial demand letter and pay the debt. Currently recoupment action happens 41 days after the initial letter. The remittance advice which describes this action serves as another notice to providers of the overpayment. Therefore, effective Tuesday, November 1, 2011, the second demand letters are no longer being sent to providers. Provider appeal rights will remain unchanged. If an overpayment is not paid within 90 days of the initial letter, providers will continue to receive a letter explaining CMS' intention to refer the debt for collection.

MLN Matters® Number: MM7682 **Revised**

Related Change Request (CR) #: 7682

Related CR Release Date: December 29, 2011

Effective Date: January 1, 2012

Related CR Transmittal #: R2378CP

Implementation Date: January 3, 2012

January 2012 Update of the Ambulatory Surgery Center (ASC) Payment System

Note: This article was updated on July 31, 2012 to reflect current Web addresses. All other content remains the same.

Provider Types Affected

This article is for Ambulatory Surgery Centers (ASCs), which submit claims to Medicare Administrative Contractors (MACs) and carriers, for services provided to Medicare beneficiaries paid under the ASC payment system.

What You Need to Know

This article is based on Change Request (CR) 7682 which describes changes to and billing instructions for payment policies implemented in the January 2012 ASC

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payment system update. CR7682 also includes updates to the Healthcare Common Procedure Coding System (HCPCS).

Included in CR7682 are Calendar Year (CY) 2012 payment rates for separately payable drugs and biologicals, including long descriptors for newly created Level II HCPCS codes for drugs and biologicals (ASC DRUG files), and the CY 2012 ASC payment rates for covered surgical and ancillary services (ASCFS file).

Many ASC payment rates under the ASC payment system are established using payment rate information in the Medicare Physician Fee Schedule (MPFS). The payment files associated with CR7682 reflect the most recent changes to CY 2012 MPFS payment.

Key Points of CR7682

New Device Pass-Through Category and Device Offset from Payment

- CMS is establishing one new device pass-through category as of January 1, 2012, for the Outpatient Prospective Payment System (OPPS) and the ASC payment system. HCPCS code C1886 (Catheter, extravascular tissue ablation, any modality (insertable)), which is assigned ASC Payment Indicator (PI) of J7 (OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced).
- CMS has determined that it is able to identify a portion of the OPPS payment associated with the cost of HCPCS code C1840 for the insertion procedure described by new HCPCS code C9732 (Insertion of ocular telescope prosthesis including removal of crystalline lens). Therefore, ASC payment for the nondevice facility resources for the insertion procedure will be based upon the nondevice portion of the related OPPS payment weight for HCPCS code C9732. The ASC Code Pair File will be used to establish the reduced ASC payment amount for HCPCS code C9732 only when billed with HCPCS code C1840.

Billing Instructions for C9732 and C1840

- Pass-through category C1840 (Lens, intraocular (telescopic)), is to be billed and paid for as a pass-through device only when provided with C9732 (Insertion of ocular telescope prosthesis including removal of crystalline lens) beginning on and after the effective date for C9732 of January 1, 2012.

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New Procedure Code

- CMS is establishing two new procedure codes effective January 1, 2012. The following table provides a listing of the descriptor and payment information for these new code.

HCPCS	Effective Date	Short Descriptor	Long Descriptor	CY2012 PI
C9732	01-01-12	Insert ocular telescope pros	Insertion of ocular telescope prosthesis including removal of crystalline lens	G2
G0448	01-01-12	Place perm pacing cardiovert	Insertion or replacement of a permanent cardioverter-defibrillator system with transvenous lead(s) single or dual chamber with insertion of pacing electrode, cardiac venous system, for left ventricular pacing	J8

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Cardiac Resynchronization Therapy Payment for Calendar Year (CY) 2012

