CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1865	**Date: December 4, 2009**
	Change Request 6746

SUBJECT: January 2010 Update of the Ambulatory Surgical Center (ASC) Payment System

I. SUMMARY OF CHANGES: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the January 2010 ASC update. As appropriate, this notification also includes updates to the Healthcare Common Procedure Coding System (HCPCS). We are also updating Pub. 100-04, Chapter 14, Sections 10.1 and 40.9

NEW / REVISED MATERIAL
EFFECTIVE DATE: ***January 1, 2010**
IMPLEMENTATION DATE: **January 4, 2010**

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	14/10/10.1/Definition of Ambulatory Surgical Center (ASC)
R	14/40/40.9/Payment and Coding for Presbyopia Correcting IOLs (P-C IOLs) and Astigmatism Correcting IOLs (A-C IOLs)

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: 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:

Manual Instruction
Recurring Update Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1865	Date: December 4, 2009	Change Request: 6746

SUBJECT: January 2010 Update of the Ambulatory Surgical Center (ASC) Payment System

EFFECTIVE DATE: January 1, 2010

IMPLEMENTATION DATE: January 4, 2010

I. GENERAL INFORMATION

A. Background:

This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the January 2010 ASC update. As appropriate, this notification also includes updates to the Healthcare Common Procedure Coding System (HCPCS).

Included in this notification are CY 2010 payment rates for separately payable drugs and biologicals, including long descriptors for newly created Level II HCPCS codes for drugs and biologicals (ASC DRUG files), and the CY 2010 ASC payment rates for covered surgical and ancillary services (ASCFS file). We are revising Chapter 14, Section 40.9 to update ASC payment and billing policies for insertion of a new technology intraocular lens (NTIOL) that is also an approved astigmatism-correcting intraocular lens (A-C IOL) or presbyopia-correcting intraocular lens (P-C IOL), concurrent with cataract extraction. We also are updating Chapter 14, Section 10.1 to reflect revised 42 CFR 416.30, which clarifies CMS policy related to the ability of ASCs that are operated by hospitals to become provider-based outpatient departments.

B. Policy:

a. Updated Core Based Statistical Areas (CBSA)

Table 1 below shows updates to eight CBSAs recognized by CMS for ASC claims with dates of service on and after January 1, 2010. Contractor systems should be updated to reflect the CY 2010 CBSA as displayed in Table 1.

Table 1- January 1, 2010 Core Based Statistical Area (CBSA) Changes

COUNTY/STATE	FIPS CODE	2009 CBSA	2010 CBSA
Alexander, IL	17003	14	16020
Geary, KS	20061	17	31740
Pottawatomie, KS	20149	17	31740
Riley, KS	20161	17	31740
Blue Earth, MN	27013	24	31860
Nicollet, MN	27103	24	31860
Bollinger, MO	29017	26	16020
Cape Girardeau, MO	29031	26	16020

b. Drugs and Biologicals with Payment Based on Average Sales Price (ASP) Effective January 1, 2010

In the CY 2010 OPPS/ASC final rule with comment period, it was stated that payments for separately payable drugs and biologicals based on the average sales prices (ASPs) will be updated on a quarterly basis as later quarter ASP submissions become available. Effective January 1, 2010, payment rates for many covered ancillary drugs and biologicals have changed from the values published in the CY 2010 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 2009. In cases where adjustments to payment rates are necessary, the updated payment rates will be incorporated in the January 2010 release of the ASC DRUG file. CMS is not publishing the updated payment rates in this Change Request implementing the January 2010 update of the ASC payment system. However, the updated payment rates effective January 1, 2010 for covered ancillary drugs and biologicals can be found in the January 2010 update of the ASC Addendum BB on the CMS Web site.

c. New HCPCS Codes for Drugs and Biologicals that are Separately Payable under the ASC Payment System as of January 1, 2010

For CY 2010, new Level II HCPCS codes have been created for reporting specific drugs and biologicals. Twenty-three of the new Level II HCPCS codes for reporting drugs and biologicals are separately payable to ASCs for dates of service on or after January 1, 2010. The new Level II HCPCS codes, their payment indicators, and long descriptors are displayed in Table 2 below and are included in the January 2010 ASC DRUG file.

