CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3939	**Date: December 22, 2017**
	Change Request 10441

SUBJECT: January 2018 Update of the Ambulatory Surgical Center (ASC) Payment System

I. SUMMARY OF CHANGES: Tthe January 2018 ASC payment system recurring update notification applies to and also updates 100-04, chapter 14 of the Internet-Only Manual (IOM).

EFFECTIVE DATE: January 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2018

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	14/10/General
R	14/10/2/Ambulatory Surgical Center Services on ASC List
R	14/10/3/Services Furnished in ASCs Which Are Not ASC Facility Services or Covered Ancillary Services
R	14/20/List of Covered Ambulatory Surgical Center Procedures
R	14/30/1/Where to Obtain Current Rates and Lists of Covered Services
R	14/40/2/Wage Adjustment of Base Payment Rates
R	14/40/3/Payment for Intraocular Lens (IOL)
R	14/40.6 Payment for Extracorporeal Shock Wave Lithotripsy (ESWL)
R	14/40/7/Offset for Payment for Pass-Through Devices Beginning January 1, 2008
R	14/50 ASC Procedures for Completing the ASC X12 837 Professional Claim Format or the Form CMS-1500
R	14/70/Ambulatory Surgical Center (ASC) HCPCS Additions, Deletions, and Master Listing

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification
Manual Instructions

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 3939	Date: December 22, 2017	Change Request: 10441

SUBJECT: January 2018 Update of the Ambulatory Surgical Center (ASC) Payment System

EFFECTIVE DATE: January 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2018

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the January 2018 ASC payment system update. This Recurring Update Notification applies to and also updates 100-04, chapter 14 of the Internet-Only Manual (IOM). As appropriate, this notification also includes updates to the Healthcare Common Procedure Coding System (HCPCS).

Included in this notification are Calendar Year (CY) 2018 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 2018 ASC Payment Rates for Covered Surgical and Ancillary Services (ASCFS file). No ASC Code Pair file is being issued with this transmittal.

ASC payment rates under the ASC payment system are generally established using payment rate information in the hospital Outpatient Prospective Payment System (OPPS) or the Medicare Physician Fee Schedule (MPFS). The payment files associated with this transmittal reflect the most recent changes to CY 2018 OPPS and CY 2018 MPFS payments.

B. Policy: 1. a. New Device Pass-Through Policies

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 two (2), but not more than three (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. This policy was implemented in the 2008 revised ASC payment system. Therefore, 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).

Effective January 1, 2018, there are no device categories eligible for pass-through payment. However, an existing device described by HCPCS code C2623 (*Catheter, transluminal angioplasty, drug coated, non laser*) was approved on August 25, 2017 by the Food and Drug Administration (FDA) for a new indication, specifically the treatment of patients with Dysfunctional Arteriovenous (AV) fistulae. Accordingly, in this January 2018 update, devices described by HCPCS code C2623, are eligible for pass through status retroactive to August 25, 2017 when the device is billed with Current Procedural Terminology (CPT) code 36902 (*Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty*) or CPT code 36903 (*Insertion of needle and/or catheter into dialysis circuit and insertion of stent in dialysis segment, with imaging including radiological supervision and interpretation*).This device pass through status will be applied retroactively from August 25, 2017 through December 31,

2017.

b. Device Offset from Payment for Device Category

Section 1833(t)(6)(D)(ii) of the Act requires that we deduct from pass-through payments for devices an amount that reflects the portion of the Ambulatory Payment Classifications (APC) payment amount. With respect to device code C2623, we have previously determined that the costs associated with C2623 are not reflected in the APC payment amount. Therefore, we are not applying a device offset to the retroactive pass-through payments for C2623. Retroactive pass-through payments for services furnished on August 25, 2017 through December 31, 2017, without deduction, will only apply when HCPCS code C2623 is billed with CPT code 36902 or 36903.

2. New Separately Payable Procedure Code Effective January 1, 2018

Effective January 1, 2018, new HCPCS code C9748 has been created as described in the Table 1. (see Attachment A: Policy Section Tables).

3. Drugs, Biologicals, and Radiopharmaceuticals

a. New CY 2018 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

For CY 2018, several new HCPCS codes have been created for reporting drugs and biologicals in the ASC payment system, where there have not previously been specific codes available. These new codes are listed in Table 2. (see Attachment A: Policy Section Tables).

b. Other Changes to CY 2018 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 2018. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2017, and replaced with permanent HCPCS codes in CY 2018. ASCs should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the CY 2018 HCPCS and CPT codes.

Table 3 notes those drugs, biologicals, and radiopharmaceuticals that have undergone changes in their HCPCS/CPT code, their long descriptor, or both. Each product's CY 2017 HCPCS/CPT code and long descriptor are noted in the two left hand columns and the CY 2018 HCPCS/CPT code and long descriptor are noted in the adjacent right hand columns. (see Attachment A: Policy Section Tables).

c. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective January 1, 2018

For CY 2018, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals continues to be 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 addition, in CY 2018, a single payment of ASP + 6 percent continues to be made 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. Effective January 1, 2018, payment rates for many drugs and biologicals have changed from the values published in the CY 2018 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 2017. In cases where adjustments to payment rates are necessary, CMS is not publishing the updated payment rates in this Change Request. However, all ASC payable drugs and biologicals effective January 1, 2018, including those that were updated as a result of the new ASP calculations, can be found in the January 2018 ASC Addendum BB on the CMS website at:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html

d. 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 on the CMS website 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.

e. Biosimilar Biological Product Payment Policy

Effective January 1, 2018, the payment rate for biosimilars approved for payment in the ASC payment system will be the same as the payment rate in the OPPS and physician office setting, calculated as the Average Sales Price (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.

