

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



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January 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 to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9484 informs MACs about changes to and billing instructions for various payment policies implemented in the January 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 staff are aware of these changes.

Background

Included in CR9484 are Calendar Year (CY) 2016 payment rates for separately payable drugs and biologicals, including descriptors for newly created Level II HCPCS codes for drugs and biologicals (ASC DRUG files), and the CY 2016 ASC payment rates for covered surgical and ancillary services (ASCFS file). There is also an update to Chapter 14 of the “Medicare Claims Processing Manual.”

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 this transmittal reflect the most recent changes to CY 2016 MPFS payment. Key updates are:

1. New Device Pass-Through Category and Device Offset for Payment

Additional payments may be made to the ASC for covered ancillary services, including certain implantable devices with pass-through status under the outpatient prospective payment system (OPPS). Section 1833(t)(6)(B) of the Social Security Act (the Act) requires that, under the OPPS,

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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 current or expired categories of devices. This policy was implemented in the 2008 revised ASC payment system.

The Centers for Medicare & Medicaid Services (CMS) is establishing one new HCPCS device pass-through category as of January 1, 2016, for the OPPS and the ASC payment systems. Table 1 provides a listing of new coding and payment information concerning the new device category for transitional pass-through payment. HCPCS code C1822 (Gen, neuro, HF, rechg bat) is assigned ASC PI=J7 (OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced). Table 1 below shows more details.

Table 1 – New Device Pass-Through Code

HCPCS Code	Effective Date	Short Descriptor	Long Descriptor	ASC PI
C1822	01-01-2015	Gen, neuro, HF, rechg bat	Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system	J7

2. Device Offset from Payment for New Device Category

Section 1833(t)(6)(D)(ii) of the Act requires that CMS deduct from pass-through payments for devices an amount that reflects the portion of the Ambulatory Payment Classification (APC) payment amount in the Outpatient Prospective Payment System (OPPS). This policy is also in effect in the ASC payment system. Basically, CMS has determined that a portion of the APC payment amount associated with the cost of HCPCS code C1822 is reflected in APC 5464. The HCPCS code C1822 device should always be billed with CPT Code 63685 (Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling) which is assigned to APC 5464 for CY 2016. The device portion included in the ASC procedure payment for 63685 is 84 percent, and is deducted from the procedure payment when performed with C1822.

3. Revised Short and Long Descriptors for Packaged code HCPCS Code C1820

ASCs do not report packaged codes but with the establishment of HCPCS code C1822, CMS is modifying the short and long descriptors for existing HCPCS code C1820 to appropriately differentiate between HCPCS code C1822 and C1820.

The revised descriptors for C1820 are (short descriptor: Gen, neuro, non-HF rechg bat; long descriptor: Generator, neurostimulator (implantable), non high-frequency with rechargeable battery and charging system).

CMS notes that HCPCS code C1820 describes an implantable **non high-frequency** neurostimulator generator device with rechargeable battery and charging system, while HCPCS code C1822 describes an implantable **high-frequency** neurostimulator generator device with rechargeable

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battery and charging system. While ASCs do not report packaged codes, it is important to announce this distinction.

4. Removal of Device Portion from Procedures that are Assigned to a Device-Intensive APC and that are Discontinued Prior to the Administration of Anesthesia

In accordance with the regulations at 42 CFR 416.172(f) and Section 40.4 of Chapter 14 of the “Medicare Claims Processing Manual,” when a surgical procedure, for which anesthesia is planned, is terminated after the patient is prepared and taken to the room where the procedure is to be performed, but prior to the administration of anesthesia, ASCs are instructed to append modifier “73” to the procedure line item on the claim. Medicare processes these line items by removing one-half of the full program allowance.

In the CY 2016 OPSS/ASC (Outpatient Prospective Payment System/Ambulatory Surgical Center) final rule, that was published in the Federal Register on November 13, 2015, CMS revised its payment policy for surgical procedures, for which anesthesia is planned and that are discontinued prior to the administration of anesthesia, appended with modifier 73. Specifically, effective January 1, 2016, for such procedures that are assigned to device-intensive procedures, CMS will remove the full device portion of the device-intensive procedure payment prior to applying the additional payment adjustments that apply when the procedure is discontinued. This policy does not apply to procedures and services that are discontinued after the administration of anesthesia and include the 74 modifier. Additional information on this policy is included in CR9297, dated November 6, 2015. An MLN Matters® article related to CR9297 is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9297.pdf> on the CMS website.