Table 2 - New Level II HCPCS Codes for Drugs and Biologicals Separately Payable under the ASC Payment System for CY 2010

CY 2010 HCPCS Code	CY 2010 Payment Indicator	Short Descriptor
A9581	K2	Gadoxetate disodium inj
A9582	K2	Iodine I-123 iobenguane
A9583	K2	Gadofosveset trisodium inj
C9254	K2	Injection, lacosamide
C9255	K2	Paliperidone palmitate inj
C9256	K2	Dexamethasone intravitreal
C9257	K2	Bevacizumab injection
J0586	K2	AbobotulinumtoxintypeA
J0598	K2	C1 esterase inhibitor inj
J0718	K2	Certolizumab pegol inj
J0833	K2	Cosyntropin injection NOS
J0834	K2	Cosyntropin cortrosyn inj
J1680	K2	Human fibrinogen conc inj
J2562	K2	Plerixafor injection
J2793	K2	Rilonacept injection
J2796	K2	Romiplostim injection
J7185	K2	Xyntha inj
J7325	K2	Synvisc or Synvisc-One
J9155	K2	Degarelix injection

J9171	K2	Docetaxel injection
J9328	K2	Temozolomide injection
Q0138	K2	Ferumoxytol, non-esrd
Q9968	K2	Visualization adjunct

d. Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2009 through June 30, 2009

The payment rates for three HCPCS codes were incorrect in the April 2009 ASC DRUG file. The corrected payment rates are listed in Table 3 below and have been included in the revised April 2009 ASC DRUG file effective for services furnished on April 1, 2009 through implementation of the July 2009 update. Suppliers who think they may have received an incorrect payment between April 1, 2009 and June 30, 2009 may request contractor adjustment of the previously processed claims.

Table 3-Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2009 through June 30, 2009

HCPCS Code	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9245	Injection, romiplostim	$44.81	$8.79
J1260	Dolasetron mesylate	$4.54	$0.91
J2778	Ranibizumab injection	$399.55	$79.91

e. Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2009 through September 30, 2009

The payment rates for three HCPCS codes were incorrect in the July 2009 ASC DRUG file. The corrected payment rates are listed in Table 4 below and have been included in the revised July 2009 ASC DRUG file effective for services furnished on July 1, 2009 through implementation of the October 2009 update. Suppliers who think they may have received an incorrect payment between July 1, 2009 and September 30, 2009 may request contractor adjustment of the previously processed claims.

Table 4-Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2009 through September 30, 2009

HCPCS Code	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
C9354	Veritas collagen matrix, cm2	$11.77	$2.31
C9364	Porcine implant, Permacol	$18.46	$3.62
J1520	Gamma globulin 7 CC inj	$102.15	$20.43

f. Correct Reporting of Drugs and Biologicals When Used As Implantable Devices

When billing for a biological for which the HCPCS code describes a product that is solely surgically implanted or inserted, and that is separately payable under the ASC payment system, the ASC should report the HCPCS code for the product. If the implanted biological is packaged, that is, not eligible for separate payment under the ASC payment system, the ASC should not report the biological product HCPCS code.

When billing for a biological for which the HCPCS code describes a product that may be either surgically implanted or inserted or otherwise applied in the care of a patient, ASCs should not report the HCPCS code for the product when the biological is used as an implantable device (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures. Under the ASC payment system, ASCs are provided a packaged payment for surgical procedures that includes the cost of supportive items. When using biologicals during surgical procedures as implantable devices, ASCs may include the charges for these items in their charge for the procedure.

g. Correct Reporting of Units for Drugs

ASCs are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the HCPCS long code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor. For example, if the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be 1. As another example, if the description for the drug code is 50 mg, but 200 mg of the drug was administered to the patient, the units billed should be 4. ASCs should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, bill 10 units, even though only 1 vial was administered. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

h. Manual Updates for ASC Terms of Agreement with CMS

Chapter 14, Section 10 is revised to update and clarify CMS policy related to the ability of ASCs that are operated by hospitals to become provider-based hospital outpatient departments.

i. Manual Updates for Insertion of an Approved A-C IOL or P-C IOL that also is Designated as an NTIOL for ASC Payment

CMS is revising Chapter 14, Section 40.9 to provide guidance on the payment and billing policies for insertion of an A-C IOL or P-C IOL that also is designated by CMS as an NTIOL for ASC payment.