As a reminder, ASC claims for separately paid biosimilar biological products are required to include the 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. Any changes to the billing requirements for biosimilar biological products will be issued to ASCs in a future transmittal.

f. Skin Substitute Assignments to High Cost and Low Cost Groups for CY 2018

The payment for skin substitute products that do not qualify for hospital OPPS pass-through status are packaged into the OPPS 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 4, 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 OPPS 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.

Please note, that all of the skin substitute products listed in this table are packaged and should not be separately billed by ASCs. (see Attachment A: Policy Section Tables).

4. Section 4011 of the 21st Century Cures Act

Section 4011 of the 21st Century Cures Act created a new subsection (t) in section 1834 of the Social Security Act that requires CMS to make available to the public a searchable Internet website that compares estimated payment and beneficiary liability for an appropriate number of items and services paid under the OPPS and the ASC Payment System. Consistent with this statute, we plan to first make this website available during CY 2018.

We believe that making available a comparison for all services that receive separate payment under both the OPPS and ASC payment system would be most useful to the public, with regards to displaying the comparison for an “appropriate number of such items and services.” We believe that displaying the national unadjusted payments and copayment amounts will allow the user to make a meaningful comparison between

the systems for items and services paid under both systems. We may consider providing payment and copayment comparisons at the locality or provider level for future years.

Along with the comparison information that we will make available to the public in accordance with the requirements of Section 4011, we also plan to include a disclaimer statement that notes some of the payment policy differences in each care setting and noting the limitations of the comparison tool, to provide users with some context for why there might be potential differences. In the case of the OPPS copayments, we plan to include an additional indicator where the service is likely to be capped at the Part A inpatient deductible, based on the unadjusted copayments, under the OPPS coinsurance rules.

5. July ASCFS Technical Record Correction

CMS is including a revised July ASCFS record to provide a technical correction to the record for 0474T, position 38, on the ASCFS record layout. The original indicator was incompatible with this code. No additional instructions are being provided to MACs at this time.

6. 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.

7. Attachments: 1

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10441.1	Contractors shall download the January 2018 ASCFS from the CMS mainframe. FILENAME: MU00.@BF12390.ASC.CY18.FS.JANA.V1218 NOTE: The January 2018 ASCFS is a full update. **NOTE: Date of retrieval will be provided in a separate email communication from CMS.**		X							VDCs
10441.2	Medicare contractors shall download and install the January 2018 ASC DRUG file. FILENAME: MU00.@BF12390.ASC.CY18.DRUG.JANA.V1215		X							VDCs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	NOTE: Date of retrieval will be provided in a separate email communication from CMS.									
10441.3	Medicare contractors shall download and install the January 2018 ASC PI file. FILENAME: MU00.@BF12390.ASC.CY18.PI.JANA.V1218 **NOTE: Date of retrieval will be provided in a separate email communication from CMS.**		X							VDCs
10441.4	Contractors and Common Working File (CWF) shall add Type of Service (TOS) F and/or revise descriptors, as appropriate, for HCPCS included in attachment A, tables 1-3, effective for services January 1, 2018 and later payable in the ASC setting.		X						X	
10441.5	Contractors and CWF shall end date as appropriate, the CY 2017 HCPCS/CPT codes in table 3, in their systems effective December 31, 2017.		X						X	
10441.6	CWF, as appropriate, shall remove the TOS F records as appropriate, the CY 2017 HCPCS/CPT codes in table 3, effective December 31, 2017.								X	
10441.7	If released by CMS, Medicare contractors shall download and install the revised October 2017 ASC DRUG file. FILENAME: MU00.@BF12390.ASC.CY17.DRUG.OCTB.V1211 **NOTE: Date of retrieval will be provided in a separate email communication from CMS.**		X							VDCs
10441.7.1	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service October 1, 2017- December 31, 2017 and ; 2) Were originally processed prior to the installation of the revised October 2017 ASC DRUG File.		X							
10441.8	If released by CMS, Medicare contractors shall		X							VDCs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	download and install the revised July 2017 ASC DRUG file. FILENAME: MU00.@BF12390.ASC.CY17.DRUG.JULC.V1211 **NOTE: Date of retrieval will be provided in a separate email communication from CMS.**									
10441.8.1	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service July 1, 2017- September 30, 2017 and ; 2) Were originally processed prior to the installation of the revised July 2017 ASC DRUG File.		X							
10441.9	If released by CMS, Medicare contractors shall download and install the revised April 2017 ASC DRUG file. FILENAME: MU00.@BF12390.ASC.CY17.DRUG.APRD.V1211 **NOTE: Date of retrieval will be provided in a separate email communication from CMS.**		X							VDCs
10441.9.1	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service April 1, 2017- June 30, 2017 and ; 2) Were originally processed prior to the installation of the revised April 2017 ASC DRUG File.		X							
10441.10	If released by CMS, Medicare contractors shall download and install the revised January 2017 ASC DRUG file. FILENAME: MU00.@BF12390.ASC.CY17.DRUG.JAND.V1211 **NOTE: Date of retrieval will be provided in a separate email communication from CMS.**		X							VDCs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10441.10.1	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service January 1, 2017- March 30, 2017 and ; 2) Were originally processed prior to the installation of the revised January 2017 ASC DRUG File.		X							
10441.11	If released by CMS, Medicare contractors shall download and install the revised July 2017 ASCFS file. FILENAME: MU00.@BF12390.ASC.CY17.FS.JULB.V1211 **NOTE: Date of retrieval will be provided in a separate email communication from CMS.**		X							VDCs
10441.12	Contractors shall make January 2018 ASCFS fee data for their ASC payment localities available on their web sites.		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10441.13	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.		X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
1-6	Attachment A: POLICY SECTION TABLES

