DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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MLN Matters® Number: MM9021	**Related Change Request (CR) #: CR 9021**
Related CR Release Date: January 9, 2015	**Effective Date: January 1, 2015**
Related CR Transmittal #: R3163CP	**Implementation Date: January 5, 2015**

January 2015 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) 9021 informs MACs about changes to and billing instructions for various payment policies implemented in the January 2015 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 this notification are Calendar Year (CY) 2015 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 covered surgical and ancillary services (ASCFS file).

Many ASC payment rates under the ASC payment system are established using payment rate information in the Medicare Physician Fee Schedule (MPFS). The payment files associated with this transmittal reflect the most recent changes to CY 2015 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, 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, 2015 for the OPPS and the ASC payment systems. That HCPCS code is HCPCS code C2624 (Wireless pressure sensor) 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

HCPCS	Short Descriptor	Long descriptor	ASC Payment Indicator (PI)
C2624	Wireless pressure sensor	Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components	J7

2. New Service

The Centers for Medicare & Medicaid Services (CMS) is establishing one new HCPCS surgical procedure code for ASC use effective January 1, 2015, as shown in table 2.

Table 2 – New Procedure Payable under the ASC Payment System Effective January 1, 2015

HCPCS	Short Descriptor	Long descriptor	ASC PI
C9742	Laryngoscopy with injection	Laryngoscopy, flexible fiberoptic, with injection into vocal cord(s), therapeutic, including diagnostic laryngoscopy, if performed	G2

3. Billing for Corneal Tissue

CMS reminds ASCs that, according to the "Medicare Claims Processing Manual," Chapter 14, Section 40 - Payment for Ambulatory Surgery (**http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c14.pdf**), corneal tissue is paid based on acquisition cost or invoice. To receive cost based reimbursement for corneal tissue acquisition, ASCs must bill charges for corneal tissue using HCPCS code V2785.

4. Coding Guidance for Intraocular or Periocular Injections of Combinations of Anti-Inflammatory Drugs and Antibiotics

Intraocular or periocular injections of combinations of anti-inflammatory drugs and antibiotics are being used with increased frequency in ocular surgery (primarily cataract surgery). One example of combined or compounded drugs includes triamcinolone and moxifloxacin with or without vancomycin. Such combinations may be administered as separate injections or as a single combined injection. Because such injections may obviate the need for post-operative anti-inflammatory and antibiotic eye drops, some have referred to cataract surgery with such injections as "dropless cataract surgery."

The CY2015 National Correct Coding Initiative (NCCI) Policy Manual states (in Chapter VIII, Section D, Item 20 in the "Downloads" Section at **http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html**) that injection of a drug during a cataract extraction procedure or other ophthalmic procedure is not separately reportable. Specifically, no separate procedure code may be reported for any type of injection during surgery or in the perioperative period. Injections are a part of the ocular surgery and are included as a part of the ocular surgery and the HCPCS code used to report the surgical procedure.

According to the "Medicare Claims Processing Manual, Chapter 17," (**http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf**) Section 90.2, the compounded drug combinations described above and similar drug combinations should be reported with HCPCS code J3490 (Unclassified drugs), regardless of the site of service of the surgery, and are packaged as surgical supplies in both the Hospital Outpatient Department (HOPD) and the ASC. Although these drugs are a covered part of the ocular surgery, no separate payment will be made. In addition, these drugs and drug combinations may not be reported with HCPCS code C9399.

According to the "Medicare Claims Processing Manual," Chapter 30, Section 40.3.6, (**http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf**) physicians or facilities should not give Advance Beneficiary Notices (ABNs) to beneficiaries for either these drugs or for injection of these drugs because they are fully covered by Medicare. Physicians or facilities are not permitted to charge the patient an extra amount (beyond the standard copayment for the surgical procedure) for these injections or the drugs used in these injections because they are a covered part of the surgical procedure. Also, physicians or facilities cannot circumvent

packaged payment in the HOPD or ASC for these drugs by instructing beneficiaries to purchase and bring these drugs to the facility for administration.

5. Drugs, Biologicals, and Radiopharmaceuticals

a) New CY 2015 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals.

For CY 2015, several new HCPCS codes have been created for reporting drugs and biologicals in the ASC setting, where there have not previously been specific codes available. These are displayed in Table 3.