Effective for services on and after January 1, 2010, ASCs shall use HCPCS code V2787 (Astigmatism-correcting function of intraocular lens) or V2788 (Presbyopia-correcting function of intraocular lens) as appropriate, to report charges associated with the non-covered functionality of the A-C IOL or P-C IOL, the appropriate HCPCS code 66982 (Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage); 66983 (Intracapsular cataract extraction with insertion of intraocular lens prosthesis (1 stage procedure)); or 66984 (Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)), to report the covered cataract extraction and insertion procedure; and Q1003 (New technology, intraocular lens, category 3 (reduced spherical aberration) as defined in Federal Register notice, Vol. 65, dated May 3, 2000) to report the covered NTIOL aspect of the lens on claims for insertion of an A-C IOL or P-C IOL that is also designated as an NTIOL. CMS-approved

Category 3 NTIOLs, A-C IOLs, and P-C IOLs are available on the CMS web site at: http://www.cms.hhs.gov/ASCPayment/.

j. Payment When a Device is Furnished With No Cost or With Full or Partial Credit

For CY 2010, CMS updated the list of ASC covered device intensive procedures and devices that are subject to the no cost/full credit and partial credit device adjustment policy. Contractors will reduce the payment for the device implantation procedures listed in Attachment B, below, by the full device offset amount for no cost/full credit cases. ASCs must append the modifier "FB" to the HCPCS procedure code when the device furnished without cost or with full credit is listed in Attachment C, below, and the associated implantation procedure code is listed in Attachment B. In addition, contractors will reduce the payment for implantation procedures listed in Attachment B by one half of the device offset amount that would be applied if a device were provided at no cost or with full credit, if the credit to the ASC is 50 percent or more of the device cost. If the ASC receives a partial credit of 50 percent or more of the cost of a device listed in Attachment C, the ASC must append the modifier "FC" to the associated implantation procedure code if the procedure is listed in Attachment B. A single procedure code should not be submitted with both modifiers "FB" and "FC."

More information regarding billing for procedures involving no cost/full credit and partial credit devices is available in the Medicare Claims Processing Manual, Pub 100-04, Chapter 14, Section 40.8.

k. Attachments

Several attachments are provided to this transmittal that contractors may wish to use as references to support their ASC module updating and validation processes.

Attachment A: ASC covered surgical procedures and ancillary services that are newly payable in ASCs effective CY 2010
Attachment B: CY 2010 ASC covered surgical procedures to which the no cost/full credit and partial credit device adjustment policy applies
Attachment C: CY 2010 devices for which modifier "FB" or "FC" must be reported with the procedure code when furnished at no cost or with full or partial credit

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6746.1	Contractors shall download the January 2010 ASCFS from the CMS mainframe. FILENAME: MU00.@BF12390.ASC.CY10.FS.JAN.J.V1124	X			X						All EDCs

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	Note: The January 2010 ASCFS includes all updates to the CBSA values and list of ASC covered services subject to the FB and FC modifier payment adjustment policy as identified in this transmittal. **Date of retrieval will be provided in a separate email communication from CMS**										
6746.2	Contractors shall incorporate updates to the Core Based Statistical Area (CBSA) into ASCFS module programming.	X			X						
6746.2.1	Contractors shall modify their systems to incorporate the CBSA updates for jurisdictional ASCs in Alexander, IL for dates of service beginning January 1, 2010. **From:** CBSA 14 **To:** CBSA 16020	X			X						
6746.2.2	Contractors shall modify their systems to incorporate the CBSA update for jurisdictional ASCs in Geary, KS, Pottawatomie, KS and Riley, KS for dates of service beginning January 1, 2010. **From:** CBSA 17 **To:** CBSA 31740	X			X						
6746.2.3	Contractors shall modify their systems to incorporate the CBSA update for jurisdictional ASCs in Blue Earth, MN and Nicollet, MN for dates of service beginning January 1, 2010. **From:** CBSA 24 **To:** CBSA 31860	X			X						
6746.2.4	Contractors shall modify their systems to incorporate the CBSA update for jurisdictional ASCs in Bollinger, MO, and Cape Girardeau, MO for dates of service beginning January 1, 2010. **From:** CBSA 26 **To:** CBSA 16020	X			X						
6746.3	Medicare contractors shall download and install the January 2010 ASC DRUG file. FILENAME: MU00.@BF12390.ASC.CY10.DRUG.JAN.J.V1223 **Date of retrieval will be provided in a separate**	X			X						All EDCs