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Chuck Braver, 410-786-6719 or chuck.braver@cms.hhs.gov (ASC Payment Policy) , Yvette Cousar, 410-786-2160 or yvette.cousar@cms.hhs.gov (B MAC Claims Processing Issues) , Mark Baldwin, 410-786-8139 or mark.baldwin@cms.hhs.gov (B MAC Claims Processing Issues)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 1

Attachment A − Tables for the Policy Section

Table 1. ─ New Separately Payable Procedure Code Effective January 1, 2018

HCPCS Code	Short Descriptor	Long Descriptor	ASC PI
C9748	Prostatic rf water vapor tx	Transurethral destruction of prostate tissue; by radiofrequency water vapor (steam) thermal therapy	G2

Table 2 ─ New CY 2018 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

HCPCS Code	Short Descriptor	Long Descriptor	ASC PI
C9014	Injection, cerliponase alfa	Injection, cerliponase alfa, 1 mg	K2
C9015	C-1 esterase, haegarda	Injection, c-1 esterase inhibitor (human), Haegarda, 10 units	K2
C9016	Inj, triptorelin ext rel	Injection, triptorelin extended release, 3.75 mg	K2
C9024	Inj, daunorubicin-cytarabine	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine	K2
C9028	Inj. inotuzumab ozogamicin	Injection, inotuzumab ozogamicin, 0.1 mg	K2
C9029	Injection, guselkumab	Injection, guselkumab, 1 mg	K2
J0606	Inj, etelcalcetide, 0.1 mg	Injection, etelcalcetide, 0.1 mg	K2
J1555	Inj cuvitru, 100 mg	Injection, immune globulin (cuvitru), 100 mg	K2
J7211	Inj, kovaltry, 1 i.u.	Injection, factor viii, (antihemophilic factor, recombinant), (kovaltry), 1 i.u.	K2
J7345	Aminolevulinic acid, 10% gel	Aminolevulinic acid hcl for topical administration, 10% gel, 10 mg	K2
J9203	Gemtuzumab ozogamicin 0.1 mg	Injection, gemtuzumab ozogamicin, 0.1 mg	K2
Q2040	Tisagenlecleucel car-pos t	Tisagenlecleucel, up to 250 million car-positive viable t cells, including leukapheresis and dose preparation	K2

HCPCS Code	Short Descriptor	Long Descriptor	ASC PI
		procedures, per infusion	

Table 3 – Other CY 2018 HCPCS and CPT Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2017 HCPCS Code	CY 2017 Long Descriptor	CY 2018 HCPCS Code	CY 2018 Long Descriptor
C9490	Injection, bezlotoxumab, 10 mg	J0565	Injection, bezlotoxumab, 10 mg
C9484	Injection, eteplirsen, 10 mg	J1428	Injection, eteplirsen, 10 mg
C9486	Injection, granisetron extended release, 0.1 mg	J1627	Injection, granisetron, extended-release, 0.1 mg
Q9986	Injection, hydroxyprogesterone caproate (Makena), 10 mg	J1726	Injection, hydroxyprogesterone caproate (Makena), 10 mg
C9489	Injection, nusinersen, 0.1 mg	J2326	Injection, nusinersen, 0.1 mg
C9494	Injection, ocrelizumab, 1 mg	J2350	Injection, ocrelizumab, 1 mg
Q9989	Ustekinumab, for Intravenous Injection, 1 mg	J3358	Ustekinumab, for intravenous injection, 1 mg
C9140	Injection, Factor VIII (antihemophilic factor, recombinant) (Afstyla), 1 I.U.	J7210	Injection, factor viii, (antihemophilic factor, recombinant), (afstyla), 1 i.u.
C9483	Injection, atezolizumab, 10 mg	J9022	Injection, atezolizumab, 10 mg
C9491	Injection, avelumab, 10 mg	J9023	Injection, avelumab, 10 mg
C9485	Injection, olaratumab, 10 mg	J9285	Injection, olaratumab, 10 mg

Table 4.—Skin Substitute Assignments to High Cost and Low Cost Groups for CY 2018

HCPCS Code	2018 Short Descriptor	ASC PI	CY 2018 High/Low Assignment
C9363	Integra meshed bil wound mat	N1	High
Q4100	Skin substitute, nos	N1	Low
Q4101	Apligraf	N1	High

HCPCS Code	2018 Short Descriptor	ASC PI	CY 2018 High/Low Assignment
Q4102	Oasis wound matrix	N1	Low
Q4103	Oasis burn matrix	N1	High
Q4104	Integra bmwd	N1	High
Q4105	Integra drt or omnigraft	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
Q4121	Theraskin	N1	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
Q4131	Epifix or epicord	N1	High
Q4132	Grafix core, grafixpl core	N1	High
Q4133	Grafix prime grafix pl prime	N1	High
Q4134	Hmatrix	N1	Low
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	High
Q4146	Tensix, 1 cm	N1	High
Q4147	Architect ecm px fx 1 sq cm	N1	High

