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October 2017 Update of the Ambulatory Surgical Center (ASC) Payment System

MLN Matters Number: MM10259

Related CR Release Date: September 1, 2017

Related CR Transmittal Number: R3854CP

Related Change Request (CR) Number: CR10259

Effective Date: October 1, 2017

Implementation Date: October 2, 2017

PROVIDER TYPE 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

Change Request (CR) 10259 informs MACs about updates to the ASC payment system for October 2017. Make sure that your billing staffs are aware of these changes.

BACKGROUND

Included in CR10259 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), the ASC PI file, the CY 2017 ASC payment rates for covered surgical and ancillary services (ASCFS file), and an ASC Code Pair file.

CR10259 also includes changes to billing instructions for various payment policies implemented in the October 2017 ASC payment system update. The changes are as follows:

1. New Procedure Requiring the Insertion of a Device

Since January 1, 2017, in both the hospital outpatient prospective payment system and ASC settings, all new procedures requiring the insertion of an implantable medical device will be assigned a default device offset percentage of at least 41%, and thereby assigned device intensive status, until claims data is available. In certain rare instances, the Centers for Medicare & Medicaid Services (CMS) may temporarily assign a higher offset percentage if

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warranted by additional information. In accordance with this current policy, the code requiring the insertion of a device listed in Table 1 will be assigned device intensive status effective October 1, 2017. CMS notes that although HCPCS code C9747 was effective in the ASC setting as of July 1, 2017, its device intensive designation is not effective until October 1, 2017. See the table below.

Table 1. - New Procedure Requiring the Insertion of a Device

HCPCS Code	Long Descriptor	ASC PI Effective Date	ASC PI
C9747	Ablation of prostate, transrectal, high intensity focused ultrasound (HIFU), including imaging guidance	10-01-2017	J8

2. Drugs, Biologicals, and Radiopharmaceuticals

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective Oct. 1, 2017

For CY 2017, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP plus 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2017, a single payment of ASP plus 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 ASP will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective October 1, 2017 are available in the October 2017 ASC Addendum BB at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html.

b. Drugs and Biologicals with Payments Based on ASP with Restated Payment Rates

Some drugs and biologicals with payments 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. Suppliers who think they may have received an incorrect payment for drugs and biologicals impacted by these corrections may request contractor adjustment of the previously processed claims.

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c. New CY 2017 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals Effective October 1, 2017

Four new HCPCS codes have been created for reporting drugs and biologicals in the ASC setting effective October 1, 2017. These new codes, their descriptors, and ASC payment indicators are listed in Table 2.

Table 2. – New CY 2017 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals Effective October 1, 2017

HCPCS Code	Short Description	Long Description	ASC PI
C9491	Injection, avelumab	Injection, avelumab, 10 mg	K2
C9492	Injection, durvalumab	Injection, durvalumab, 10 mg	K2
C9493	Injection, edaravone	Injection, edaravone, 1 mg	K2
C9494	Injection, ocrelizumab	Injection, ocrelizumab, 1 mg	K2

d. New Modifier for Biosimilar Biological Product

HCPCS Code Q5102 can be reported with either the existing modifier ZB or new modifier ZC effective July 1, 2017. See Table 3.

Table 3. – Biosimilar Biological Product Payment and Required Modifiers

HCPCS Code	Short Descriptor	Long Descriptor	ASC PI	HCPCS Code Effective Date	Modifier	Modifier Effective Date
Q5102	Injection, infliximab biosimilar	Injection, Infliximab, Bio similar, 10 mg	K2	04/05/2016	ZB – Pfizer/Hospira	04/01/2016

HCPCS Code	Short Descriptor	Long Descriptor	ASC PI	HCPCS Code Effective Date	Modifier	Modifier Effective Date
Q5102	Injection, infliximab biosimila	Injection, Infliximab, Biosimilar, 10 mg	K2	04/05/2016	ZC – Merck/Samsung Bioepis	07/01/2017

e. New Flu Vaccine

The existing influenza vaccine CPT code 90674 (Cciiv4 vaccine, no preservative, 0.5 ml, intramuscular) with trade name Flucelvax Quadrivalent was effective January 1, 2017, and is a preservative-free and antibiotic-free vaccine. A new preservative, antibiotic-free influenza vaccine CPT code with the same trade name, Flucelvax Quadrivalent, will be effective on January 1, 2018. For the period between August 1, 2017 and December 31, 2017, Flucelvax Quadrivalent Preservative should be reported as Q2039. The permanent CPT code for the Flucelvax Quadrivalent preservative influenza vaccine will be released on a later date, see Table 4 below. ASCs are reminded that ASCPI “L1” vaccine codes are packaged in the ASC payment system.

Table 4. –Flucelvax Quadrivalent Flu Vaccine Codes

Vaccine Type	HCPCS Code	Short Descriptor	Long Descriptor	ASC PI
Flucelvax Quadrivalent Preservative-Free and Antibiotic-Free Flu Vaccine	90674	Cciiv4 vaccine, no preservative, 0.5 ml, intramuscular	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use	L1
Flucelvax Quadrivalent Preservative Flu Vaccine	Q2039	Cciiv4 vaccine, nos, intramuscular	Influenza virus vaccine, not otherwise specified	L1

3. Upper Eyelid Blepharoplasty and Blepharoptosis Repair
As indicated in Chapter VIII of the CY 2017 National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services, CMS payment policy does not allow separate payments for a blepharoptosis procedure (CPT code 67901-67908) and a blepharoplasty procedure (CPT codes 15822-15823) on the ipsilateral upper eyelid. Under this policy, any removal of upper eyelid skin in the context of an upper eyelid blepharoptosis surgery was considered a part of the blepharoptosis surgery. CMS clarified this instruction in the July 2016 ASC Payment System Update Change Request (Transmittal 3531, Change Request 9668 dated May 27, 2016) and the July 2016 ASC MLN Matters Article MM9668 which is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9668.pdf.

However, effective October 1, 2017, CMS is revising this policy to allow either cosmetic or medically necessary blepharoplasty to be performed in conjunction with a medically necessary upper eyelid blepharoptosis surgery. Specifically, physicians may receive payment for a medically necessary upper eyelid blepharoptosis from Medicare even when performed with (non-covered) cosmetic blepharoplasty on the same eye during the same visit. Since cosmetic procedures are not covered by Medicare, Advance Beneficiary Notice of noncoverage (ABN) instructions would apply for cosmetic blepharoplasty. However, medically necessary blepharoplasty will continue to be bundled into the payment for blepharoptosis when performed with and as a part of a blepharoptosis surgery.

Other aspects of the July 2016 ASC Update CR and MLN guidance on upper eyelid blepharoplasty and blepharoptosis remain unchanged. Specifically, CMS notes that Medicare does not allow separate payment for the following:

- 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 removing orbital fat when a blepharoplasty or a blepharoptosis repair is performed.
- Performing a medically necessary blepharoplasty on a different date of service than the blepharoptosis procedure for the purpose of unbundling the medically necessary blepharoplasty.
- 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 medically necessary blepharoplasty performed with a blepharoptosis repair.
- Using modifier 59 to unbundle a medically necessary 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.

- In the rare event that a blepharoplasty is performed on one eye and a blepharoptosis repair is performed on the other eye, the services must each be billed with the appropriate RT or LT modifier.

4. 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, CR10259, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3854CP.pdf.

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/

DOCUMENT HISTORY

Date of Change	Description
September 5, 2017	Initial article released.

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