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	email communication from CMS										
6746.4	Medicare contractors shall download and install a revised April 2009 ASC DRUG file. FILENAME: MU00.@BF12390.ASC.CY09.DRUG.APR.J.V1223 **Confirmation and date of retrieval will be provided in a separate email communication from CMS**	X			X						All EDCs
6746.4.1	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service on or after April 1, 2009 prior to July 1, 2009 and ; 2) Were originally processed prior to the installation of the revised July 2009 ASC DRUG File.	X			X						
6746.5	Medicare contractors shall download and install a revised July 2009 ASC DRUG file. FILENAME: MU00.@BF12390.ASC.CY09.DRUG.JUL.J.V1223 **Confirmation and date of retrieval will be provided in a separate email communication from CMS**	X			X						All EDCs
6746.5.1	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service on or after July 1, 2009 prior to October 1, 2009 and ; 2) Were originally processed prior to the installation of the revised October 2009 ASC DRUG File.	X			X						
6746.6	Medicare contractors shall download and install the January 2010 ASC PI file FILENAME: MU00.@BF12390.ASC.CY10.IND.JAN.J.V1203 **Confirmation and date of retrieval will be provided in a separate email communication from CMS.**	X			X						All EDCs
6746.7	Contractors shall accept claims for Category III	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	NTIOLs with A-C IOL or P-C IOL functionality billed using V2787or V2788, AND CPT 66982, 66983, or 66984, AND Q1003.										
6746.8	Contractors shall make January 2010 ASCFS fee data for their ASC payment localities available on their web sites.	X			X						
6746.9	Contractors shall modify procedure code files and TOS tables to accept HCPCS A9581, A9582, and A9583 as approved ASC procedures.	X			X						
6746.10	CWF shall add TOS F for HCPCS A9581, A9582, and A9583 effective January 1, 2010.									X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6746.11	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/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 site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your 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			X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

Section B: For all other recommendations and supporting information, use this space:

Attachment A: ASC Covered Surgical Procedures and Ancillary Services that are Newly Payable in ASCs Effective CY 2010

Attachment B**:** CY 2010 ASC Covered Surgical Procedures to Which the No Cost/Full Credit and Partial Credit Device Adjustment Policy Applies

V. CONTACTS

Pre-Implementation Contact(s): ASC Payment Policy: Chuck Braver at chuck.braver@cms.hhs.gov or 410-786-6719;. Carrier/ AB MAC Claims Processing Issues: Yvette Cousar at yvette.cousar@cms.hhs.gov or 410-786-2160.

Post-Implementation Contact(s): ASC Payment Policy: Chuck Braver at chuck.braver@cms.hhs.gov or 410-786-6719; Carrier/ AB MAC Claims Processing Issues: Yvette Cousar at yvette.cousar@cms.hhs.gov or 410-786-2160.