HCPCS Code	2018 Short Descriptor	ASC PI	CY 2018 High/Low Assignment
Q4148	Neox neox rt or clarix cord	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, plurivest sq cm	N1	High
Q4154	Biovance 1 square cm	N1	High
Q4156	Neox 100 or clarix 100	N1	High
Q4157	Revitalon 1 square cm	N1	High
Q4158	Neox 100 or clarix 100	N1	High
Q4159	Neox 100 or clarix 100	N1	High
Q4160	Neox 100 or clarix 100	N1	High
Q4161	Bio-Connekt per square cm	N1	High
Q4163	Woundex, bioskin, per sq cm	N1	High
Q4164	Helicoll, per square cm	N1	High
Q4165	Keramatrix, per square cm	N1	Low
Q4166	Cytal, per square cm	N1	Low
Q4167	Truskin, per square cm	N1	Low
Q4169	Artacent wound, per square cm	N1	High
Q4170	Cygnus, per square cm	N1	Low
Q4172*	Puraply or puraply am	N1	High
Q4173	Palingen or palingen xplus	N1	High
Q4175	Miroderm	N1	High
Q4176*	Neopatch, per sq centimeter	N1	Low
Q4178*	Floweramniopatch, per sq cm	N1	Low
Q4179*	Flowerderm, per sq cm	N1	Low
Q4180*	Revita, per sq cm	N1	Low
Q4181*	Amnio wound, per square cm	N1	Low
Q4182*	Transcyte, per sq centimeter	N1	Low

* HCPCS codes Q4176, Q4178, Q4179, Q4180, Q4181, and Q4182 were assigned to the low cost group in CY 2018 OPPS/ASC final rule with comment period. Pass-through status for HCPCS code Q4172 ended on December 31, 2017.

Medicare Claims Processing Manual
Chapter 14 - Ambulatory Surgical Centers

10 - General
(Rev. 3939; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

Prior to January 1, 2008, payment was made under Part B for certain surgical procedures that were furnished in ASCs and were approved for being furnished in an ASC. These procedures were those that generally did not exceed 90 minutes in length and did not require more than 4 hours of recovery or convalescent time. Prior to January 1, 2008, Medicare did not pay an ASC for those procedures that required more than an ASC level of care, or for minor procedures that were normally performed in a physician's office.

Prior to January 1, 2008, the CMS published updates to the list of procedures for which an ASC may be paid each year. The complete list of procedures is available on the CMS Web site at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html* . These files include applicable codes, payment groups, and payment amounts for each ASC group before adjustments for regional wage variations. Applicable wage indices were also published via change requests.

Beginning January 1, 2008, payment is made to ASCs under Part B for all surgical procedures except those that CMS determines may pose a significant safety risk to beneficiaries or that are expected to require an overnight stay when furnished in an ASC. Also, beginning January 1, 2008, separate payment is made to ASCs under Part B for certain ancillary services such as certain drugs and biologicals, OPPS pass-through devices, brachytherapy sources, and radiology procedures. Medicare does not pay an ASC for procedures that are excluded from the list of covered surgical procedures. Medicare continues to pay ASCs for new technology intraocular lenses and corneal tissue acquisition as it did prior to January 1, 2008.

Beginning January 1, 2008, the CMS publishes updates to the list of procedures for which an ASC may be paid each year. In addition, CMS publishes quarterly updates to the lists of covered surgical procedures and covered ancillary services to establish payment indicators and payment rates for newly created Level II HCPCS and Category III CPT codes. The complete lists of ASC covered surgical procedures and ASC covered ancillary services, the applicable payment indicators, payment rates for each covered surgical procedure and ancillary service before adjustments for regional wage variations, the wage adjusted payment rates, and wage indices are *accessible* on the CMS Web site at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html* .

To be paid under this provision, a facility must be certified as meeting the requirements for an ASC and must enter into a written agreement with CMS. The certification process is described in the State Operations Manual.

ASCs must accept Medicare's payment as payment in full for services with respect to those services defined as ASC services. The physician and anesthesiologist may bill and be paid for the professional component of the service also.

Certain other services such as lab services or non-implantable DME may be performed when billed using the appropriate certified provider/supplier UPIN/NPI.

10.2 - Ambulatory Surgical Center Services on ASC List
(Rev. 3939; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

Covered ASC services are those surgical procedures that are identified by CMS on a listing that is updated at least annually. Some surgical procedures *are* covered by Medicare *but* are not on the list of *ASC* covered surgical procedures. For surgical procedures *that are performed but* not covered in ASCs, the related

professional services may be billed by the rendering provider as Part B services and the beneficiary is liable for the facility charges, which are non-covered by Medicare.

Under the ASC payment system, Medicare makes facility payments to ASCs only for the specific ASC covered surgical procedures on the ASC list of covered surgical procedures. In addition, Medicare makes separate payment to ASCs for certain covered ancillary services that are provided integral to a covered ASC surgical procedure. All other non-ASC services, such as physician services and prosthetic devices may be covered and separately billable under other provisions of Medicare Part B. The Medicare definition of covered ASC facility services for a covered surgical procedure includes services that would be covered if furnished on an inpatient or outpatient basis in connection with a covered surgical procedure. This includes operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used by the patient or offered for use to patients needing surgical procedures. It includes all services and procedures provided in connection with covered surgical procedures furnished by nurses, technical personnel and others involved in patient care. These do not include physician services or medical and other health services for which payment may be made under other Medicare provisions (e.g., services of an independent laboratory located on the same site as the ASC, anesthetist professional services, non-implantable DME).

