Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-For-Service Health Care Professionals

News Flash – ICD-10 Medicare Severity Diagnosis Related Grouper (MS-DRG), Version 30.0 (FY 2013) mainframe and PC software is now available. This software is being provided to offer the public a better opportunity to review and comment on the ICD-10 MS-DRG conversion of the MS-DRGs. This software can be ordered through the National Technical Information Service (NTIS) website. A link to NTIS is also available in the Related Links section of the ICD-10 MS-DRG Conversion Project website. The final version of the ICD-10 MS-DRGs will be subject to formal rulemaking and will be implemented on October 1, 2014.

MLN Matters® Number: MM7147 | Related Change Request (CR) #: 7147

Related CR Release Date: September 10, 2010 | Effective Date: October 1, 2010

Related CR Transmittal #: R2045CP | Implementation Date: October 4, 2010

Note: This article was revised on March 22, 2013, with an updated ICD-10 News Flash. All other information remains unchanged.

October 2010 Update of the Ambulatory Surgical Center (ASC) Payment System

Provider Types Affected

This article is for ASCs, who submit claims to Medicare Administrative Contractors (MACs) and carriers, for services provided to Medicare beneficiaries paid under the ASC payment system.

Provider Action Needed

This article is based on Change Request (CR) 7147 which describes changes to, and billing instructions for, payment policies implemented in the October 2010 ASC update. CR 7147 provides information on one newly created pass-through device Healthcare Common Procedure Coding System (HCPCS) code, five newly created drug HCPCS codes, and six newly created HCPCS codes describing imaging services that will be added to the ASC list of covered ancillary services effective October 1, 2010. Be sure your billing staff is aware of these changes.

Background

Final policy under the revised ASC payment system, as set forth in the Medicare Program; Revised Payment System Policies for Services Furnished in Ambulatory Surgical Centers (ASCs), beginning in CY 2008 (72 FR 42470), requires that ASC payment rates for covered separately payable drugs and biologicals be consistent with the payment rates under the Medicare hospital outpatient prospective payment system (OPPS). Those rates are updated quarterly.

The key updates effective on October 1, 2010, are as follows:

New HCPCS Codes for Drugs and Biologicals Separately Payable under the ASC Payment System Effective October 1, 2010

Five new HCPCS codes have been created for drugs that are payable as covered ancillary services for dates of service on and after October 1, 2010. The new HCPCS codes, the short descriptors, the long descriptors, and payment indicators are identified in Table 1 below.

The new separately payable drug and biological codes and their payment rates are included in the October 2010 ASC DRUG file.

Table 1 – New Drugs and Biologicals Separately Payable under the ASC Payment System Effective October 1, 2010

HCPCS Code	Long Descriptor	Short Descriptor	Payment Indicator Effective 10/01/10
C9269	Injection, C-1 esterase inhibitor (human), Berinert, 10 units	C-1 esterase, berinert	K2
C9270	Injection, immune globulin (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg	Gammaplex IVIG	K2
C9271	Injection, velaglucerase alfa, 100 units	Velaglucerase alfa	K2
C9272	Injection, denosumab, 1 mg	Inj, denosumab	K2
C9273	Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF in 250 mL of Lactated Ringer's, including leukapheresis and all other preparatory procedures, per infusion	Sipuleucel-T, per infusion	K2

Supplemental Information for HCPCS Code C9273

The Centers for Medicare & Medicaid Services (CMS) has opened a national coverage determination (NCD) analysis for HCPCS code C9273, Provenge (Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF in 250mL of Lactated Ringer's, including leukapheresis and all other preparatory procedures, per infusion). A final decision on coverage is forthcoming

in 2011. As with other drugs and biologicals, at this time, local carriers and MACs will retain the discretion to make individual claim determinations for Provenge based on the medical necessity of the service(s) being provided.

Additionally, CMS clarifies that the language given in the long descriptor of Provenge states that "all other preparatory procedures" refers to the transportation process of collecting immune cells from a patient during a non-therapeutic leukapheresis procedure, subsequently sending the immune cells to the manufacturing facility, and then transporting the immune cells back to the site of service to be administered to the patient.

Updated Payment Rate for HCPCS Code 90476 Effective April 1, 2010 through June 30, 2010

The payment rate for one HCPCS code was incorrect in the April 2010 ASC DRUG file. That HCPCS code is 90476 (Adenovirus vaccine, type 4). The corrected payment rate is $72.17 with an ASC Payment Indicator (PI) of K2. The corrected code has been included in the revised April 2010 ASC DRUG file effective for services furnished on April 1, 2010, through implementation of the July 2010 update. Suppliers who think they may have received an incorrect payment between April 1, 2010, and June 30, 2010, may request contractor adjustment of the previously processed claims.

Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2010, through September 30, 2010

The payment rates for two HCPCS codes were incorrect in the July 2010 ASC DRUG file. The corrected payment rates are listed in Table 2 below and have been included in the revised July 2010 ASC DRUG file effective for services furnished on July 1, 2010, through implementation of the October 2010 update. Suppliers who think they may have received an incorrect payment between July 1, 2010, and September 30, 2010, may request contractor adjustment of the previously processed claims.

Table 2-Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2010, through September 30, 2010

HCPCS Code	Short Descriptor	ASC Payment Rate	ASC PI
J9264	Paclitaxel protein bound	$9.22	K2
C9268	Capsaicin patch	$25.55	K2

Payment for Vaccine CPT Code 90670 Effective April 1, 2010

CPT code 90670 (Pneumococcal conjugate vaccine, 13 valent, for intramuscular use) was erroneously assigned ASC PI=K2 (Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate) in the July 2010 ASC update (CR 7008), effective April 1, 2010. Effective April 1, 2010, the payment for CPT code 90670 will change from ASC PI=K2 to ASC PI=L1 (Influenza vaccine; pneumococcal vaccine. Packaged item/service; no separate payment made). As a result, CPT code 90670 does not appear in the revised April 2010 and revised July 2010 ASC DRUG files.

Payment for Vaccine CPT Code 90662

CPT code 90662 (Long Descriptor: Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use; Short Descriptor: Flu vacc prsv free inc antig) has been assigned ASC PI=Y5. However, 90662 received approval from the Food and Drug Administration (FDA) on December 23, 2009. Therefore, effective December 23, 2009, CPT code 90662 is assigned ASC PI=L1 (Influenza vaccine; pneumococcal vaccine. Packaged item/service; no separate payment made).

New Device Pass-Through Category

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 requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that we create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

The OPPS has established one new pass-through device category as of October 1, 2010. The ASC payment system is also establishing the same device pass-through code for separate payment effective October 1, 2010. CMS has determined that it is not able to identify a portion of the OPPS procedure payment amount associated with the cost of the device; therefore, CMS will not reduce the ASC procedure payment to remove the costs of related predecessor devices packaged into the base procedure's OPPS payment weight. Table 3 provides a listing of new ASC coding and payment information concerning the new device category for transitional pass-through payment. HCPCS code C1749 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 3-New ASC Device Pass-Through HCPCS Code Effective October 1, 2010

HCPCS	Short Descriptor	Long Descriptor	ASC PI
C1749	Endo, colon, retro imaging	Endoscope, retrograde imaging/illumination colonoscope device (implantable)	J7

Coding and Payment for Magnetic Resonance Angiography (MRA)

Effective for claims with dates of service on and after June 3, 2010, CMS permits local Medicare contractors to cover (or not cover) all indications of MRA that are not specifically nationally covered or nationally non-covered. CMS has created the six Level II HCPCS codes in Table 4 below to allow ASCs to bill for certain MRA services that were previously non-covered but may now be covered at local Medicare contractor discretion. These HCPCS codes are assigned ASC PI=Z2 (Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight) with the update to the Medicare Physician Fee Schedule authorized for June 1 through November 30, 2010, under the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010. The six Level II HCPCS codes must be used in place of existing CPT codes for the previously non-covered MRA procedures due to a statutory requirement that the OPPS provide payment for imaging services provided with contrast and without contrast through separate payment groups. Specifically, HCPCS codes C8931, C8932, and C8933 replace CPT code 72159 (Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)), while HCPCS codes C8934, C8935, and C8936 replace CPT code 73225 (Magnetic resonance angiography, upper extremity, with or without contrast material(s)).

Further information on billing and coverage for MRA is available to contractors in Transmittal 123 (CR7040), issued July 9, 2010. A related MLN Matters® article is available for that CR at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7040.pdf on the CMS website.

Table 4 – Carrier Determination MRA Codes Effective June 3, 2010

HCPCS Code	Long Descriptor	Short Descriptor	Payment Indicator Effective 06/03/10
C8931	Magnetic resonance angiography with contrast, spinal canal	MRA, w/dye, spinal canal	Z2

HCPCS Code	Long Descriptor	Short Descriptor	Payment Indicator Effective 06/03/10
	and contents		
C8932	Magnetic resonance angiography without contrast, spinal canal and contents	MRA, w/o dye, spinal canal	Z2
C8933	Magnetic resonance angiography without contrast followed by with contrast, spinal canal and contents	MRA, w/o & w/dye, spinal canal	Z2
C8934	Magnetic resonance angiography with contrast, upper extremity	MRA, w/dye, upper extremity	Z2
C8935	Magnetic resonance angiography without contrast, upper extremity	MRA, w/o dye, upper extr	Z2
C8936	Magnetic resonance angiography without contrast followed by with contrast, upper extremity	MRA, w/o&w/dye, upper extr	Z2

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. Carriers/Medicare Administrative Contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, Carriers/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, CR 7147 issued to your carrier and MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2045CP.pdf on the CMS website.

If you have any questions, please contact your carrier and MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.