

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



News Flash –

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- [“Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and RAC,”](#) Booklet, ICN 006973, Downloadable only.

MLN Matters® Number: MM8148

Related Change Request (CR) #: CR 8148

Related CR Release Date: December 28, 2012

Effective Date: January 1, 2013

Related CR Transmittal #: R2626CP

Implementation Date: January 7, 2013

January 2013 Update of the Ambulatory Surgery Center (ASC) Payment System

Provider Types Affected

This MLN Matters® Article is intended for Ambulatory Surgery Centers (ASCs) submitting claims to Medicare contractors (carriers or Part B Medicare Administrative Contractors (B MACs)), for ASC payment system-paid services provided to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 8148, from which this article is taken, describes changes to, and billing instructions for, payment policies implemented in the January 2013 Ambulatory Surgery Center (ASC) payment system update. It also includes updates to the Healthcare Common Procedure Coding System (HCPCS).

Included in CR8148 are Calendar Year (CY) 2013 payment rates for separately payable drugs and biologicals, including long descriptors for newly created Level II HCPCS codes for drugs and

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biologicals (ASC DRUG files), and the CY 2013 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 CR8148 reflect the most recent changes to CY 2013 MPFS payment. You can learn more about the MPFS at <http://www.cms.gov/apps/physician-fee-schedule/> on the Centers for Medicare & Medicaid Services (CMS) website.

Key Points of CR 8148

1. *New Procedure Codes*

CMS is establishing one new HCPCS procedure code for ASC use effective January 1, 2013. The following table provides a listing of the descriptor and Payment Indicator (PI) for the new code.

New HCPCS Procedure Code – Effective January 1, 2013

HCPCS	Effective Date	Short Descriptor	Long Descriptor	CY2013 PI
G0458	01-01-13	LDR pros brachy comp rat	Low dose rate (ldr) prostate brachytherapy services, composite rate	G2

2. *Billing for Drugs, Biologicals, and Radiopharmaceuticals*

- ***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 HCPCS codes for the items used. Many HCPCS codes, including those for drugs, biologicals, and radiopharmaceuticals, have undergone changes in their HCPCS and CPT code descriptors that will be effective in CY 2013. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2012, and replaced with permanent HCPCS codes in CY 2013.

Further, you should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the active CY 2013 HCPCS codes. You 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.

HCPCS payment updates are posted to the CMS website quarterly at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html on the CMS website.

- ***Drugs and Biologicals with Payment Based on Average Sales Price (ASP) Effective January 1, 2013***

Payments for separately payable drugs and biologicals based on the Average Sales Prices (ASPs) are updated quarterly, as later quarter ASP submissions become available. Effective January 1, 2013, payment rates for many covered ancillary drugs and biologicals have

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changed from the values published in the CY 2013 Outpatient Prospective Payment System (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 2012. In cases where adjustments to payment rates are necessary, the updated payment rates will be incorporated in the January 2013 release of the ASC DRUG file. CMS is not publishing the updated payment rates in this Change Request implementing the January 2013 update of the ASC payment system. However, the updated payment rates effective January 1, 2013 for covered ancillary drugs and biologicals can be found in the January 2013 update of the ASC Addendum BB, at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html on the CMS website.

- ***New CY 2013 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals***

For CY 2013, 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 following table.

New CY 2013 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals – Effective January 1, 2013

CY 2013 HCPCS Code	CY 2013 Long Descriptor	CY 2013 PI
C9294	Injection, taliglucerase alfa, 10 units	K2
C9295	Injection, carfilzomib, 1 mg	K2
C9296	Injection, ziv-aflibercept, 1 mg	K2
J1744	Injection, icatibant, 1 mg	K2
J2212	Injection, methylnaltrexone, 0.1 mg	K2
J7315	Mitomycin, ophthalmic, 0.2 mg	N1

- ***Discontinued CY 2012 HCPCS and other Changes to CY 2013 HCPCS for Certain Drugs, Biologicals, and Radiopharmaceuticals***

The following table notes those drugs, biologicals, and radiopharmaceuticals that have undergone changes in their HCPCS codes and/or their long descriptors. Each product’s CY 2012 HCPCS code and CY 2012 long descriptors are noted in the two left-hand columns, and the CY 2013 HCPCS code and long descriptors are noted in the adjacent right-hand columns.

Effective December 31, 2012, the Type of Service (TOS) F (Ambulatory Surgical Center) records for HCPCS C9279, C9286-C9289, C9366, C9368, C9369, J1051, J8561, and Q2045-Q2048 will be removed to prevent claims from incorrectly processing as ASC approved services for Dates of Service (DOS) on/after January 1, 2013.