ASC services for which payment is included in the ASC payment for a covered surgical procedure under 42 CFR *416.166* include, but are not limited to-

(a) Included facility services:

(1) Nursing, technician, and related services;

(2) Use of the facility where the surgical procedures are performed;

(3) Any laboratory testing performed under a Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate of waiver;

(4) Drugs and biologicals for which separate payment is not allowed under the hospital outpatient prospective payment system (OPPS);

(5) Medical and surgical supplies not on pass-through status under Subpart G of Part 419 of 42 CFR;

(6) Equipment;

(7) Surgical dressings;

(8) Implanted prosthetic devices, including intraocular lenses (IOLs), and related accessories and supplies not on pass-through status under Subpart G of Part 419 of 42 CFR;

(9) Implanted DME and related accessories and supplies not on pass-through status under Subpart G of Part 419 of 42 CFR;

(10) Splints and casts and related devices;

(11) Radiology services for which separate payment is not allowed under the OPPS, and other diagnostic tests or interpretive services that are integral to a surgical procedure;

(12) Administrative, recordkeeping and housekeeping items and services;

(13) Materials, including supplies and equipment for the administration and monitoring of anesthesia; and

(14) Supervision of the services of an anesthetist by the operating surgeon.

Under the revised ASC payment system, the above items and services fall within the scope of ASC facility services, and payment for them is packaged into the ASC payment for the covered surgical procedure. ASCs must incorporate charges for packaged services into the charges reported for the separately payable services with which they are provided. Because contractors *price ASC services based on the lower* of *submitted* charges or the ASC payment rate for the separately payable procedure, and because this comparison is made at the claim line-item level, facilities may not be paid appropriately if they unbundle charges and report those charges for packaged codes as separate line-item charges.

There is a payment adjustment for insertion of an IOL approved as belonging to a class of NTIOLs, for the 5-year period of time established for that class, as set forth at 42CFR416.200.

Covered ancillary items and services that are integral to a covered surgical procedure, as defined in 42 CFR 416.61, and for which separate payment to the ASC is allowed include:

(b) Covered ancillary services

(1) Brachytherapy sources;

(2) Certain implantable items that have pass-through status under the OPPS;

(3) Certain items and services that CMS designates as contractor-priced, including, but not limited to, the procurement of corneal tissue;

(4) Certain drugs and biologicals for which separate payment is allowed under the OPPS;

(5) Certain radiology services for which separate payment is allowed under the OPPS.

NOTE: Effective for dates of service on or after January 1, 2009 for allowed ASC claims, if modifier = TC, contractors must ensure that either:

- ordering physician name and NPI or
- referring physician name and NPI

are present on electronic or paper claims.

If this information is missing, contractors shall return as unprocessable.

The contractor shall use the following remittance advice messages and associated codes when returning claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: N264, N265, N285 or N286 as appropriate
MSN: N/A

Definitions of ASC Facility Services:

Nursing Services, Services of Technical Personnel, and Other Related Services

These include all services in connection with covered procedures furnished by nurses and technical personnel who are employees of the ASC. In addition to the nursing staff, this category includes orderlies, technical personnel, and others involved in patient care.

Use by the Patient of the ASC Facilities

This category includes operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used by the patient or offered for use by the patient's relatives in connection with surgical services.

Drugs, Biologicals, Surgical Dressings, Supplies, Splints, Casts, Appliances, and Equipment

This category includes all supplies and equipment commonly furnished by the ASC in connection with surgical procedures. See the following paragraphs for certain exceptions. Drugs and biologicals are limited to those which cannot be self-administered. See the Medicare Benefit Policy Manual, Chapter 15, §50.2, for a description of how to determine whether drugs can be self-administered.

Under Part B, coverage for surgical dressings is limited to primary dressings, i.e., therapeutic and protective coverings applied directly to lesions on the skin or on openings to the skin required as the result of surgical procedures. (Items such as Ace bandages, elastic stockings and support hose, Spence boots and other foot coverings, leotards, knee supports, surgical leggings, gauntlets and pressure garments for the arms and hands are used as secondary coverings and therefore are not covered as surgical dressings.) Although surgical dressings usually are covered as "incident to" a physician's service in a physician's office setting, in the ASC setting, such dressings are included in the facility's services.

However, surgical dressings may be reapplied later by others, including the patient or a member of his family. When surgical dressings are obtained by the patient on a physician's order from a supplier, e.g., a drugstore, the surgical dressing is covered under Part B. The same policy applies in the case of dressings obtained by the patient on a physician's order following surgery in an ASC; the dressings are covered and paid as a Part B service by the DME MAC.

Similarly, "other supplies, splints, and casts" include only those furnished by the ASC at the time of the surgery. Additional covered supplies and materials furnished later are generally furnished as "incident to" a physician's service, not as an ASC facility service. The term "supplies" includes those required for both the patient and ASC personnel, e.g., gowns, masks, drapes, hoses, and scalpels, whether disposable or reusable. Payment for these is included in the rate for the surgical procedure.

Beginning January 1, 2008, the ASC facility payment for a surgical procedure includes payment for drugs and biologicals that are not usually self-administered and that are considered to be packaged into the payment for the surgical procedure under the OPPS. Also, beginning January 1, 2008, Medicare makes separate payment to ASCs for drugs and biologicals that are furnished integral to an ASC covered surgical procedure and that are separately payable under the OPPS.