5. New Brachytherapy Source HCPCS

Section 1833(t)(2)(H) of the Act mandates the creation of additional groups of covered Outpatient Department (OPD) services that classify devices of brachytherapy consisting of a seed or seeds (or radioactive source) (“brachytherapy sources”) separately from other services or groups of services. The additional groups must reflect the number, isotope, and radioactive intensity of the brachytherapy sources furnished. CivaSheet is a new brachytherapy source.

This new brachytherapy source is payable in the ASC payment system. The HCPCS code assigned to this source and the payment rate under OPSS are listed in Table 2.

Table 2 – New Brachytherapy Source HCPCS

HCPCS Code	Effective Date	Short Descriptor	Long Descriptor	ASC PI
C2645	1/1/2016	Brachytx planar, p-103	Brachytherapy planar source, palladium - 103, per square millimeter	H2

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6. Billing Instructions for Corneal Tissue

As finalized in the CY 2016 OPPS/ASC final rule with comment period (80 FR 70472), procurement/acquisition of corneal tissue will be paid separately only when it is used in corneal transplant procedures. Specifically, corneal tissue will be separately paid when used in procedures performed in the OPD only when the corneal tissue is used in a corneal transplant procedure described by one of the following CPT codes:

- 65710 (Keratoplasty (corneal transplant); anterior lamellar);
- 65730 (Keratoplasty (corneal transplant); penetrating (except in aphakia or pseudophakia));
- 65750 (Keratoplasty (corneal transplant); penetrating (in aphakia));
- 65755 (Keratoplasty (corneal transplant); penetrating (in pseudophakia));
- 65756 (Keratoplasty (corneal transplant); endothelial and any successor code or new code describing a new type of corneal transplant procedure that uses eye banked corneal tissue.

HCPCS code V2785 (Processing, preserving, and transporting corneal tissue) should only be reported when corneal tissue is used in a corneal transplant procedure; V2785 should not be reported in any other circumstances.

7. Drugs, Biologicals, and Radiopharmaceuticals

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

For CY 2016, several new HCPCS codes were created for reporting drugs and biologicals in the ASC setting. These new codes, their descriptors, and payment indicator (PI) are listed in Table 3.

Table 3 – New CY 2016 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2016 HCPCS Code	Effective Date	Short Descriptor	Long Descriptor	ASC PI
C9458	1/1/2016	Florbetaben f18	Florbetaben F18, diagnostic, per study dose, up to 8.1 millicuries	K2
C9459	1/1/2016	Flutemetamol f18	Flutemetamol F18, diagnostic, per study dose, up to 5 millicuries	K2
C9460	1/1/2016	Injection, cangrelor	Injection, cangrelor, 1 mg	K2
J0714	1/1/2016		Injection, ceftazidime and avibactam, 0.5g/0.125g	K2

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CY 2016 HCPCS Code	Effective Date	Short Descriptor	Long Descriptor	ASC PI
J1575	1/1/2016	Hyqvia 100mg immunoglobulin	Injection, immune globulin/hyaluronidase, (hyqvia), 100 mg immunoglobulin	K2
J7188	1/1/2016	Factor viii recomb obizur	Injection, factor viii (antihemophilic factor, recombinant), (obizur), per i.u.	K2
J7340	1/1/2016	Carbidopa levodopa enteral	Carbidopa 5 mg/levodopa 20 mg enteral suspension	K2

a. Other Changes to CY 2016 HCPCS and CPT Codes 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 2016. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2015, and replaced with permanent HCPCS codes in CY 2016. ASCs should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the CY 2016 HCPCS and CPT codes. Table 4 notes those drugs, biologicals, and radiopharmaceuticals that have undergone changes in their HCPCS/CPT code, their long descriptor, and/or short descriptor. Each product's CY 2015 HCPCS/CPT code and long descriptor are noted in the two left hand columns and the CY 2016 HCPCS/CPT code and long descriptor are noted in the adjacent right hand columns. CY2016 HCPCS short descriptors that are unchanged from their crosswalked CY2015 short descriptor are annotated with an asterisk (*). CY2016 short descriptors are provided if changed from the CY2015 crosswalked short descriptor.