Table 3 – New CY 2015 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2015 HCPCS Code	CY 2015 Long Descriptor	CY 2015 Payment Indicator
C9027	Injection, pembrolizumab, 1 mg	K2
C9136	Injection, factor viii, fc fusion protein, (recombinant), per i.u.	K2
C9349	FortaDerm, and FortaDerm Antimicrobial, any type, per square centimeter	K2
C9442	Injection, belinostat, 10 mg	K2
C9443	Injection, dalbavancin, 10 mg	K2
C9444	Injection, oritavancin, 10 mg	K2
C9446	Injection, tedizolid phosphate, 1 mg	K2
C9447	Injection, phenylephrine and ketorolac, 4 ml vial	K2
J7180	Factor XIII anti-hem factor	K2
J7327	Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose	K2

b) Other CY 2015 HCPCS and CPT Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals.

Table 4 notes those separately payable drugs, biologicals, and radiopharmaceuticals that have undergone changes in their HCPCS codes, their long descriptors, or both. Each product's CY

2014 HCPCS code and CY 2014 long descriptors are noted in the two left-hand columns. The CY 2015 HCPCS code and long descriptors are noted in the adjacent right-hand columns.

Table 4 – Other CY 2015 HCPCS and CPT Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2014 HCPCS /CPT code	CY 2014 Long Descriptor	CY 2015 HCPCS /CPT Code	CY 2015 Long Descriptor
J7195	Factor ix (antihemophilic factor, recombinant) per i.u.	J7195	Injection, Factor ix (antihemophilic factor, recombinant) per i.u., not otherwise specified
C9021	Injection, obinutuzumab, 10 mg	J9301	Injection, obinutuzumab, 10 mg
C9022	Injection, elosulfase alfa, 1mg	J1322	Injection, elosulfase alfa, 1mg
C9023	Injection, testosterone undecanoate, 1 mg	J3145	Injection, testosterone undecanoate, 1 mg
C9133	Factor ix (antihemophilic factor, recombinant), Rixubis, per i.u.	J7200	Factor ix (antihemophilic factor, recombinant), Rixubis, per i.u.
C9134	Factor XIII (antihemophilic factor, recombinant), Tretten, per i.u.	J7181	Factor XIII (antihemophilic factor, recombinant), Tretten, per i.u.
C9135	Factor ix (antihemophilic factor, recombinant), Alprolix, per i.u.	J7201	Factor ix (antihemophilic factor, recombinant), Alprolix, per i.u.
J7335	Capsaicin 8% patch, per 10 square centimeters	J7336	Capsaicin 8% patch, per square centimeter
Q9970	Injection, ferric carboxymaltose, 1mg	J1439	Injection, ferric carboxymaltose, 1 mg

c. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective January 1, 2015

For CY 2015, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP plus six percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2015, 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.

Effective January 1, 2015, payment rates for many drugs and biologicals have changed from the values published in the CY 2015 Outpatient Payment Prospective System (OPPS)/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2014. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2015 ASC Drug file.

CMS is not publishing the updated payment rates in this CR implementing the January 2015 update of the ASC Payment System. The updated payment rates effective January 1, 2015, can be found in the January 2015 ASC Addendum BB at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html** on the CMS website.

d. Skin Substitute Procedure Edits

The payment for skin substitute products that do not qualify for 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 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 OPPS pass-through skin substitute products (ASC PI=K2) should be billed in combination with one of the skin application procedures described by CPT codes 15271-15278.

Table 5 – Skin Substitute Product Assignment to High Cost/Low Cost Status for CY 2015

CY 2015 HCPCS Code	CY 2015 Short Descriptor	ASC PI	Low/High Cost Skin Substitute
C9349	Fortaderm, fortaderm antimic	N1	High

CY 2015 HCPCS Code	CY 2015 Short Descriptor	ASC PI	Low/High Cost Skin Substitute
C9358	SurgiMend, fetal	N1	Low
C9360	SurgiMend, neonatal	N1	Low
C9363	Integra Meshed Bil Wound Mat	N1	High
Q4100	Skin substitute, NOS	N1	Low
Q4101	Apligraf	N1	High
Q4102	Oasis wound matrix	N1	Low
Q4103	Oasis burn matrix	N1	Low
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
Q4112	Cymetra injectable	N1	N/A
Q4113	GraftJacket Xpress	N1	N/A
Q4114	Integra Flowable Wound Matrix	N1	N/A
Q4115	Alloskin	N1	Low
Q4116	Alloderm	N1	High
Q4117	Hyalomatrix	N1	Low
Q4118	Matristem Micromatrix	N1	N/A
Q4119	Matristem Wound Matrix	N1	Low
Q4120	Matristem Burn Matrix	N1	Low
Q4121	Theraskin	K2	High
Q4122	Dermacell	K2	High
Q4123	Alloskin	N1	High