VI. FUNDING

Section A: For *Carriers:*
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *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

Attachment A

ASC Covered Surgical Procedures and Ancillary Services that are Newly Payable in ASCs Effective CY 2010

HCPCS Code	Short Descriptor
0193T	Rf bladder neck microremodel
0213T	Us facet jt inj cerv/t 1 lev
0214T	Us facet jt inj cerv/t 2 lev
0215T	Us facet jt inj cerv/t 3 lev
0216T	Us facet jt inj ls 1 level
0217T	Us facet jt inj ls 2 level
0218T	Us facet jt inj ls 3 level
14301	Skin tissue rearrangement
14302	Skin tissue rearrange add-on
21011	Exc face les sc < 2 cm
21012	Exc face les sc = 2 cm
21013	Exc face tum deep < 2 cm
21014	Exc face tum deep = 2 cm
21016	Resect face tum = 2 cm
21552	Exc neck les sc = 3 cm
21554	Exc neck tum deep = 5 cm
21558	Resect neck tum = 5 cm
21931	Exc back les sc = 3 cm
21932	Exc back tum deep < 5 cm
21933	Exc back tum deep = 5 cm
21936	Resect back tum = 5 cm
22901	Exc back tum deep = 5 cm
22902	Exc abd les sc < 3 cm
22903	Exc abd les sc > 3 cm
22904	Resect abd tum < 5 cm
22905	Resect abd tum > 5 cm
23071	Exc shoulder les sc > 3 cm
23073	Exc shoulder tum deep > 5 cm
23078	Resect shoulder tum > 5 cm
24071	Exc arm/elbow les sc = 3 cm
24073	Ex arm/elbow tum deep > 5 cm
24079	Resect arm/elbow tum > 5 cm
25071	Exc forearm les sc > 3 cm
25073	Exc forearm tum deep = 3 cm

25078	Resect forearm/wrist tum=3cm
26037	Decompress fingers/hand
26111	Exc hand les sc > 1.5 cm
26113	Exc hand tum deep > 1.5 cm
26118	Exc hand tum ra > 3 cm
27043	Exc hip pelvis les sc > 3 cm
27045	Exc hip/pelv tum deep > 5 cm
27059	Resect hip/pelv tum > 5 cm
27337	Exc thigh/knee les sc > 3 cm
27339	Exc thigh/knee tum deep >5cm
27364	Resect thigh/knee tum >5 cm
27475	Surgery to stop leg growth
27479	Surgery to stop leg growth
27616	Resect leg/ankle tum > 5 cm
27632	Exc leg/ankle les sc > 3 cm
27634	Exc leg/ankle tum deep >5 cm
27720	Repair of tibia
28039	Exc foot/toe tum sc > 1.5 cm
28041	Exc foot/toe tum deep >1.5cm
28047	Resect foot/toe tumor > 3 cm
29581	Apply multlay comprs lwr leg
31626	Bronchoscopy w/markers
32552	Remove lung catheter
32553	Ins mark thor for rt perq
35460	Repair venous blockage
35475	Repair arterial blockage
36147	Access av dial grft for eval
37761	Ligate leg veins open
41512	Tongue suspension
42225	Reconstruct cleft palate
42227	Lengthening of palate
43130	Removal of esophagus pouch
43752	Nasal/orogastric w/stent
45171	Exc rect tum transanal part
45172	Exc rect tum transanal full
45541	Correct rectal prolapse
46707	Repair anorectal fist w/plug
49411	Ins mark abd/pel for rt perq
49435	Insert subq exten to ip cath
49436	Embedded ip cath exit-site
49442	Place cecostomy tube perc
50080	Removal of kidney stone
50081	Removal of kidney stone
50727	Revise ureter
51535	Repair of ureter lesion
51727	Cystometrogram w/up