- Effective for services furnished on or after January 1, 2012, cardiac resynchronization therapy involving an implantable cardioverter defibrillator (CRT-D) will be recognized as a single, composite service combining implantable cardioverter defibrillator procedures (described by Current Procedural Terminology (CPT) code 33249 (Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator)) and pacing electrode insertion procedures (described by CPT code 33225 (Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (including upgrade to dual chamber system))) when performed on the same Date of Service in an ASC.
- The payment rate for CRT-D services in ASCs will be based on the OPPS payment rate applicable to APC 0108 and ASCs will use the HCPCS Level II G-code G0448 (Insertion or replacement of a permanent pacing cardioverter-defibrillator system with transvenous lead(s) single or dual chamber with insertion of pacing electrode, cardiac venous system, for left ventricular pacing) for proper reporting when the procedures described by CPT codes 33225 and 33249 are performed on the same Date of Service. When these procedures are not performed on the same Date of Service, the ASC payment rate will be based on the standard APC assignment for each service and ASCs should report the appropriate CPT codes for the individual procedures.

Reporting HCPCS Codes for All Drugs, Biologicals, and Radiopharmaceuticals

- CMS strongly encourages ASCs to report charges for all separately payable drugs and biologicals, using the correct Healthcare Common Procedure Coding System (HCPCS) codes for the items used. ASCs billing for these products must make certain that the reported units of service for the reported HCPCS codes are consistent with the quantity of the drug or biological that was used in the care of the patient. ASCs should not report HCPCS codes and separate charges for drugs and biologicals that receive packaged payment through the payment for the associated covered surgical procedure.
- CMS reminds ASCs that under the ASC payment system if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used in the care of the patient. The mixing together of two or more products does not constitute a "new" drug as regulated by the Food and Drug Administration (FDA) under the New Drug Application (NDA) process. In these situations, ASCs are reminded that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, Unclassified

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drug or biological, is for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned.

- Unless otherwise specified in the long description, HCPCS descriptions refer to the non-compounded, FDA-approved final product. If a product is compounded and a specific HCPCS code does not exist for the compounded product, the ASC should include the charge for the compounded product in the charge for the surgical procedure performed. HCPCS payment updates are posted to the CMS website quarterly at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html> on the Centers for Medicare & Medicaid Services (CMS) website.

Drugs and Biologicals with Payment Based on Average Sales Price (ASP) Effective January 1, 2012

- Payments for separately payable drugs and biologicals based on the Average Sales Prices (ASPs) are updated on a quarterly basis as later quarter ASP submissions become available. Effective January 1, 2012, payment rates for many covered ancillary drugs and biologicals have changed from the values published in the CY 2012 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2011. In cases where adjustments to payment rates are necessary, the updated payment rates will be incorporated in the January 2012 release of the ASC DRUG file. CMS is not publishing the updated payment rates in CR7682 implementing the January 2012 update of the ASC payment system. However, the updated payment rates effective January 1, 2012, for covered ancillary drugs and biologicals can be found in the January 2012 update of the ASC, Addendum BB. That addendum is available at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html> on the CMS Website.

New CY 2012 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

- For CY 2012, several new HCPCS codes have been created for reporting drugs and biologicals in the ASC setting, where there have not previously been specific codes available. These new codes are listed in the table below.

CY 2012 HCPCS Code	CY 2012 Long Descriptor	CY 2012 P I
A9585	Injection gadobutrol, 0.1 ml	N1
C9287	Injection, brentuximab vedotin, 1 mg	K2
C9366	EpiFix, per square centimeter	K2
J0257	Injection, alpha 1 proteinase inhibitor (human), (glassia), 10 mg	K2
J7180	Injection, factor xiii (antihemophilic factor, human), 1 i.u.	K2

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CY 2012 HCPCS Code	CY 2012 Long Descriptor	CY 2012 P I
J7326	Hyaluronan or derivative, gel-one, for intra-articular injection, per dose	K2
J8561	Everolimus, oral, 0.25 mg	K2
Q4122	Dermacell, per square centimeter	K2

Other Changes to CY 2012 HCPCS for Certain Drugs, Biologicals, and Radiopharmaceuticals

- Many HCPCS and CPT codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS and CPT code descriptors that will be effective in CY 2012. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2011, and replaced with permanent HCPCS codes in CY 2012. ASCs should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the active CY 2012 HCPCS and CPT codes. These changes are reflected in the following table:

