

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



**NEW products from the Medicare Learning Network® (MLN)**

- ["Quick Reference Chart: Short & Long Descriptors for Therapy Functional Reporting G-Codes,"](#) Educational Tool, ICN908924, Downloadable only.

MLN Matters® Number: MM8437

Related Change Request (CR) #: CR 8437

Related CR Release Date: August 16, 2013

Effective Date: October 1, 2013

Related CR Transmittal #: R2770CP

Implementation Date: October 7, 2013

## **October 2013 Update of the Ambulatory Surgery Center (ASC) Payment System**

### **Provider Types Affected**

---

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (carriers and A/B Medicare Administrative Contractors (A/B MACs)) for services to Medicare beneficiaries.

### **Provider Action Needed**

---

This article is based on Change Request (CR) 8437 which informs Medicare contractors about the changes to, and billing instructions for, various payment policies implemented in the October 2013 Ambulatory Surgery Center (ASC) payment system update. CR8437 also includes updates to the Healthcare Common Procedure Coding System (HCPCS). Make sure that your billing staffs are aware of these changes.

### **Key Points of CR8437**

---

#### **New Device Pass-Through Categories**

Additional payments may be made to an ASC for covered ancillary services, including certain implantable devices with pass-through status under the Outpatient Prospective Payment System

#### **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 2012 American Medical Association.

(OPPS). Section 1833(t)(6)(B) of the Social Security Act requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that we create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices. The ASC payment system follows this OPPS policy and implements new device pass-through codes, as appropriate, in the ASC payment system.

The Centers for Medicare & Medicaid Services (CMS) is establishing one new device pass-through category as of October 1, 2013, for the OPPS and the ASC payment system. The new HCPCS code, descriptor, and ASC payment indicator is as follows:

HCPCS	Short Descriptor	Long Descriptor	ASC Payment Indicator
C1841	Retinal prosth int/ext comp	Retinal prosthesis, includes all internal and external components	J7

The device offset is a payment deduction from the device pass-through payment that reflects the device portion of the surgical procedure payment. CMS has determined that they are not able to identify a device portion of the surgical procedure payment amount associated with the cost of C1841. Therefore, they will not make any offset deduction from the pass-through payment for C1841.

### **Billing for Drugs, Biologicals, and Radiopharmaceuticals**

a. **Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective October 1, 2013:** Payments for separately payable drugs and biologicals based on the ASPs are updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the October 2013 release of the ASC DRUG file. The updated payment rates, effective October 1, 2013, are included in the October 2013 update of ASC Addendum BB, and are available at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11\\_Addenda\\_Updates.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html) on the CMS website.

b. **New HCPCS Codes for Drugs and Biologicals Separately Payable under the ASC Payment System Effective October 1, 2013:** Two drugs and biologicals have been granted ASC payment status effective October 1, 2013. These items, along with their descriptors and ASC payment indicator, 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 2012 American Medical Association.

HCPCS Code	Short Descriptor	Long Descriptor	ASC Payment Indicator
C1204	Tc 99m tilmanocept	Technetium Tc 99m tilmanocept, diagnostic, up to 0.5 millicuries	K2
C9132	Kcentra, per i.u.	Prothrombin complex concentrate (human), Kcentra, per i.u. of Factor IX activity	K2

c. **Fluzone (Influenza virus vaccine):** CPT code 90685 was effective January 1, 2013, however, the flu vaccine associated with this code was not approved by the FDA until June 7, 2013. Because of this recent FDA approval, CMS is revising the ASC payment indicator for CPT code 90685 from "Y5" (Nonsurgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made) to "L1" ((Influenza vaccine; pneumococcal vaccine; packaged item/service; no separate payment made) effective June 7, 2013.

d. **Revised ASC Payment Indicators for HCPCS Codes Q4135 and Q4136 Effective October 1, 2013:** Effective October 1, 2013, the ASC payment indicators for HCPCS code Q4135 (Mediskin, per square centimeter) and HCPCS code Q4136 (Ez-derm, per square centimeter) will change from "Y5" (Nonsurgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made) to "K2" (Drugs and biological paid separately when provided integral to a surgical procedure on the ASC list). For the remainder of CY 2013, HCPCS code Q4135 and Q4136 will be separately paid and the prices for these codes will be updated on a quarterly basis. The codes are as follows:

HCPCS Code	Long Descriptor	ASC Payment Indicator
Q4135	Mediskin, per square centimeter	K2
Q4136	Ez-derm, per square centimeter	K2

e. **Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2013 through September 30, 2013:** The payment rate for one HCPCS code was incorrect in the July 2013 ASC Drug File. The corrected payment rate is shown below and has been installed in the revised July 2013 ASC Drug File, effective for services furnished on July 1, 2013, through September 30, 2013. Suppliers who received an incorrect payment for dates of service between July 1, 2013, and September 30, 2013 may request contractor adjustment of the previously processed claims.

HCPCS Code	Short Descriptor	Corrected Payment Rate	ASC Payment Indicator
J1566	Immune globulin, powder	\$30.66	K2

#### 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 2012 American Medical Association.

### 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. 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, CR8437 issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2770CP.pdf> on the CMS website.

If you have any questions, please contact your Medicare contractor 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.

#### 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 2012 American Medical Association.