Table 4 – Other CY 2016 HCPCS and CPT Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2015 HCPCS /CPT code	CY 2015 Long Descriptor	CY 2016 HCPCS/ CPT Code	CY 2016 Long Descriptor	CY 2016 Short Descriptors
C9025	Injection, ramucirumab, 5 mg	J9308	Injection, ramucirumab, 5 mg	*
C9026	Injection, vedolizumab, 1 mg	J3380	Injection, vedolizumab, 1 mg	*

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CY 2015 HCPCS /CPT code	CY 2015 Long Descriptor	CY 2016 HCPCS/ CPT Code	CY 2016 Long Descriptor	CY 2016 Short Descriptors
C9027	Injection, pembrolizumab, 1 mg	J9271	Injection, pembrolizumab, 1 mg	*
Q9975	Injection, Factor VIII, FC Fusion Protein (Recombinant), per iu	J7205	Injection, factor viii fc fusion (recombinant), per iu	*
C9442	Injection, belinostat, 10 mg	J9032	Injection, belinostat, 10 mg	Injection, belinostat, 10mg
C9443	Injection, dalbavancin, 10 mg	J0875	Injection, dalbavancin, 5 mg	*
C9444	Injection, oritavancin, 10 mg	J2407	Injection, oritavancin, 10 mg	*
C9445	Injection, c-1 esterase inhibitor (recombinant), Ruconest, 10 units	J0596	Injection, c1 esterase inhibitor (recombinant), ruconest, 10 units	*
C9446	Injection, tedizolid phosphate, 1 mg	J3090	Injection, tedizolid phosphate, 1 mg	*
Q9978	Netupitant 300 mg and Palonosetron 0.5 mg, oral	J8655	Netupitant 300 mg and palonosetron 0.5 mg	*
C9449	Injection, blinatumomab, 1 mcg	J9039	Injection, blinatumomab, 1 microgram	*
C9450	Injection, fluocinolone acetonide intravitreal implant, 0.01 mg	J7313	Injection, fluocinolone acetonide, intravitreal implant, 0.01 mg	Fluocinol acet intravit imp
C9451	Injection, peramivir, 1 mg	J2547	Injection, peramivir, 1 mg	*
C9452	Injection, ceftolozane 50 mg and tazobactam 25 mg	J0695	Injection, ceftolozane 50 mg and tazobactam 25 mg	*
C9453	Injection, nivolumab, 1 mg	J9299	Injection, nivolumab, 1 mg	*

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CY 2015 HCPCS /CPT code	CY 2015 Long Descriptor	CY 2016 HCPCS/ CPT Code	CY 2016 Long Descriptor	CY 2016 Short Descriptors
C9454	Injection, pasireotide long acting, 1 mg	J2502	Injection, pasireotide long acting, 1 mg	*
C9455	Injection, siltuximab, 10 mg	J2860	Injection, siltuximab, 10 mg	*
C9456	Injection, isavuconazonium sulfate, 1 mg	J1833	Injection, isavuconazonium, 1 mg	*
C9457	Injection, sulfur hexafluoride lipid microsphere, per ml	Q9950	Injection, sulfur hexafluoride lipid microspheres, per ml	Inj sulf hexa lipid microsph
J1446	Injection, tbo-filgrastim, 5 micrograms	J1447	Injection, tbo-filgrastim, 1 microgram	Inj tbo filgrastim 1 microg
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg	J7297	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 3 year duration	*
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg	J7298	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5 year duration	*
J7506	Prednisone, oral, per 5mg	J7512	Prednisone, immediate release or delayed release, oral, 1 mg	*
J7508	Tacrolimus, extended release, oral, 0.1 mg	J7508	Tacrolimus, extended release, (astagraf xl), oral, 0.1 mg	*
Q9979	Injection, alemtuzumab, 1 mg	J0202	Injection, alemtuzumab, 1 mg	*
Q4153	Dermavest, per square centimeter	Q4153	Dermavest and plurivest, per square centimeter	*
Q9976	Injection, ferric pyrophosphate citrate solution, 0.1 mg of iron	J1443	Injection, ferric pyrophosphate citrate solution, 0.1 mg of iron	*

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CY 2015 HCPCS /CPT code	CY 2015 Long Descriptor	CY 2016 HCPCS/ CPT Code	CY 2016 Long Descriptor	CY 2016 Short Descriptors
Q9977	Compounded Drug, Not Otherwise Classified	J7999	Compounded Drug, Not Otherwise Classified	*
S5011	5 % dextrose in lactated ringers, 1000 ml	J7121	5 % dextrose in lactated ringers infusion, up to 1000 cc	*