CY 2011 HCPCS Code	CY 2011 Long Descriptor	CY 2012 HCPCS Code	CY 2012 Long Descriptor
C9270	Injection, immune globulin (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg	J1557	Injection, immune globulin, (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg
C9272	Injection, denosumab, 1 mg	J0897	Injection, denosumab, 1 mg
C9273	Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion	Q2043*	Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion
C9274	Crotalidae Polyvalent Immune Fab (Ovine), 1 vial	J0840	Injection, crotalidae polyvalent immune fab (ovine), up to 1 gram
C9276	Injection, cabazitaxel, 1 mg	J9043	Injection, cabazitaxel, 1 mg

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CY 2011 HCPCS Code	CY 2011 Long Descriptor	CY 2012 HCPCS Code	CY 2012 Long Descriptor
C9277	Injection, alglucosidase alfa (Lumizyme), 1 mg	J0221	Injection, alglucosidase alfa, (lumizyme), 10 mg
C9278**	Injection, incobotulinumtoxin A, 1 unit	J0588	Injection, incobotulinumtoxin A, 1 unit
Q2040**	Injection, incobotulinumtoxin A, 1 unit	J0588	Injection, incobotulinumtoxin A, 1 unit
C9280	Injection, eribulin mesylate, 1 mg	J9179	Injection, eribulin mesylate, 0.1 mg
C9281	Injection, pegloticase, 1 mg	J2507	Injection, pegloticase, 1 mg
C9282	Injection, ceftaroline fosamil, 10 mg	J0712	Injection, ceftaroline fosamil, 10 mg
C9283	Injection, acetaminophen, 10 mg	J0131	Injection, acetaminophen, 10 mg
C9284	Injection, ipilimumab, 1 mg	J9228	Injection, ipilimumab, 1 mg
C9365	Oasis Ultra Tri-Layer matrix, per square centimeter	Q4124	Oasis ultra tri-layer wound matrix, per square centimeter
C9406	Iodine I-123 ioflupane, diagnostic, per study dose, up to 5 millicuries	A9584	Iodine i-123 ioflupane, diagnostic, per study dose, up to 5 millicuries
J0220	Injection, alglucosidase alfa, 10 mg	J0220	Injection, alglucosidase alfa, 10 mg, not otherwise classified
J0256	Injection, alpha 1 - proteinase inhibitor - human, 10 mg	J0256	Injection, alpha 1 proteinase inhibitor (human), not otherwise specified, 10mg
J1561	'Injection, immune globulin, (Gamunex), intravenous, non-lyophilized (e.g. liquid), 500 mg	J1561	Injection, immune globulin, (Gamunex/Gamunex-c/Gammaked), non-lyophilized (e.g., liquid), 500 mg
Q2044	Injection, belimumab, 10 mg	J0490	Injection, belimumab, 10 mg
Q2042	Injection, hydroxyprogesterone caproate, 1 mg	J1725	Injection, hydroxyprogesterone caproate, 1 mg
J7130	Hypertonic saline solution, 50 or 100 meq, 20 cc vial	J7131	Hypertonic saline solution, 1 ml
Q2041	Injection, von willebrand factor complex (human), wilate, 1 i.u. vwf:rc0	J7183	Injection, von willebrand factor complex (human), wilate, 1 i.u. vwf:rc0

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CY 2011 HCPCS Code	CY 2011 Long Descriptor	CY 2012 HCPCS Code	CY 2012 Long Descriptor
Q1079	Ondansetron hydrochloride 8 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	Q0162	Ondansetron 1 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen

*HCPCS code Q2043 was effective July 1, 2011 ** HCPCS code C9278 was replaced with HCPCS code Q2040 effective April 1, 2011. HCPCS code Q2040 was subsequently replaced with HCPCS code J0588, effective January 1, 2012.

Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2011, through December 31, 2011

- The payment rates for HCPCS codes J9600 and Q4121 were incorrect in the October 2011 ASC Drug file. The corrected payment rates are \$19,143.46 for J9600 and \$20.77 for Q4121. They have been included in the revised October 2011 ASC Drug file, effective for services furnished on October 1, 2011, through implementation of the January 2012 update. Suppliers who think they may have received an incorrect payment between October 1, 2011, and December 31, 2011, may request contractor adjustment of the previously processed claims.

