

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



REVISED product from the Medicare Learning Network® (MLN)

- [“Medicare Enrollment for Institutional Providers”](#) Fact Sheet, ICN 903783, Downloadable only

MLN Matters® Number: MM9310

Related Change Request (CR) #: CR 9310

Related CR Release Date: September 25, 2015

Effective Date: October 1, 2015

Related CR Transmittal #: R3361CP

Implementation Date: October 5, 2015

October 2015 Update of the Ambulatory Surgical Center (ASC) Payment System

Provider Types Affected

This MLN Matters® Article is intended for providers submitting claims to Medicare Administrative Contractors (MACs) paid under the Ambulatory Surgical Center (ASC) Payment system for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9310 describes changes to billing instructions for various payment policies implemented in the October 2015 ASC payment system update and includes updates to the Healthcare Common Procedure Coding System (HCPCS) used in the ASC payment system. Make sure that your billing staffs are aware of these updates.

Background

Key changes to be implemented in the October 2015 ASC payment system update are as follows:

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2014 American Medical Association. All rights reserved.

New Separately Payable Procedure Code

Effective October 1, 2015, a new HCPCS code C9743 has been created. The short descriptor is: Bulking/spacer material impl (NOTE: The short descriptor field is limited to 28-characters, including spaces. This short descriptor is exactly 28 characters.)

The long descriptor is: Injection/implantation of bulking or spacer material (any type) with or without image guidance (not to be used if a more specific code applies). This code is being assigned the ASC Payment Indicator ASC PI) of “G2” (Non office-based surgical procedure added in CY 2008 or later; payment based on OPSS relative payment weight).

Revised Coding Guidance for Intraocular or Periocular Injections of Combinations of Anti-Inflammatory Drugs and Antibiotics

Intraocular or periocular injections of combinations of anti-inflammatory drugs and antibiotics are being used with increased frequency in ocular surgery (primarily cataract surgery). One example of combined or compounded drugs includes triamcinolone and moxifloxacin with or without vancomycin. Such combinations may be administered as separate injections or as a single combined injection. Because such injections may obviate the need for post-operative anti-inflammatory and antibiotic eye drops, some have referred to cataract surgery with such injections as “droppless cataract surgery.”

As stated in Chapter VIII, Section D, Item 20 of the CY 2015 “NCCI Policy Manual,” injection of a drug during a cataract extraction procedure or other ophthalmic procedure is not separately reportable. (The “NCCI Policy Manual” is available in the Downloads section at <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html> on the Centers for Medicare & Medicaid Services (CMS) website.) Specifically, no separate procedure code may be reported for any type of injection during surgery or in the perioperative period. Injections are a part of the ocular surgery and are included as a part of the ocular surgery and the HCPCS code used to report the surgical procedure.

According to [Chapter 17](#), Section 90.2, of the “Medicare Claims Processing Manual,” the compounded drug combinations described above and similar drug combinations should be reported with HCPCS code Q9977 (Compounded Drug, Not Otherwise Classified), and are packaged as surgical supplies in both the Hospital Outpatient Department (HOPD) and the ASC. Although these drugs are a covered part of the ocular surgery, no separate payment will be made. In addition, these drugs and drug combinations may not be reported with HCPCS code C9399.

According to [Chapter 30](#), Section 40.3.6 of the “Medicare Claims Processing Manual,” physicians or facilities should not give Advance Beneficiary Notices (ABNs) to beneficiaries for either these drugs or for injection of these drugs because they are fully covered by Medicare. Physicians or facilities are not permitted to charge the patient an extra amount (beyond the standard copayment for the surgical procedure) for these injections or the drugs used in these injections because they are a covered part of the surgical procedure. Also, physicians or facilities cannot circumvent packaged payment in the HOPD or ASC for

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2014 American Medical Association. All rights reserved

these drugs by instructing beneficiaries to purchase and bring these drugs to the facility for administration.

Drugs, Biologicals, and Radiopharmaceuticals

- **Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective October 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 October 1, 2015, are available in the October 2015 ASC Addendum BB at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html on the CMS website.
- **Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates**
 - Some drugs and biologicals based on ASP methodology may 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 <http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html> on the CMS website. Suppliers who think they may have received an incorrect payment for drugs and biologicals impacted by these corrections may request their MAC to adjust previously processed claims.
- **Drugs and Biologicals with Outpatient Prospective Payment System (OPPS) Pass-Through Status Effective October 1, 2015**
 - For October 2015, two new HCPCS codes have been created and are shown in Table 1 below for reporting drugs and biologicals in the ASC setting with OPPS pass-through status, where there have not previously been specific codes available.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2014 American Medical Association. All rights reserved

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

HCPCS Code	Short Descriptor	Long Descriptor	ASC PI
C9456	Inj, isavuconazonium sulfate	Injection, isavuconazonium sulfate, 1 mg	K2
C9457	Lumason contrast agent	Injection, sulfur hexafluoride lipid microsphere, per ml	K2

- **New HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Biosimilar Biological Products**
 - Effective October 1, 2015, one new HCPCS code has been created for reporting drugs and biologicals in the ASC setting, where there have not previously been specific codes available. This new code is listed in Table 2 below.

Table 2 – New HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Biosimilar Biological Products Effective October 1, 2015

HCPCS Code	Short Descriptor	Long Descriptor	ASC PI
Q9979	Injection, alemtuzumab	Injection, alemtuzumab, 1 mg	K2

- **Revised Payment Indicators and Effective Dates for HCPCS Codes 90620, 90621, and Q5101**
 - Effective January 23, 2015, the payment indicators for HCPCS codes 90620 (Menb pr w/omv vaccine im) will change from ASC PI=Y5 (Non-Surgical Procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made) to ASC PI=K2 (Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate).
 - Effective October 29, 2014, the payment indicator for HCPCS code 90621 (Menb rlp vaccine im) will change from ASC PI=Y5 (Non-Surgical Procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made.) to ASC PI=K2 (Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate).
 - Effective September 3, 2015, the payment indicator for HCPCS code Q5101 (Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram) will change from ASC PI Y5 (Non-Surgical Procedure/item not valid for Medicare purposes because of

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2014 American Medical Association. All rights reserved

coverage, regulation and/or statute; no payment made.) to ASC PI=K2 (Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate).

Suppliers who think they may have received an incorrect payment impacted by this change may request their MAC to adjust previously processed claims.

These codes are listed below in Table 3, along with the effective date for the revised payment indicator.

Table 3 – Drug and Biological with Revised Payment Indicator and Effective Date

HCPCS Code	Short Descriptor	Long Descriptor	ASC PI	Effective Date
90620	Menb rp w/omv vaccine im	Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B, 2 dose schedule, for intramuscular use	K2	2/1/2015
90621	Menb rlp vaccine im	Meningococcal recombinant lipoprotein vaccine, serogroup B, 3 dose schedule, for intramuscular use	K2	2/1/2015
Q5101	Inj filgrastim g-csf biosim	Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram	K2	09/03/2015

Coverage Determinations

The fact that a drug, device, procedure, or service is assigned an HCPCS code and a payment rate under the ASC payment system 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. 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.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2014 American Medical Association. All rights reserved

Additional Information

The official instruction, CR9310 issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3361CP.pdf> on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - How Does It Work.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2014 American Medical Association. All rights reserved