DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

News Flash –

Revised product from the Medicare Learning Network® (MLN)

- "Ambulatory Surgical Center Fee Schedule," Fact Sheet, ICN 006819, downloadable

MLN Matters® Number: MM8237	Related Change Request (CR) #: CR 8237
Related CR Release Date: March 1, 2013	Effective Date: April 1, 2013
Related CR Transmittal #: R2662CP	Implementation Date: April 1, 2013

April 2013 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 Contractors (Carriers or Part B Medicare Administrative Contractors (Part B MACs)) for ASC payment system-paid services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8237 describes changes to and billing instructions for various payment policies implemented in the April 2013 Ambulatory Surgical Center (ASC) payment system update, and it applies to the "Medicare Claims Processing Manual," Chapter 14, section 10. See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

CR8237 describes changes to and billing instructions for various payment policies implemented in the April 2013 ASC payment system update. Key changes to and billing instructions for various payment policies implemented in the April 2013 ASC payment system update are as follows:

New Healthcare Common Procedure Coding System (HCPCS) Procedure Codes

The new HCPCS procedure code listed in Table 1 below (also included as Attachment A of CR8237) is assigned for payment under the ASC Payment System effective April 1, 2013.

Table 1 – New HCPCS Procedure Code

HCPCS	Effective Date	Short Descriptor	Long Descriptor	ASC PI
C9735	04-01-13	Anoscopy, submucosal inj	Anoscopy; with directed submucosal injection(s), any substance	G2

Billing for Drugs, Biologicals, and Radiopharmaceuticals

Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective April 1, 2013

Payments for separately payable drugs and biologicals based on ASPs are updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, the Centers for Medicare & Medicaid Services (CMS) will incorporate changes to the payment rates in the April 2013 ASC DRUG FILE. The updated payment rates, effective April 1, 2013, will be included in the April 2013 update of the ASC Addendum BB, which will be posted at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices.html on the Centers for Medicare & Medicaid Services (CMS) website.

Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2013

Five drugs and biologicals have been granted ASC payment status effective April 1, 2013. These items, along with their descriptors and APC assignments, are identified in Table 2, below (also included as Attachment A, CR8237).

Table 2 – New HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals Effective April 1, 2013

HCPCS Code	Long Descriptor	ASC PI
C9130*	Injection, immune globulin (Bivigam), 500 mg	K2

HCPCS Code	Long Descriptor	ASC PI
C9297*	Injection, omacetaxine mepesuccinate, 0.01 mg	K2
C9298*	Injection, ocriplasmin, 0.125 mg	K2
J7315	Mitomycin, ophthalmic, 0.2 mg	K2
Q4127	Talymed, per square centimeter	K2

Note: The HCPCS codes identified with an **"*"** indicate that these are new codes effective April 1, 2013.

Additional Information on HCPCS Code C9298 (Injection, Ocriplasmin, 0.125 mg):

Jetrea (ocriplasmin) is packaged in a sterile, single-use vial containing 0.5 mg ocriplasmin in a 0.2 mL solution for intravitreal injection (2.5 mg/mL). As approved by the U.S. Food and Drug Administration (FDA), the recommended dose for Jetrea (NDC 24856-0001-00) is 0.125 mg. Use of the contents of an entire single-use vial to obtain one recommended dose for one eye of one patient per the FDA-approved label would result in reporting 4 units of C9298 on a claim.

In addition, as indicated in the Code of Federal Regulations, Title 42 (Public Health), Part 414 (Payment for Part B Medical and Other Health Services), Subpart K (Payment for Drugs and Biologicals Under Part K), CMS calculates an average sales price (ASP) payment limit based on the amount of product included in a vial or other container as reflected on the FDA-approved label, and any additional product contained in the vial or other container does not represent a cost to providers and is not incorporated into the ASP payment limit. In addition, no payment is made for amounts of product in excess of that reflected on the FDA-approved label. See 42 CFR 414.904 at http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=95a35802cef2dd89565a03c3542c5b18&rgn=div5&view=text&node=42:3.0.1.1.1&idno=42 on the Internet.

Additional Information Related to HCPCS Code J7315 (Mitomycin, ophthalmic, 0.2 mg):

HCPCS Code J7315 should only be used for Mitosol and should not be used for compounded mitomycin or other forms of mitomycin.

Flucelvax (Influenza virus vaccine)

Flucelvax (Influenza virus vaccine) was approved by the FDA on November 20, 2012. Although this vaccine recently received FDA approval, CPT code 90661, which was established by the CPT Editorial Panel effective January 1, 2008, describes Flucelvax. Since January 1, 2008, CPT code 90661 (Flu vacc cell cult prsv free) has been assigned to ASC payment indicator "Y5" (Nonsurgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made) because the product associated with this code had not received FDA approval until recently. CMS is revising the ASC payment indicator for CPT code 90661 from "Y5" to "L1" (Influenza

vaccine; pneumococcal vaccine. Packaged item/service; no separate payment made.) effective November 20, 2012. This change will be reflected in the April 2013 ASC PI file.

Updated Payment Rates for Certain Drug, Biological, and Radiopharmaceutical HCPCS Codes Effective January 1, 2013, through March 31, 2013

The payment rates for two HCPCS codes: J9263 and Q4106 were incorrect in the January 2013 ASC Drug File. The corrected payment rates are listed in Table 3 below (also included as Attachment A of CR8237), and they have been installed in the revised January 2013 ASC Drug File, effective for services furnished on January 1, 2013, through March 31, 2013. Suppliers who received an incorrect payment for dates of service between January 1, 2013, and March 31, 2013, may request contractor adjustment of the previously processed claims.

Table 3 – Updated Payment Rates for Certain Drugs, Biologicals, and Radiopharmaceuticals HCPCS Codes Effective January 1, 2013 through March 31, 2013

HCPCS Code	Short Descriptor	Corrected Payment Rate	ASC PI
J9263	Oxaliplatin	$3.95	K2
Q4106	Dermagraft	$42.55	K2

Additional Information

The official instruction, CR 8237 issued to your carrier and Part B MAC, regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2662CP.pdf on the CMS website.

If you have any questions, please contact your carrier or Part B 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.