

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



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Implementation Date: July 5, 2016

July 2016 Update of the Ambulatory Surgical Center (ASC) Payment System

Provider Types Affected

This MLN Matters® Article is intended for Ambulatory Surgical Centers (ASCs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

Request (CR) 9668 informs MACs about changes to and billing instructions for various payment policies implemented in the July 2016 ASC payment system update. As appropriate, this notification also includes updates to the Healthcare Common Procedure Coding System (HCPCS). Make sure that your billing staffs are aware of these changes.

Background

Included in CR9668 are updates to the ASC payment system, payment rates for separately payable drugs and biologicals, including descriptors for newly created Level II HCPCS codes for drugs and biologicals (ASC DRUG files), ASC billing edits, and the CY 2016 ASC payment rates for covered surgical and ancillary services (ASCFS file). There is also an update to Chapter 14, Section 10 of the “Medicare Claims Processing Manual,” which is attached to CR9668.

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Key Changes in CR9668

1. Billing Instructions for Intensity Modulated Radiation Therapy (IMRT) Planning

Payment for the services identified by Current Procedural Terminology (CPT) codes 77280, 77285, 77290, 77295, 77306 through 77321, 77331, and 77370 are already included in the ASC payment for CPT code 77301 (IMRT planning). Effective, July 1, 2016, these codes should not be reported by ASCs in addition to CPT code 77301 when provided as part of the development of the IMRT plan.

2. Upper Eyelid Blepharoplasty and Blepharoptosis Repair

The Centers for Medicare & Medicaid Services (CMS) payment policy does not allow ASCs to bill for separate payment for a blepharoplasty procedure (CPT codes 15822, 15823) in addition to a blepharoptosis procedure (CPT codes 67901-67908) on the ipsilateral upper eyelid. Any removal of upper eyelid skin in the context of an upper eyelid blepharoptosis surgery is considered a part of the blepharoptosis surgery and is already be included in the payment rate. Also ASCs cannot bill a blepharoplasty to Medicare and the beneficiary cannot be separately charged for a cosmetic surgery regardless of the amount of upper eyelid skin that is removed on a patient receiving a blepharoptosis repair because removal of (any amount) of upper eyelid skin is part of the blepharoptosis repair. In addition, the following are not permitted:

- Operating on the left and right eyes on different days when the standard of care is bilateral eyelid surgery
- Charging the beneficiary an additional amount for a cosmetic blepharoplasty when a blepharoptosis repair is performed
- Charging the beneficiary an additional amount for removing orbital fat when a blepharoplasty or a blepharoptosis repair is performed
- Performing a blepharoplasty on a different date of service than the blepharoptosis procedure for the purpose of unbundling the blepharoplasty or charging the beneficiary for a cosmetic surgery
- Performing blepharoplasty as a staged procedure, either by one or more surgeons (note that under certain circumstances a blepharoptosis procedure could be a staged procedure)
- Billing for two procedures when two surgeons divide the work of a blepharoplasty performed with a blepharoptosis repair
- Using modifier 59 to unbundle the blepharoplasty from the ptosis repair on the claim form; this applies to both physicians and facilities
- Treating medically necessary surgery as cosmetic for the purpose of charging the beneficiary for a cosmetic surgery
- Using an Advance Beneficiary Notice of Noncoverage for a service that would be bundled into another service if billed to Medicare.

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3. Category III CPT Codes Effective July 1, 2016

The American Medical Association (AMA) releases Category III CPT codes twice per year: in January, for implementation beginning the following July, and in July, for implementation beginning the following January.

For the July 2016 update, CMS is implementing in the ASC Payment System five Category III CPT codes that the AMA released in January 2016 for implementation on July 1, 2016. The long and short descriptors, and ASC Payment Indicators (PIs) for these codes are shown in Table 1.

Table 1 - Category III CPT Codes Effective July 1, 2016

CPT Code	Long Descriptor	Short Descriptor	ASC PI
0438T	Transperineal placement of biodegradable material, peri-prostatic (via needle), single or multiple, includes image guidance	Tprnl plmt biodegrdabl matrl	G2
0440T	Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve	Abltj perc uxtr/perph nrv	G2
0441T	Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve	Abltj perc lxtr/perph nrv	G2
0442T	Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other truncal nerve (eg, brachial plexus, pudendal nerve)	Abltj perc plex/trncl nrv	G2
0443T	Real time spectral analysis of prostate tissue by fluorescence spectroscopy	R-t spctrl alys prst8 tiss	G2

Payment rates for these services are in Addendum AA of the July 2016 ASC Update that is posted at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11 Addenda Updates.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html). HCPCS code C9743 will be deleted June 30, 2016 since it will be replaced with Category III CPT code 0438T effective July 1, 2016.

4. Drugs, Biologicals, and Radiopharmaceuticals

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective July 1, 2016

For CY 2016, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent, which provides

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payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2016, 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 July 1, 2016 are in the July 2016 ASC Addendum BB at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html.

b. 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 at <http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html> on the first date of the quarter. Suppliers who think they may have received an incorrect payment for drugs and biologicals impacted by these corrections may request MAC adjustment of the previously processed claims.

c. New CY 2016 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals Seven new HCPCS codes have been created for reporting drugs and biologicals in the ASC setting. These new codes, their descriptors, PIs, and their effective dates are listed in Table 2.