*CY2016 HCPCS short descriptors that are unchanged from their crosswalked CY2015 short descriptor.

b. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective January 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 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 January 1, 2016, are available in the January 2016 ASC Addendum BB 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%20Addenda%20Updates.html) on the CMS website.

c. 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 are 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 the previously processed claims.

d. Biosimilar Payment Policy

Effective January 1, 2016, the payment rate for biosimilars approved for payment in the ASC payment system will be the same as the payment rate in the OPSS and physician office setting, calculated as the ASP of the biosimilar(s) described by the HCPCS code + 6 percent of the ASP of the reference product. Payment will be made at the single ASP + 6 percent rate.

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e. Updated Guidance: Billing and Payment for New Drugs, Biologicals, or Radiopharmaceuticals Approved by the FDA but Before Assignment of a Product-Specific HCPCS Code

As in the OPPTS, ASCs are allowed to bill for new drugs, biologicals, and therapeutic radiopharmaceuticals that are approved by the FDA on or after January 1, 2004, for which OPPTS pass-through status has not been approved and a C-code and APC payment have not been assigned using the “unclassified” drug/biological HCPCS code C9399 (Unclassified drugs or biological). Drugs, biologicals, and therapeutic radiopharmaceuticals that are assigned to HCPCS code C9399 are MAC priced.

Diagnostic radiopharmaceuticals and contrast agents are policy packaged under both the OPPTS and ASC payment system unless they have been granted pass-through status. Therefore, new diagnostic radiopharmaceuticals and contrast agents are an exception to the above policy and should not be billed with C9399 prior to the approval of pass-through status. Instead, they are packaged in the ASC setting with payment already included in the surgical procedure performed, and are not billed.

f. Skin Substitute Procedure Edits

The payment for skin substitute products that do not qualify for OPPTS pass-through status are packaged into the OPPTS payment for the associated skin substitute application procedure. This policy is also implemented in the ASC payment system. The skin substitute products are divided into two groups: 1) high cost skin substitute products and 2) low cost skin substitute products for packaging purposes. Table 5 lists the skin substitute products and their assignment as either a high cost or a low cost skin substitute product, when applicable. ASCs should not separately bill for packaged skin substitutes (ASC PI=N1).

High cost skin substitute products should only be utilized in combination with the performance of one of the skin application procedures described by CPT codes 15271-15278. Low cost skin substitute products should only be utilized in combination with the performance of one of the skin application procedures described by HCPCS code C5271-C5278. All OPPTS pass-through skin substitute products (ASC PI=K2) should be billed in combination with one of the skin application procedures described by CPT code 15271-15278.

Table 5 – Skin Substitute Product Assignment to High Cost/Low Cost Status for CY 2016

CY 2016 HCPCS Code	CY 2016 Short Descriptor	ASC PI	Low/High Cost Skin Substitute
C9349	PuraPly, PuraPly antimic	K2	High
C9363	Integra Meshed Bil Wound Mat	N1	High
Q4101	Apligraf	N1	High

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CY 2016 HCPCS Code	CY 2016 Short Descriptor	ASC PI	Low/High Cost Skin Substitute
Q4102	Oasis Wound Matrix	N1	Low
Q4103	Oasis Burn Matrix	N1	High
Q4104	Integra BMWD	N1	High
Q4105	Integra DRT	N1	High
Q4106	Dermagraft	N1	High
Q4107	GraftJacket	N1	High
Q4108	Integra Matrix	N1	High
Q4110	Primatrix	N1	High
Q4111	Gammagraft	N1	Low
Q4115	Alloskin	N1	Low
Q4116	Alloderm	N1	High
Q4117	Hyalomatrix	N1	Low
Q4119	Matristem Wound Matrix	N1	Low
Q4120	Matristem Burn Matrix	N1	High
Q4121	Theraskin	K2	High
Q4122	Dermacell	N1	High
Q4123	Alloskin	N1	High
Q4124	Oasis Tri-layer Wound Matrix	N1	Low
Q4126	Memoderm/derma/tranz/integup	N1	High
Q4127	Talymed	N1	High
Q4128	Flexhd/Allopatchhd/Matrixhd	N1	High
Q4129	Unite Biomatrix	N1	Low
Q4131	Epifix	N1	High
Q4132	Grafix Core	N1	High
Q4133	Grafix Prime	N1	High
Q4134	hMatrix	N1	Low