51728	Cystometrogram w/vp
51729	Cystometrogram w/vp&up
53855	Insert prost urethral stent
57295	Revise vag graft via vagina
57426	Revise prosth vag graft lap
60210	Partial thyroid excision
60212	Partial thyroid excision
60220	Partial removal of thyroid
60225	Partial removal of thyroid
61770	Incise skull for treatment
63661	Remove spine eltrd perq aray
63662	Remove spine eltrd plate
63663	Revise spine eltrd perq aray
63664	Revise spine eltrd plate
64490	Inj paravert f jnt c/t 1 lev
64491	Inj paravert f jnt c/t 2 lev
64492	Inj paravert f jnt c/t 3 lev
64493	Inj paravert f jnt l/s 1 lev
64494	Inj paravert f jnt l/s 2 lev
64495	Inj paravert f jnt l/s 3 lev
74261	Ct colonography, w/o dye
74262	Ct colonography, w/dye
75571	Ct hrt w/o dye w/ca test
75572	Ct hrt w/3d image
75573	Ct hrt w/3d image, congen
75574	Ct angio hrt w/3d image
77338	Design mlc device for imrt
78451	Ht muscle image spect, sing
78452	Ht muscle image spect, mult
78453	Ht muscle image,planar,sing
78454	Ht musc image, planar, mult
90476	Adenovirus vaccine, type 4
90680	Rotovirus vacc 3 dose, oral
90725	Cholera vaccine, injectable
90735	Encephalitis vaccine, sc
A9581	Gadoxetate disodium inj
A9582	Iodine I-123 iobenguane
A9583	Gadofosveset trisodium inj
C9254	Injection, lacosamide
C9255	Paliperidone palmitate inj
C9256	Dexamethasone intravitreal
C9257	Bevacizumab injection
J0586	AbobotulinumtoxintypeA
J0598	C1 esterase inhibitor inj
J0718	Certolizumab pegol inj
J0833	Cosyntropin injection NOS

J0834	Cosyntropin cortrosyn inj
J0945	Brompheniramine maleate inj
J1324	Enfuvirtide injection
J1680	Human fibrinogen conc inj
J1817	Insulin for insulin pump use
J2320	Nandrolone decanoate 50 MG
J2321	Nandrolone decanoate 100 MG
J2322	Nandrolone decanoate 200 MG
J2562	Plerixafor injection
J2793	Rilonacept injection
J2796	Romiplostim injection
J7185	Xyntha inj
J7197	Antithrombin iii injection
J7325	Synvisc or Synvisc-One
J7515	Cyclosporine oral 25 mg
J9155	Degarelix injection
J9171	Docetaxel injection
J9212	Interferon alfacon-1 inj
J9328	Temozolomide injection
Q0138	Ferumoxytol, non-esrd
Q2004	Bladder calculi irrig sol
Q9968	Visualization adjunct

Attachment B

CY 2010 ASC Covered Surgical Procedures to Which the No Cost/Full Credit and Partial Credit Device Adjustment Policy Applies

HCPCS Code	Short Descriptor	CY 2010 Device Offset Amount for No Cost/ Full Credit Case	CY 2010 Device Offset Amount for Partial Credit Case
24361	Reconstruct elbow joint	$4,607.23	$2,303.62
24363	Replace elbow joint	$4,607.23	$2,303.62
24366	Reconstruct head of radius	$4,607.23	$2,303.62
25441	Reconstruct wrist joint	$4,607.23	$2,303.62
25442	Reconstruct wrist joint	$4,607.23	$2,303.62
25446	Wrist replacement	$4,607.23	$2,303.62
27446	Revision of knee joint	$4,607.23	$2,303.62
33206	Insertion of heart pacemaker	$5,750.42	$2,875.21
33207	Insertion of heart pacemaker	$5,750.42	$2,875.21
33208	Insertion of heart pacemaker	$7,169.69	$3,584.85
33212	Insertion of pulse generator	$4,925.26	$2,462.63
33213	Insertion of pulse generator	$5,451.67	$2,725.84
33214	Upgrade of pacemaker system	$7,169.69	$3,584.85
33224	Insert pacing lead & connect	$11,169.79	$5,584.90
33225	Lventric pacing lead add-on	$11,169.79	$5,584.90
33240	Insert pulse generator	$19,533.73	$9,766.87
33249	Eltrd/insert pace-defib	$24,535.85	$12,267.93
33282	Implant pat-active ht record	$3,833.98	$1,916.99
53440	Male sling procedure	$3,915.41	$1,957.71
53444	Insert tandem cuff	$3,915.41	$1,957.71
53445	Insert uro/ves nck sphincter	$7,812.01	$3,906.01
53447	Remove/replace ur sphincter	$7,812.01	$3,906.01
54400	Insert semi-rigid prosthesis	$3,915.41	$1,957.71
54401	Insert self-contd prosthesis	$7,812.01	$3,906.01
54405	Insert multi-comp penis pros	$7,812.01	$3,906.01
54410	Remove/replace penis prosth	$7,812.01	$3,906.01
54416	Remv/repl penis contain pros	$7,812.01	$3,906.01
61885	Insrt/redo neurostim 1 array	$11,868.32	$5,934.16
61886	Implant neurostim arrays	$16,331.99	$8,166.00
62361	Implant spine infusion pump	$11,071.42	$5,535.71
62362	Implant spine infusion pump	$11,071.42	$5,535.71
63650	Implant neuroelectrodes	$2,553.00	$1,276.50
63655	Implant neuroelectrodes	$3,707.26	$1,853.63
63685	Insrt/redo spine n generator	$11,868.32	$5,934.16
64553	Implant neuroelectrodes	$2,553.00	$1,276.50
64555	Implant neuroelectrodes	$2,553.00	$1,276.50
64560	Implant neuroelectrodes	$2,553.00	$1,276.50
64561	Implant neuroelectrodes	$2,553.00	$1,276.50