CY 2015 HCPCS Code	CY 2015 Short Descriptor	ASC PI	Low/High Cost Skin Substitute
Q4124	Oasis Tri-layer Wound Matrix	N1	Low
Q4125	Arthroflex	N1	High
Q4126	Memoderm/derma/tranz/integup	N1	High
Q4127	Talymed	K2	High
Q4128	Flexhd/Allopatchhd/matrixhd	N1	High
Q4129	Unite Biomatrix	N1	High
Q4131	Epifix	N1	High
Q4132	Grafix core	N1	High
Q4133	Grafix prime	N1	High
Q4134	HMatrix	N1	High
Q4135	Mediskin	N1	Low
Q4136	EZderm	N1	Low
Q4137	Amnioexcel or Biodexcel, 1cm	N1	High
Q4138	BioDfence DryFlex, 1cm	N1	High
Q4139	Amniomatrix or Biodmatrix, 1cc	N1	N/A
Q4140	Biodfence 1cm	N1	High
Q4141	Alloskin ac, 1 cm	N1	Low
Q4142	Xcm biologic tiss matrix 1cm	N1	Low
Q4143	Repriza, 1cm	N1	Low
Q4145	Epifix, 1mg	N1	N/A
Q4146	Tensix, 1cm	N1	Low
Q4147	Architect ecm px fx 1 sq cm	N1	High
Q4148	Neox 1k, 1cm	N1	High
Q4149	Excellagen, 0.1 cc	N1	N/A
Q4150	Allowrap DS or Dry 1 sq cm	N1	Low
Q4151	AmnioBand, Guardian 1 sq cm	N1	Low

CY 2015 HCPCS Code	CY 2015 Short Descriptor	ASC PI	Low/High Cost Skin Substitute
Q4152*	Dermapure 1 square cm	N1	High
Q4153	Dermavest 1 square cm	N1	Low
Q4154	Biovance 1 square cm	N1	High
Q4155	NeoxFlo or ClarixFlo 1 mg	N1	N/A
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

*HCPCS code Q4152 was assigned to the low cost group in the CY 2015 OPPS/ASC final rule with comment period. Upon submission of updated pricing information, Q4152 is assigned to the high cost group for CY 2015.

6. 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 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's adjustment of the previously processed claims.

7. CY2015 ASC Wage index

As discussed and finalized in the CY 2015 OPPS/ASC final rule with comment (79 FR 66937), in CY2015, CMS is using the new Core Based Statistical Area (CBSA) delineations issued by the Office of Management and Budget (OMB) in OMB Bulletin 13-01, dated February 28, 2013, for the IPPS hospital wage index. Therefore, because the ASC wage indexes are the pre-floor and pre-reclassified IPPS hospital wage indexes, the CY 2015 ASC wage indexes reflect the new OMB delineations.

In CY2015, where the CY 2015 ASC wage index value with the CY 2015 CBSAs is lower than the CY 2014 CBSA values, CMS calculates, or blends, the CY 2015 ASC wage index

adjusted payment rates such that it will equal 50 percent of the ASC wage index based on the CY 2014 CBSA value and 50 percent of the ASC wage index based on the new CY 2015 CBSA value. The blending of these specific wage index values will mitigate any short-term instability to ASC payments. CY2015 CBSAs with wage index values that are higher than the CY2014 are not transitioned or blended and reflect the full higher wage index value. For additional information on this ASC wage index policy, please refer to page 66937 in the CY 2015 OPPS/ASC Final Rule (CMS-1613-FC), which is accessible at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1613-FC.html** on the CMS website.

8. Coverage Determinations

The fact that a drug, device, procedure, or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. MACs determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Additional Information

The official instruction, CR9021, issued to your MAC regarding this change, is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3163CP.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?