Table 2 – New CY 2016 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

HCPCS Code	Long Descriptor	Short Descriptor	ASC PI	Effective Date
C9476	Injection, daratumumab, 10 mg	Injection, daratumumab	K2	7/1/2016
C9477	Injection, elotuzumab, 1 mg	Injection, elotuzumab	K2	7/1/2016
C9478	Injection, sebelipase alfa, 1 mg	Injection, sebelipase alfa	K2	7/1/2016
C9479*	Instillation, ciprofloxacin otic suspension, 6 mg	Instill, ciprofloxacin otic	K2	7/1/2016
C9480	Injection, trabectedin, 0.1 mg	Injection, trabectedin	K2	7/1/2016
Q9981	Rolapitant, oral, 1 mg	Rolapitant, oral, 1mg	K2	7/1/2016
Q5102**	Injection, infliximab, biosimilar, 10 mg	Inj., infliximab biosimilar	K2	4/5/2016

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*Note on reporting C9479: Each vial of C9479 contains 60 mg, or 10 doses. If one single use vial is used for both patient's ears with the remainder of the drug in the vial unused, then two units of C9479 should be reported as administered to the patient; any discarded amount should be reported with the JW modifier according to the Medicare Claims Processing Manual, Chapter 17 - Drugs and Biologicals, Section 40 - Discarded Drugs and Biologicals.

**Note on Q5102: the effective date of Q5102 is 4/5/2016.

d. Biosimilar Biological Product Payment and Required Modifiers

ASC claims for separately paid biosimilar biological products are now required to include a modifier that identifies the manufacturer of the specific product. The modifier does not affect payment determination, but is used to distinguish between biosimilar products that appear in the same HCPCS code but are made by different manufacturers.

- Q5101: This is a reminder that for claims with dates of service January 1, 2016 and later, Q5101 must be submitted with a modifier to identify the manufacturer of the biosimilar product. Currently, the ZA modifier is the only manufacturer/modifier that may be submitted with Q5101. Claims submitted without the modifier cannot be processed.
- Q5102: Effective April 5, 2016, Q5102 (Inj., infliximab biosimilar) is payable in the ASC setting, where there has not previously been a specific code available. Q5102 must be submitted with a modifier to identify the manufacturer of the biosimilar product. Currently, the ZB modifier is the only manufacturer/modifier that may be submitted with this HCPCS. Claims submitted without the modifier will be returned as unprocessable.

When these claims are returned, MACs will use the following messages when returning these claims:

- Claim Adjustment Reason Code (CARC) 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance Advice Remark Code (RARC) MA-130- Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
- Group Code: CO (Contractual Obligation)

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The biosimilar HCPCS codes and required modifiers are listed in Table 3.

Table 3 – Biosimilar Biological Product Payment and Required Modifiers

HCPCS Code	Short Descriptor	ASC PI	FDA Approval Date	Modifier	Modifier Effective Date
Q5101	Inj filgrastim g-csf biosim	K2	03/06/2015	ZA- Novartis/Sandoz	01/01/2016
Q5102	Inj., infliximab biosimilar	K2	04/05/2016	ZB – Pfizer/Hospira	04/05/2016

e. Other Changes to CY 2016 HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals

Effective July 1, 2016, HCPCS code Q9982, flutemetamol f18 diagnostic, will replace HCPCS code C9459, Flutemetamol f18. The ASC payment indicator will remain K2. “Pass-Through Drugs and Biologicals.”

Effective July 1, 2016, HCPCS code Q9983, florbetaben f18 diagnostic, will replace HCPCS code C9458, Florbetaben f18. The ASC payment will remain K2, “Pass-Through Drugs and Biologicals.”

Both C9458 and C9459 have a termination date of 6/30/2016. Other Changes to CY 2016 HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals Effective July 1, 2016 are listed in Table 4.

Table 4 – Other Changes to CY 2016 HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals Effective July 1, 2016

HCPCS Code	Short Descriptor	Long Descriptor	ASC PI	Added Date	Termination Date
C9459	Flutemetamol f18	Flutemetamol f18, diagnostic, per study dose, up to 5 millicuries	K2	01/01/2016	06/30/2016
Q9982	flutemetamol f18 diagnostic	Flutemetamol F18, diagnostic, per study dose, up to 5 millicuries	K2	07/01/2016	
C9458	Florbetaben f18	Florbetaben f18, diagnostic, per study dose, up to 8.1 millicuries	K2	01/01/2016	06/30/2016

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HCPCS Code	Short Descriptor	Long Descriptor	ASC PI	Added Date	Termination Date
Q9983	florbetaben f18 diagnostic	Florbetaben f18, diagnostic, per study dose, up to 8.1 millicuries	K2	07/01/2016	
C9743	Bulking/spacer material impl	Injection/implantation of bulking or spacer material (any type) with or without image guidance (not to be used if a more specific code applies)	G2		06/30/2016

5. Coverage Determinations

The fact that a drug, device, procedure or service is assigned a 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. 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, CR9668 issued to your MAC regarding this change is available at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3531CP.pdf>.

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.

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