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CY 2016 HCPCS Code	CY 2016 Short Descriptor	ASC PI	Low/High Cost Skin Substitute
Q4135	Mediskin	N1	Low
Q4136	Ezderm	N1	Low
Q4137	Amnioexcel or Biodexcel, 1cm	N1	High
Q4138	Biodfence DryFlex, 1cm	N1	High
Q4140	Biodfence 1cm	N1	High
Q4141	Alloskin ac, 1cm	N1	High
Q4143	Repriza, 1cm	N1	Low
Q4146	Tensix, 1CM	N1	Low
Q4147	Architect ecm, 1cm	N1	High
Q4148	Neox 1k, 1cm	N1	High
Q4150	Allowrap DS or Dry 1 sq cm	N1	High
Q4151*	AmnioBand, Guardian 1 sq cm	N1	High
Q4152*	Dermapure 1 square cm	N1	High
Q4153	Dermavest 1 square cm	N1	High
Q4154*	Biovance 1 square cm	N1	High
Q4156*	Neox 100 1 square cm	N1	High
Q4157	Revitalon 1 square cm	N1	Low
Q4158	MariGen 1 square cm	N1	Low
Q4159	Affinity 1 square cm	N1	High
Q4160	NuShield 1 square cm	N1	High
Q4161	Bio-Connekt per square cm	N1	Low
Q4162	Amnio bio and woundex flow	N1	Low
Q4163	Amnion bio and woundex sq cm	N1	Low
Q4164	Helicoll, per square cm	N1	Low
Q4165	Keramatrix, per square cm	N1	Low

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*HCPCS codes Q4151, Q4152, Q4154, and Q4156 were assigned to the low cost group in the CY 2016 OPPS/ASC final rule with comment period. Upon submission of updated pricing information, Q4151, Q4152, Q4154, and Q4156 are assigned to the high cost group for CY 2016.

8. CY 2016 ASC Wage Index

In the CY 2016 OPPS/ASC final rule, CMS-1633-FC, and CMS-1607-F2 (80 FR 70298), CMS reminded readers that in the CY 2015 OPPS/ASC final rule with comment period (79 FR 66937), CMS finalized a 1-year transition or “blended” policy that it applied in CY 2015 for all ASCs that experienced any decrease in their actual wage index exclusively due to the implementation of the new OMB delineations. When the CY 2015 wage index blended value did not correspond to an existing Core Based Statistical Area (CBSA) number, CMS implemented this transition by creating alternate or pseudo CBSA numbers (50000 series) to accommodate those wage index values. This transition became operational via CR9021, dated January 9, 2015. This transition does not apply in CY 2016. For CY 2016, the final CY 2016 ASC wage indexes fully reflect the new OMB labor market area delineations and the pseudo-CBSAs are being end dated.

The complete set of pseudo-CBSAs and their crosswalk to their final CY2016 ASC wage indices are included in Attachment B of CR9484. Attachment B is an Excel® spreadsheet that is sorted in this manner: columns A-C show State/county and state/county code, columns D-E are provided as a historical reference, and columns F-H show the CY2015 pseudo-CBSA related data that will be crosswalked to the final CY2016 CBSA information contained in columns I-K.

9. Continued Use of C1841 in ASCs

Effective October 1, 2013, and expiring December 31, 2015, one device (C1841 - Retinal prosthesis, includes all internal and external components) was eligible for pass-through payment in the OPPS and ASC payment systems. After pass-through status expires for a medical device, the payment for the device is packaged into the payment for the associated procedure. Effective January 1, 2016, in the OPPS and ASC payment systems, C1841 is now packaged into CPT code 0100T, which is assigned to New Technology APC 1599 with a final payment of \$95,000 for CY 2016.

Due to current ASC systems limitations, CMS cannot implement the identical policy in ASCs. As an administrative workaround until CMS can correct this system limitation, both C1841 and 0100T must be reported when a retinal prosthesis is implanted in the ASC.

10. 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.

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Additional Information

The official instruction, CR9484, issued to your MAC regarding this change, is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3430CP.pdf> on the CMS website.

If you have questions, please contact your MAC at their toll-free number. The 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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