HCPCS Code	Short Descriptor	CY 2010 Device Offset Amount for No Cost/ Full Credit Case	CY 2010 Device Offset Amount for Partial Credit Case
64565	Implant neuroelectrodes	$2,553.00	$1,276.50
64573	Implant neuroelectrodes	$7,779.06	$3,889.53
64575	Implant neuroelectrodes	$3,707.26	$1,853.63
64577	Implant neuroelectrodes	$3,707.26	$1,853.63
64580	Implant neuroelectrodes	$3,707.26	$1,853.63
64581	Implant neuroelectrodes	$3,707.26	$1,853.63
64590	Insrt/redo pn/gastr stimul	$11,868.32	$5,934.16
69714	Implant temple bone w/stimul	$4,607.23	$2,303.62
69715	Temple bne implnt w/stimulat	$4,607.23	$2,303.62
69717	Temple bone implant revision	$4,607.23	$2,303.62
69718	Revise temple bone implant	$4,607.23	$2,303.62
69930	Implant cochlear device	$24,434.36	$12,217.18

Attachment C

CY 2010 Devices for Which Modifier “FB” or “FC” Must be Reported with the Procedure Code When Furnished at No Cost or With Full or Partial Credit

HCPCS Code	Short Descriptor
C1721	AICD, dual chamber
C1722	AICD, single chamber
C1764	Event recorder, cardiac
C1767	Generator, neurostim, imp
C1771	Rep dev, urinary, w/sling
C1772	Infusion pump, programmable
C1776	Joint device (implantable)
C1778	Lead, neurostimulator
C1779	Lead, pmkr, transvenous VDD
C1785	Pmkr, dual, rate-resp
C1786	Pmkr, single, rate-resp
C1813	Prosthesis, penile, inflatab
C1815	Pros, urinary sph, imp
C1820	Generator, neuro rechg bat sys
C1881	Dialysis access system
C1882	AICD, other than sing/dual
C1891	Infusion pump, non-prog, perm
C1897	Lead, neurostim, test kit
C1898	Lead, pmkr, other than trans
C1900	Lead coronary venous
C2619	Pmkr, dual, non rate-resp
C2620	Pmkr, single, non rate-resp
C2621	Pmkr, other than sing/dual
C2622	Prosthesis, penile, non-inf
C2626	Infusion pump, non-prog, temp
C2631	Rep dev, urinary, w/o sling
L8614	Cochlear device/system
L8680	Implt neurostim elctr each
L8685	Implt nrostm pls gen sng rec
L8686	Implt nrostm pls gen sng non
L8687	Implt nrostm pls gen dua rec
L8688	Implt nrostm pls gen dua non
L8690	Aud osseo dev, int/ext comp

10.1 - Definition of Ambulatory Surgical Center (ASC)

(Rev.1865, Issued: 12-04-09, Effective: 01-01-10, Implementation: 01-04-10)

An ASC for Medicare purposes is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients. The ASC must *have in effect an agreement with CMS obtained in accordance with 42 CFR 416 subpart B (General Conditions and Requirements).* An ASC is either independent (i.e., not a part of a provider of services or any other facility), or operated by a hospital (i.e., under the common ownership, licensure or control of a hospital). A hospital-operated facility has the option of being *considered by* Medicare *either to be* an ASC *or to be a provider-based* department *of the hospital as defined in 42 CFR 413.65*.