Diagnostic or Therapeutic Items and Services

These are items and services furnished by ASC staff in connection with covered surgical procedures. Many ASCs perform diagnostic tests prior to surgery that are generally included in the facility charges, such as urinalysis, blood hemoglobin, hematocrit levels, etc. To the extent that such simple tests are included in the ASC facility charges, they are considered facility services. However, under the Medicare program, diagnostic tests are not covered in laboratories independent of a physician's office, rural health clinic, or hospital unless the laboratories meet the regulatory requirements for the conditions for coverage of services of independent laboratories. (See 42 CFR 416.49) Therefore, diagnostic tests performed by the ASC other than those generally included in the facility's charge are not covered under Part B and are not to be billed as diagnostic tests. If the ASC has its laboratory certified, the laboratory itself may bill for the tests performed.

The ASC may make arrangements with an independent laboratory or other laboratory, such as a hospital laboratory, to perform diagnostic tests it requires prior to surgery. In general, however, the necessary laboratory tests are done outside the ASC prior to scheduling of surgery, since the test results often determine whether the beneficiary should have the surgery done on an outpatient basis in the first place.

Administrative, Recordkeeping and Housekeeping Items and Services

These include the general administrative functions necessary to run the facility e.g., scheduling, cleaning, utilities, and rent.

Blood, Blood Plasma, Platelets, etc., Except Those to Which Blood Deductible Applies

While covered procedures are not expected to result in extensive loss of blood, in some cases, blood or blood products are required. Usually the blood deductible results in no expenses for blood or blood products being included under this provision. However, where there is a need for blood or blood products beyond the deductible, they are considered ASC facility services and no separate charge is permitted to the beneficiary or the program.

Materials for Anesthesia

These include the anesthetic agents that are not paid separately under the OPPS, and any materials, whether disposable or re-usable, necessary for its administration.

Intraocular Lenses (IOLs) and New Technology IOLs (NTIOLs)

The ASC facility services include IOLs (effective for services furnished on or after March 12, 1990), and NTIOLs (effective for services furnished on or after May 18, 2000), approved by the Food and Drug Administration (FDA) for insertion during or subsequent to cataract surgery.

FDA has classified IOLs into the following categories, any of which are included:

1. Anterior chamber angle fixation lenses;

2. Iris fixation lenses;

3. Irido-capsular fixation lenses; and

4. Posterior chamber lenses.

5. NTIOL Category 1 (as defined in "Federal Register" Notice, VOL 65, dated May 3, 2000). Note: This category expired May 18, 2005

6. NTIOL Category 2 (as defined in "Federal Register" Notice, VOL 65, dated May 3, 2000). Note: This category expired May 18, 2005

7. NTIOL Category 3 (as defined in Federal Register Notice, 71 FR 4586, dated January 27, 2006): This category will expire on February 26, 2011.

Note that while generally no separate charges for intraocular lenses (IOLs) are allowed, approved NTIOLS may be billed separately and an adjustment to the facility payment will be made for those lenses that are eligible. (See §40.3.)

10.3 - Services Furnished in ASCs Which Are Not ASC Facility Services or Covered Ancillary Services

(Rev. 3939; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

A single payment is made to an ASC for facility services furnished by the ASC in connection with a covered surgical procedure. Additional payments may be made to the ASC for covered ancillary services, specifically brachytherapy sources, certain implantable devices with pass-through status under the OPPS,

corneal tissue acquisition, drugs and biologicals for which separate payment is allowed under the OPPS, radiology services for which separate payment is allowed under the OPPS, *and certain other integral services not included in the primary procedure payment*. To be covered ancillary services for which separate payment is made, these items and services must be provided integral to covered surgical procedures, that is, immediately before, during, or immediately after the covered surgical procedure.

However, a number of items and services covered under Medicare may be furnished in an ASC which are not considered ASC services, and which payment for ASC services does not include. These non-ASC services are covered and paid for under the applicable provisions of Part B. In addition, the ASC may be part of a medical complex that includes other entities, such as an independent laboratory, supplier of durable medical equipment, or a physician's office, which are covered as separate entities under Part B. In general, an item or service provided in a separate part of the complex is not considered an ASC service, except as defined above.

Examples of payment and billing for items or services that are not ASC services:

Items not included in payment for ASC services	**Who may receive payment**	**Submit bills to:**
Physicians' services (including surgical procedures excluded from ASC payment)	Physician	A/B MAC (B)
The purchase or rental of non-implantable durable medical equipment (DME) to ASC patients for use in their homes	Supplier- An ASC can be a supplier of DME if it has a supplier number from the National Supplier Clearinghouse.	DME MAC, or A/B MAC (B) as directed by the current DME jurisdiction list
Non-implantable prosthetic devices	Supplier. An ASC can be a supplier of non-implantable prosthetics if it has a supplier number from the National Supplier Clearinghouse.	DME MAC, or A/B MAC (B), as directed by the current DME jurisdiction list
Ambulance services	Certified Ambulance supplier	A/B MAC (B)
Leg, arm, back and neck braces	Supplier	DME MAC, or A/B MAC (B), as directed by the current DME jurisdiction list
Artificial legs, arms, and eyes	Supplier	DME MAC, or A/B MAC (B), as directed by the current DME jurisdiction list
Services furnished by an independent laboratory	Certified lab. ASCs can receive lab certification and a CLIA number.	A/B MAC (B)
Facility services for surgical procedures excluded from the ASC list	ASC	ASC bills beneficiary for facility charges associated with the non-covered procedure