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**Discontinued CY 2012 HCPCS and other CY 2013 HCPCS and CPT Code Changes for Certain
Drugs, Biologicals, and Radiopharmaceuticals – Effective January 1, 2013**

CY 2012 HCPCS code	CY 2012 Long Descriptor	CY 2013 HCPCS Code	CY 2013 Long Descriptor
C9286	Injection, belatacept, 1 mg	J0485	Injection, belatacept, 1 mg
C9287	Injection, brentuximab vedotin, 1 mg	J9042	Injection, brentuximab vedotin, 1 mg
C9288	Injection, centruroides (scorpion) immune f(ab)2 (equine), 1 vial	J0716	Injection, centruroides immune f(ab)2, up to 120 milligrams
C9289	Injection, asparaginase erwinia chrysanthemi, 1,000 international units (i.u.)	J9019	Injection, asparaginase (Erwinaze), 1,000 IU
C9366	EpiFix, per square centimeter	Q4131	Epifix, per square centimeter
C9368	Grafix core, per square centimeter	Q4132	Grafix core, per square centimeter
C9369	Grafix prime, per square centimeter	Q4133	Grafix prime, per square centimeter
J8561	Everolimus, oral, 0.25 mg	J7527	Everolimus, oral, 0.25 mg
J9020	Injection, asparaginase, 10,000 units	J9020	Injection, Asparaginase, Not Otherwise Specified, 10,000 Units
J9280	Mitomycin, 5 mg	J9280	Injection, mitomycin, 5 mg
Q2045*	Injection, human fibrinogen concentrate, 1 mg	J7178	Injection, human fibrinogen concentrate, 1 mg
Q2046**	Injection, aflibercept, 1 mg	J0178	Injection, aflibercept, 1 mg
Q2048***	Injection, doxorubicin hydrochloride, liposomal, doxil, 10 mg	J9002	Injection, doxorubicin hydrochloride, liposomal, doxil, 10 mg
Q4119	Matristem wound matrix, per square centimeter	Q4119	Matristem wound matrix, psmx, rs, or psm, per square centimeter
Q4128	Flexhd or allopatch hd, per square centimeter	Q4128	Flex hd, allopatch hd, or matrix hd, per square centimeter

*HCPCS code J1680 was replaced with HCPCS code Q2045 effective July 1, 2012. HCPCS code Q2045 was subsequently replaced with HCPCS code J7178, effective January 1, 2013.

**HCPCS code C9291 was replaced with HCPCS code Q2046 effective July 1, 2012. HCPCS code Q2046 was subsequently replaced with HCPCS code J0178, effective January 1, 2013.

***HCPCS code J9001 was replaced with HCPCS code Q2048 effective July 1, 2012. HCPCS code Q2048 was subsequently replaced with HCPCS code J9002, effective January 1, 2013.

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3. Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2012, through June 30, 2012

The payment rate for one HCPCS code was incorrect in the April 2012 ASC Drug file. The corrected payment rate is listed in the following table and has been included in the revised April 2012 ASC Drug file, effective for services furnished on April 1, 2012, through implementation of the July 2012 update.

Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2012, Through June 30, 2012

HCPCS Code	Short Descriptor	Corrected Payment Rate
Q4112	Cymetra allograft	\$271.12

Providers who think they may have received an incorrect payment between April 1, 2012, and June 30, 2012, may request contractor adjustment of the previously processed claims.

4. Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2012, through September 30, 2012

The payment rate for one HCPCS code was incorrect in the July 2012 ASC Drug file. The corrected payment rate is listed in the following table; and has been included in the revised July 2012 ASC Drug file, effective for services furnished on July 1, 2012, through implementation of the October 2012 update.

Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2012, Through September 30, 2012

HCPCS Code	Short Descriptor	Corrected Payment Rate
Q4112	Cymetra allograft	\$323.65

Providers who think they may have received an incorrect payment between July 1, 2012, and September 30, 2012, may request contractor adjustment of the previously processed claims.

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

For CY 2013, CMS updated the list of ASC covered devices and device intensive procedures 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 CR8148 by the full device offset amount for no cost/full credit cases.

You must append the modifier "FB" (Item provided without cost to provider, supplier or practitioner, or full credit received for replaced device (including: covered under warranty, replaced due to defect and free samples)) to the HCPCS procedure code when the device furnished without cost or with full credit is listed in Attachment B of CR8148, and the associated implantation procedure code is listed in Attachment A. CR8148 is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2626CP.pdf> on the CMS website.

In addition, contractors will reduce the payment for implantation procedures listed in Attachment A of CR8148 by one half of the device offset amount that would be applied if a device were provided

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at no cost or with full credit, if the credit to the ASC is 50 percent or more of the device cost. If you receive a partial credit of 50 percent or more of the cost of a device listed in Attachment B, you must append the modifier "FC" (Partial credit received for replaced device) to the associated implantation procedure code if the procedure is listed in Attachment A. You should not submit a single procedure code 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 (Ambulatory Surgical Centers), Section 40.8 (Payment When a Device is Furnished With No Cost or With Full or Partial Credit Beginning January 1, 2008), which you can find at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c14.pdf> on the CMS website.

Note: 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. Carriers/MACs determine whether a drug, device, procedure, or other service meets all program requirements for coverage.

Additional Information

The official instruction, CR8148, issued to your carrier and B MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2626CP.pdf> on the CMS website.

It contains the following attachments:

- 1) Attachment A: POLICY SECTION TABLES
- 2) Attachment B: CY 2013 ASC COVERED SURGICAL PROCEDURES AND ANCILLARY SERVICES THAT ARE NEWLY PAYABLE IN ASCs
- 3) Attachment C: CY 2013 ASC PROCEDURES TO WHICH THE NO COST/FULL CREDIT AND PARTIAL CREDIT DEVICE ADJUSTMENT POLICY APPLIES
- 4) Attachment D: CY 2013 DEVICES FOR WHICH THE "FB" OR "FC" MODIFIER MUST BE REPORTED WITH THE ASC PROCEDURE CODE WHEN FURNISHED AT NO COST OR WITH FULL OR PARTIAL CREDIT

If you have any questions, please contact your carrier or B 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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