Correct Reporting of Biologicals When Used As Implantable Devices

- ASCs are reminded that HCPCS codes describing skin substitutes (Q4100 – Q4130) should only be reported when used with one of the CPT codes describing application of a skin substitute (15271-15278). These Q codes for skin substitutes should not be billed when used with any other procedure besides the skin substitute application procedures.

ASC Quality Measures

In Transmittal 934, issued August 1, 2011, CMS announced that the G codes tied to the M5 PI indicator would be effective 1/1/2012. CMS intends to include these HCPCS and further clarification in the April 2012 ASC quarterly update.

Billing for Thermal Anal Lesions by Radiofrequency Energy

- For CY 2012, the CPT Editorial Panel created new CPT code 0288T (Anoscopy, with delivery of thermal energy to the muscle of the anal canal (e.g., for fecal incontinence)) to describe the procedure associated with radiofrequency energy

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of thermal anal lesions. Prior to CY 2012, this procedure was described by HCPCS code C9716 (Creations of thermal anal lesions by radiofrequency energy). In Addendum B of the CY 2012 OPPS/ASC final rule, both HCPCS code C9716 and 0288T were assigned to specific APCs. Specifically, HCPCS code C9716 was assigned to APC 0150 (Level IV Anal/Rectal Procedures) and CPT code 0288T was assigned to APC 0148 (Level I Anal/Rectal Procedures). Because HCPCS code C9716 is described by CPT code 0288T, CMS is deleting HCPCS code C9716 on December 31, 2011, since it will be replaced with CPT code 0288T effective January 1, 2012. In addition, CMS is reassigning CPT code 0288T from APC 0148 to APC 0150 effective January 1, 2012. The table below lists the final ASC payment indicator for HCPCS codes C9716 and 0288T. The ASCPI file will reflect this deletion with PI=D5 for C9716 effective 1/1/2012.

HCPCS Code	Short Descriptor	CY 2012 PI
C9716	Radiofrequency energy to anu	D5
0288T	Anoscopy w/rf delivery	G2

Payment When a Device is Furnished With No Cost or With Full or Partial Credit

- For CY 2012, CMS updated the list of ASC covered device intensive procedures and devices that are subject to the no cost/full credit and partial credit device adjustment policy. Contractors will reduce the payment for the device implantation procedures listed in Attachment A of CR7682, by the full device offset amount for no cost/full credit cases. ASCs must append the modifier “FB” to the HCPCS procedure code when the device furnished without cost or with full credit is listed in Attachment B of CR7682, and the associated implantation procedure code is listed in Attachment A of CR7682. In addition, contractors will reduce the payment for implantation procedures listed in Attachment A of CR7682 by one half of the device offset amount that would be applied if a device were provided at no cost or with full credit, if the credit to the ASC is 50 percent or more of the device cost. If the ASC receives a partial credit of 50 percent or more of the cost of a device listed in Attachment B of CR7682, the ASC must append the modifier “FC” to the associated implantation procedure code if the procedure is listed in Attachment A of CR7682. A single procedure code should not be submitted with both modifiers “FB” and “FC.”
- More information regarding billing for procedures involving no cost/full credit and partial credit devices is available in the “Medicare Claims Processing Manual,” Chapter 14, Section 40.8. This manual section is at

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<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c14.pdf> on the CMS website.

Additional Information

Three attachments are included in CR7682. They are:

- Attachment A: **CY2012 ASC COVERED SURGICAL PROCEDURES AND ANCILLARY SERVICES THAT ARE NEWLY PAYABLE IN ASCs;**
- Attachment B: **CY 2012 ASC PROCEDURES TO WHICH THE NO COST/FULL CREDIT AND PARTIAL CREDIT DEVICE ADJUSTMENT POLICY APPLIES;**
- Attachment C: **CY 2012 DEVICES FOR WHICH THE "FB" OR "FC" MODIFIER MUST BE REPORTED WITH THE ASC.**

CR 7682 may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2378CP.pdf> on the CMS website. If you have any questions, please contact your carrier or MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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