Examples of payment and billing for items or services that are included in payment for ASC facility services beginning January 1, 2008

Items included in payment for ASC facility services beginning January 1, 2008	Who may receive payment beginning January 1, 2008	Submit bills to:
Implantable DME and accessories without OPPS pass-through status	ASC	A/B MAC (B)
Implantable nonpass-through prosthetic devices (except NTIOLs), and accessories without OPPS pass-through status	ASC	A/B MAC (B)
Radiology services for which there is no separate OPPS payment	ASC	A/B MAC (B)
Drugs and biologicals for which there is no separate OPPS payment	ASC	A/B MAC (B)

20 - List of Covered Ambulatory Surgical Center Procedures

(Rev. 3939; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

The complete lists of ASC covered surgical procedures and ASC covered ancillary services, the applicable payment indicators, payment rates for each covered surgical procedure and ancillary service before adjustments for regional wage variations, and wage indices are available on the CMS Web site at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices.html*.

30.1 - Where to Obtain Current Rates and Lists of Covered Services

(Rev. 3939; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

The CMS performs the functions and calculations described above and publishes a list of covered surgical procedures and covered ancillary services for which an ASC may be paid each year, as well as quarterly updates via Medicare contractor instructions. Regulations pertaining to Medicare rates for ASC facility services are contained in Part 416 of the Code of Federal Regulations, at http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42tab_02.tpl

ASC services are subject to the usual Medicare Part B deductible and coinsurance requirements. There is no deductible and a 25 percent coinsurance is applied to colorectal cancer screening colonoscopies and screening flexible sigmoidoscopy services performed in the ASC setting.

Prior to the revised ASC payment system implemented January 1, 2008, the ASC facility payment rate was a standard overhead amount based on CMS' estimate of a fair fee and the costs incurred by the ASCs providing the procedures. HCPCS codes for procedures covered in the ASC were compiled into 9 groups with a separate rate set for each group.

Beginning January 1, 2008, CMS updates payment rates and codes for covered surgical procedures and covered ancillary services on a calendar year basis. Payable services are updated on a quarterly basis. Also, CMS calculates and makes available to the claims processing contractors CBSA-specific wage-adjusted payment rates for each of the ASC payable codes to which geographic adjustment applies. The complete lists of ASC covered surgical procedures and ASC covered ancillary services, the applicable payment indicators, payment rates for each covered surgical procedure and ancillary service before adjustments for regional wage variations, and wage indices are available on the CMS Web site at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html* and available to contractors on the CMS mainframe.

40.2 - Wage Adjustment of Base Payment Rates

(Rev. 3939; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

Prior to January 1, 2008, the payment rates established for ASC procedures (see §30) are standard base rates that have been adjusted to remove the effects of regional wage variations. When contractors process claims for ASC services, they adjust the base rates for services subject to geographic adjustment to reflect

the wage index value applicable to the area in which the ASC is located. The Medicare payment for ASC services is equal to 80 percent of the wage-adjusted standard payment rate. Beneficiaries are responsible for a 20 percent coinsurance payment for ASC services once their deductible is satisfied. The exception is for colorectal cancer screening colonoscopies and screening flexible sigmoidoscopies. There is no deductible and a 25 percent coinsurance payment applies for these services. Use Medicare Summary Notice (MSN) 18.23, "You pay 25% of the Medicare-approved amount for this service."

The wage index includes the wage and salary levels of certain health care professionals in both urban and nonurban locations, compared to a national norm of 1.0. Areas with above average wage levels have index numbers greater than 1.0, while areas with below average wage levels have index numbers below l.0.

Each Core-Based Statistical Area (CBSA) within a State has a separate index. If a specific city or county does not have a CBSA value, the default is to the overall state wage index.

For dates of service on or after January 1, 2008, the ASC payment rates are geographically wage adjusted based on the wage index for the CBSA. Beginning January 1, 2008 CMS calculates and makes available to the contractors CBSA-specific ASC payment rates for services subject to geographic adjustment. The wage index values for urban and rural areas that CMS applies to all non-acute providers are used in the calculation of the ASC wage adjusted payment rates. With the implementation of the ASC revised payment system, the labor related portion of the payment rate is 50 percent and the remaining non-labor related portion is 50 percent.

There is no adjustment for geographic wage differences for the following:

- Corneal tissue acquisition;
- Drugs and devices that have pass-through status under the OPPS;
- Brachytherapy sources;
- Payment adjustment for NTIOLs; or
- Separately payable drugs and biologicals.

40.3 - Payment for Intraocular Lens (IOL)

(Rev. 3939; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

Prior to January 1, 2008, payment for facility services furnished by an ASC for IOL insertion during or subsequent to cataract surgery includes an allowance for the lens. The procedures that include insertion of an IOL are:

Payment Group 6: CPT-4 Codes 66985 and 66986

Payment Group 8: CPT-4 Codes 66982, 66983 and 66984

Physicians or suppliers are not paid for an IOL furnished to a beneficiary in an ASC after July 1, 1988. Separate claims for IOLs furnished to ASC patients beginning March 12, 1990 are denied. Also, effective March 12, 1990, procedures 66983 and 66984 are treated as single procedures for payment purposes.