To *participate in Medicare* as an ASC operated by a hospital, a facility:

- Elects to do so.
- Is a separately identifiable entity, physically, administratively, and financially independent and distinct from other operations of the hospital with costs for the ASC treated as a non-reimbursable cost center on the hospital's cost report;
- Meets all the requirements with regard to health and safety, and agrees to the assignment, coverage and payment rules applied to independent ASCs; and
- Is surveyed and approved as complying with the conditions for coverage for ASCs in 42 CFR 416.25-49.

Related survey requirements are published in the State Operations Manual, Pub. 100-07, Appendix L.

If a facility meets the above requirements, it bills the Medicare contractor on Form CMS-1500 or the related electronic data set and is paid the ASC payment amount.

A hospital-operated facility that decides to discontinue participation in Medicare as an ASC must terminate its ASC agreement with CMS. Guidance regarding the termination of ASC agreements with CMS is provided in 42 CFR 416.35. Voluntary terminations are those initiated by an ASC and, as specified in 42 CFR 416.35, an ASC may terminate its agreement either by sending written notice to CMS or by ceasing to furnish services to the community.

To participate in Medicare as a provider-based department of the hospital, the hospital must comply with CMS requirements to certify the hospital-operated facility as a provider-based department of the hospital as described in 42 CFR 413.65, including meeting all of the hospital conditions of participation specified in 42 CFR 482. See Pub 100-07, State Operations Manual,

Appendix A, “Survey Protocol, Regulations and Interpretive Guidelines for Hospitals,” for information on survey requirements.

Certain Indian Health Service (IHS) and Tribal hospital outpatient departments may elect to enroll and be paid as ASCs. See Pub. 100-04, chapter 19 for more information.

40.9 - Payment and Coding for Presbyopia Correcting IOLs (P-C IOLs) and Astigmatism Correcting IOLs (A-C IOLs)

(Rev.1865, Issued: 12-04-09, Effective: 01-01-10, Implementation: 01-04-10)

CMS payment policies and recognition of P-C IOLs and A-C IOLs are contained in Transmittal 636 (CR3927) and Transmittal 1228 (CR5527) respectively.

Effective for dates of service on and after January 1, 2008, when inserting an approved A-C IOL in an ASC *concurrent with cataract extraction*, *HCPCS code V2787 (Astigmatism-correcting function of intraocular lens)* should be billed to report the non-covered charges for the A-C IOL functionality of the inserted intraocular lens. Additionally, note that *HCPCS code V2788 (Presbyopia-correcting function of intraocular lens)* is no longer valid to report non-covered charges associated with the A-C IOL. However, this code continues to be valid to report non-covered charges for a P-C IOL. The payment for the conventional lens portion of the A-C IOL and P-C IOL continues to be bundled with the ASC procedure payment.

Effective for services on and after January 1, 2010, ASCs are to bill for insertion of a Category 3 new technology intraocular lens (NTIOL) that is also an approved A-C IOL or P-C IOL, concurrent with cataract extraction, using three separate codes. ASCs shall use HCPCS code V2787 or V2788, as appropriate, to report charges associated with the non-covered functionality of the A-C IOL or P-C IOL, the appropriate HCPCS code 66982 (Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage); 66983 (Intracapsular cataract extraction with insertion of intraocular lens prosthesis (1 stage procedure)); or 66984 (Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)), to report the covered cataract extraction and insertion procedure; and Q1003 (New technology, intraocular lens, category 3 (reduced spherical aberration) as defined in Federal Register notice, Vol. 65, dated May 3, 2000) to report the covered NTIOL aspect of the lens on claims for insertion of an A-C IOL or P-C IOL that is also designated as an NTIOL. Listings of the CMS-approved Category 3 NTIOLs, A-C IOLs, and P-C IOLs are available on the CMS web site.