CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3854	**Date: September 1, 2017**
	Change Request 10259

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

I. SUMMARY OF CHANGES: Included in this change request (CR) are updates to the ASC payment system, payment rates for separately payable drugs and biologicals, including descriptors for newly created Level II **Healthcare Common Procedure Coding System (**HCPCS) codes for drugs and biologicals (ASC DRUG files), the ASC PI file, the CY 2017 ASC payment rates for covered surgical and ancillary services (ASCFS file), and an ASC Code Pair file, if applicable.

EFFECTIVE DATE: October 1, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 2, 2017

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
N/A	N/A

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

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 3854	Date: September 1, 2017	Change Request: 10259

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

EFFECTIVE DATE: October 1, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 2, 2017

I. GENERAL INFORMATION

A. Background: Included in this notification are updates to the ASC payment system, payment rates for separately payable drugs and biologicals, including descriptors for newly created Level II HCPCS codes for drugs and biologicals (ASC DRUG files), the ASC PI file, the CY 2017 ASC payment rates for covered surgical and ancillary services (ASCFS file), and an ASC Code Pair file.

This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the October 2017 ASC payment system update. This Recurring Update Notification applies to chapter 14, section 10. As appropriate, this notification also includes updates to the Healthcare Common Procedure Coding System (HCPCS).

B. Policy: 1. New Procedure Requiring the Insertion of a Device

Since January 1, 2017, in both the hospital outpatient prospective payment system and ASC settings, all new procedures requiring the insertion of an implantable medical device will be assigned a default device offset percentage of at least 41%, and thereby assigned device intensive status, until claims data is available. In certain rare instances, we may temporarily assign a higher offset percentage if warranted by additional information. In accordance with this current policy, the following code requiring the insertion of a device listed in Table 1 will be assigned device intensive status effective October 1, 2017. We note that although HCPCS code C9747 was effective in the ASC setting as of July 1, 2017, its device intensive designation is not effective until October 1, 2017 (see Attachment A: Policy Section Tables).

2. Drugs, Biologicals, and Radiopharmaceuticals

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

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

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

Some drugs and biologicals with payments based on ASP methodology may have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the CMS Web site 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.

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

Four new HCPCS codes have been created for reporting drugs and biologicals in the ASC setting effective October 1, 2017. These new codes, their descriptors, and ASC payment indicators are listed in Table 2. (see Attachment A: Policy Section Tables).

d. New Modifier for Biosimilar Biological Product

HCPCS Code Q5102 can be reported with either the existing modifier ZB or new modifier ZC effective July 1, 2017 (see Table 3 Attachment A: Policy Section Tables).

e. New Flu Vaccine

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

3. Upper Eyelid Blepharoplasty and Blepharoptosis Repair

As indicated in Chapter VIII of the CY 2017 National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services, CMS payment policy does not allow separate payments for a blepharoptosis procedure (CPT code 67901-67908) and a blepharoplasty procedure (CPT codes 15822-15823) on the ipsilateral upper eyelid. Under this policy, any removal of upper eyelid skin in the context of an upper eyelid blepharoptosis surgery was considered a part of the blepharoptosis surgery. This instruction was clarified in the July 2016 ASC Payment System Update Change Request (Transmittal 3531, Change Request 9668 dated May 27, 2016) and the July 2016 ASC Medicare Learning Network (MLN) Matters Article MM9668.

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

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

- Operating on the left and right eyes on different days when the standard of care is bilateral eyelid surgery.

- Charging the beneficiary an additional amount for removing orbital fat when a blepharoplasty or a blepharoptosis repair is performed.

- Performing a medically necessary blepharoplasty on a different date of service than the blepharoptosis procedure for the purpose of unbundling the medically necessary blepharoplasty.

- Performing blepharoplasty as a staged procedure, either by one or more surgeons (note that under certain circumstances a blepharoptosis procedure could be a staged procedure).

- Billing for two procedures when two surgeons divide the work of a medically necessary blepharoplasty performed with a blepharoptosis repair.

- Using modifier 59 to unbundle a medically necessary blepharoplasty from the ptosis repair on the claim form; this applies to both physicians and facilities.

- Treating medically necessary surgery as cosmetic for the purpose of charging the beneficiary for a cosmetic surgery.

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

4. Coverage Determinations

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

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	
10259.1	Medicare contractors shall download and install the October 2017 ASCFS from the CMS mainframe. FILENAME: MU00.@BF12390.ASC.CY17.FS.OCTA.V0901 **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	
10259.2	Medicare contractors shall download and install the October 2017 ASC DRUG file. FILENAME: MU00.@BF12390.ASC.CY17.DRUG.OCTA.V0922 **NOTE: Date of retrieval will be provided in a separate email communication from CMS.**		X							VDCs
10259.3	Medicare contractors shall download and install the October 2017 ASC PI file. FILENAME: MU00.@BF12390.ASC.CY17.PI.OCTA.V0908 **NOTE: Date of retrieval will be provided in a separate email communication from CMS.**		X							VDCs
10259.4	Contractors and CWF shall add TOS F for HCPCS that are included in attachment A, table 2, effective for services October 1, 2017 and later payable in the ASC setting.		X						X	
10259.5	If released by CMS, Medicare contractors shall download and install the revised July 2017 ASC DRUG file. FILENAME: MU00.@BF12390.ASC.CY17.DRUG.JULB.V0922 **NOTE: Date of retrieval will be provided in a separate email communication from CMS.**		X							VDCs
10259.5.1	Medicare contractors shall adjust as appropriate claims brought to their attention that:		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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.									
10259.6	If released by CMS, Medicare contractors shall download and install the revised April 2017 ASC DRUG file. FILENAME: MU00.@BF12390.ASC.CY17.DRUG.APRC.V0922 **NOTE: Date of retrieval will be provided in a separate email communication from CMS.**		X							VDCs
10259.6.1	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							
10259.7	If released by CMS, Medicare contractors shall download and install the revised January 2017 ASC DRUG file. FILENAME: MU00.@BF12390.ASC.CY17.DRUG.JANC.V0922 **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	
10259.7.1	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service January 1, 2017- March 31, 2017 and ; 2) Were originally processed prior to the installation of the revised January 2017 ASC DRUG File.		X							
10259.8	If released by CMS, Medicare contractors shall download and install the revised October 2016 ASC DRUG file. FILENAME: MU00.@BF12390.ASC.CY16.DRUG.OCTC.V0922 **NOTE: Date of retrieval will be provided in a separate email communication from CMS.**		X							VDCs
10259.8.1	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service October 1, 2016- December 31, 2016 and ; 2) Were originally processed prior to the installation of the revised October 2016 ASC DRUG File.		X							
10259.9	Effective July 1, 2017, Medicare contractors shall return as unprocessable claim lines for Q5102 that do not include the “ZB” or “ZC” modifiers.		X							
10259.9.1	Contractors shall use the following messages when returning these claims: • Claim Adjustment Reason Code (CARC) 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	2110 Service Payment Information REF), if present. • Remittance Advice Remark Code (RARC) MA-130- Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim cannot be processed. Please submit a new claim with the complete/correct information. • Group Code: CO (Contractual Obligation)									
10259.10	Contractors shall make October 2017 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		
10259.11	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: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
9	Attachment A: Policy Section Tables
1-4	Attachment A: Polciy Section Tables

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

V. CONTACTS

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

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 Procedure Requiring the Insertion of a Device

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

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

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

Table 3. – Biosimilar Biological Product Payment and Required Modifiers

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

Table 4. –Flucelvax Quadrivalent Flu Vaccine Codes

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