Beginning January 1, 2008, the Medicare payment for the IOL is included in the Medicare ASC payment for the associated surgical procedure. Consequently, no separate payment for the IOL is made, except for a payment adjustment for NTIOLs established according to the process outlined in 42 CFR 416.185. ASCs should not report separate charges for conventional IOLs because their payment is included in the Medicare payment for the associated surgical procedure. The ASC payment system logic that excluded $150 for IOLs for purposes of the multiple surgery reduction in cases of cataract surgery prior to January 1, 2008 no longer applies, effective for dates of service on or after January 1, 2008.

Effective for dates of service on and after February 27, 2006, through February 26, 2011, Medicare pays an additional $50 for specified Category 3 NTIOLs that are provided in association with a covered ASC

surgical procedure. The list of Category 3 NTIOLS is available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/NTIOLs.html

ASCs should use HCPCS code Q1003 to bill for a Category 3 NTIOL. HCPCS code Q1003, along with one of the approved surgical procedure codes (CPT codes 66982, 66983, 66984, 66985, 66986) are to be used on all NTIOL Category 3 claims associated with reduced spherical aberration from February 27, 2006, through February 26, 2011. The payment adjustment for the NTIOL is subject to beneficiary coinsurance but is not wage-adjusted.

Any subsequent IOL *recognized by CMS as* having the same characteristics as the first NTIOL recognized by CMS for a payment adjustment as a Category III NTIOL (those of reduced spherical aberration) will receive the same adjustment for the remainder of the 5-year period established by the first recognized IOL.

40.6 - Payment for Extracorporeal Shock Wave Lithotripsy (ESWL)

(Rev. 3939; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

A ninth ASC payment group was established in a "Federal Register" notice (56 FR 67666) published December 31, 1991. The ninth payment group amount ($1,150) was assigned to only one procedure, CPT code 50590, extracorporeal shock wave lithotripsy (ESWL). However, a court order issued March 12, 1992, has stayed the Group 9 payment rate until the Secretary publishes all information relevant to the setting of the ESWL rate, receives comments, and publishes a subsequent final notice. This has not yet been completed.

CMS advised contractors to make payment to ASCs for ESWL services furnished after January 29, 1992, and through the date when the ASC received notice from the contractor of the court order staying the Group 9 payment rate. This was a temporary measure to avoid penalizing ASCs that furnished ESWL services in accordance with the December 31, 1991, "Federal Register" notice and that could not have been expected to know that the March 12, 1992, court order set aside the ESWL provisions of that notice. Contractors did not make Medicare payment for ESWL as an ASC procedure when such services were furnished after the date that the carrier advised an ASC of the court order.

However contractors were instructed to retain all ASC claims for ESWL with a service date after January 29, 1992, and before the date when they were notified about the court order. It may be necessary to retrieve these clams for further action at some later date.

Beginning January 1, 2008 with the revised ASC payment system, contractors may pay for any of the ESWL services that are included on the ASC list of covered surgical procedures.

40.7 - Offset for Payment for Pass-Through Devices Beginning January 1, 2008

(Rev. 3939; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

Under the revised payment system, there can be situations where contractors must reduce (cut back) the approved payment amount for specifically identified procedures when provided in conjunction with a specific pass-through device. This reduction would only be applicable when services for specific pairs of codes are provided on the same day by the same provider.

Code pairs subject to this policy would be updated on a quarterly basis. CMS will inform contractors of the code pairs and the percent reduction *removed* from the procedure payment rate through a "look-up" table. *As an example, contractors would perform the procedure percent reduction as follows: If the example code pair Cxxxx (device) and 2xxxx (procedure) were on the code pair file with a procedure percent reduction of 0.008, contractors would remove 0.008 device offset amount from the payment rate assigned to the ASC's jurisdictional CBSA, and therefore effectively pay 0.992 of the payment rate. Paying 0.992 of the payment rate, in this example, is equivalent to implementing the 0.008 procedure percent reduction. The contractors would then pay Cxxxx according to the ASCFS, including current payment and claims processing*

instructions. No code pair file related calculation or offset is performed on the device. Calculations to implement the code pair file procedure percent reductions, impact only the CBSA procedure payment rate.

50 - ASC Procedures for Completing the ASC X12 837 Professional Claim Format or the Form CMS-1500

(Rev. 3939; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

The Place of Service (POS) code is 24 for procedures performed in an ASC.

Prior to January 1, 2008, type of Service (TOS) code is "F" (ASC Facility Usage for Surgical Services) is appropriate when modifier SG appears on an ASC claim. Otherwise TOS "2" (surgery) for professional services rendered in an ASC is appropriate. Beginning January 1, 2008, ASCs no longer are required to include the SG modifier on facility claims in Medicare. The contractors shall assign TOS code "F" to codes billed by specialty 49 for Place of Service 24.

70 - Ambulatory Surgical Center (ASC) HCPCS Additions, Deletions, and Master Listing

(Rev. 3939; Issued: 12-22-17; Effective: 01- 01-18; Implementation: 01-02-18)

Prior to January 1, 2018, the CMS Division of Data Systems (DDS) releases the ASC HCPCS, additions, deletions, and master listing files of ASC codes on a periodic basis. Instructions on how to retrieve these files from the CMS mainframe telecommunications system are also published on the same periodic basis. The Office of Information Services (OIS) announces the dates that the files are available.

Beginning January 1, 2008, the CMS Division of Data Systems (DDS) releases the ASCFS, ASC Drug File, ASC Restated Drug Files, ASC PI file, and the ASC Code Pair file, as appropriate. Instructions on how to retrieve these files from the CMS mainframe are communicated at the time that the files are released. The ASC payment system quarterly recurring update notifications, also identify the files that are applicable to that quarter's update of the payment system.