CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2128	**Date: DECEMBER 29, 2010**
	Change Request 7275

SUBJECT: January 2011 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 2011 ASC update. As appropriate, this notification also includes updates to the Healthcare Common Procedure Coding System (HCPCS).

EFFECTIVE DATE: January 1, 2011
IMPLEMENTATION DATE: January 3, 2011

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	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 2128	Date: December 29, 2010	Change Request: 7275

SUBJECT: January 2011 Update of the Ambulatory Surgical Center (ASC) Payment System

Effective Date: January 1, 2011
Implementation Date: January 3, 2011

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the January 2011 ASC update. As appropriate, this notification also includes updates to the Healthcare Common Procedure Coding System (HCPCS).

Included in this notification are CY 2011 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 2011 ASC payment rates for 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 are final files reflecting the most recent legislative changes to CY 2011 MPFS payment under the Medicare and Medicaid Extenders Act of 2010.

B. Policy:

a. Updated Core Based Statistical Areas (CBSA)

Table 1 below shows updates to three CBSAs recognized by CMS for ASC claims with dates of service on and after January 1, 2011. Contractor systems should be updated to reflect the CY 2011 CBSA as displayed in Table 1.

Table 1- January 1, 2011 Core Based Statistical Area (CBSA) Changes

COUNTY/STATE	2010 CBSA	2011 CBSA
Crestview-Fort Walton Beach-Destin, FL	23020	18880
North Port-Bradenton-Sarasota-Venice, FL	14600	35840
Steubenville-Weirton, OH-WV	48260	44600

b. Drugs and Biologicals with Payment Based on Average Sales Price (ASP) Effective January 1, 2011

Payments for separately payable drugs and biologicals based on the average sales prices (ASPs) are updated on a quarterly basis as later quarter ASP submissions become available. Effective January 1, 2011, payment rates for many covered ancillary drugs and biologicals have changed from the values published in the CY 2011 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 2010. In cases where adjustments to payment rates are necessary, the updated payment rates will be incorporated in the January 2011 release of the ASC DRUG file. CMS is not publishing the updated payment rates in this Change Request implementing the January

2011 update of the ASC payment system. However, the updated payment rates effective January 1, 2011 for covered ancillary drugs and biologicals can be found in the January 2011 update of the ASC Addendum BB on the CMS Website.

c. Payment for Category 3 New Technology IOLs (NTIOLs); Q1003

Medicare pays an additional $50 for specified Category 3 NTIOLs (reduced spherical aberration) that are provided in association with a covered ASC surgical procedure. This current active class of NTIOLs, reported using HCPCS code Q1003, has expired for dates of service beginning on February 27, 2011. Upon expiration of this NTIOL class, Q1003 will be packaged (PI=N1) and no separate payment will be provided for the IOL in addition to the IOL insertion procedure (effective February 27, 2011).

CMS did not approve a new NTIOL class for CY 2011. Therefore, after the expiration of the Category 3 NTIOL class, there are no active NTIOL classes. ASCs are reminded that Medicare beneficiaries cannot be billed for amounts above the coinsurance payment in order to mitigate any loss of the $50 Medicare payment associated with the expiration of the Category 3 NTIOL class.

d. New HCPCS Codes for Drugs and Biologicals that are Separately Payable under the ASC Payment System as of January 1, 2011

For CY 2011, thirty 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, 2011. The new Level II HCPCS codes, their payment indicators, and short descriptors are displayed in Table 2 below and are included in the January 2011 ASC DRUG file.

Table 2 - New Level II HCPCS Codes for Drugs and Biologicals Separately Payable under the ASC Payment System for CY 2011

CY 2011 HCPCS Code	CY 2011 Payment Indicator	Short Descriptor
C9274	K2	Crotalidae Poly Immune Fab
C9275	K2	Hexaminolevulinate HCl
C9276	K2	Cabazitaxel injection
C9277	K2	Lumizyme, 1 mg
C9278	K2	Incobotulinumtoxin A
C9279	K2	Injection, ibuprofen
J0597	K2	C-1 esterase, berinert
J0638	K2	Canakinumab injection
J0775	K2	Collagenase, clost hist inj
J1290	K2	Ecallantide injection
J1559	K2	Hizentra injection
J1786	K2	Imuglucerase injection
J2358	K2	Olanzapine long-acting inj
J2426	K2	Paliperidone palmitate inj
J3095	K2	Televancin injection
J3262	K2	Tocilizumab injection
J3357	K2	Ustekinumab injection
J3385	K2	Velaglucerase alfa
J7184	K2	Wilate injection
J7196	K2	Antithrombin recombinant

J7309	K2	Methyl aminolevulinate, top
J7312	K2	Dexamethasone intra implant
J7335	K2	Capsaicin 8% patch
J8562	K2	Oral fludarabine phosphate
J9302	K2	Ofatumumab injection
J9307	K2	Pralatrexate injection
J9315	K2	Romidepsin injection
J9351	K2	Topotecan injection
Q4118	K2	Matristem micromatrix
Q4121	K2	Theraskin

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

The payment rates for fourteen HCPCS codes were incorrect in the July 2010 ASC DRUG file. The corrected payment rates are listed in Table 3 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 through September 30, 2010 may request contractor adjustment of the previously processed claims.

Table 3-Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2010 through September 30, 2010

HCPCS Code	Short Descriptor	Corrected Payment Rate
J0150	Injection adenosine 6 MG	$13.74
J0641	Levoleucovorin injection	$0.73
J2430	Pamidronate disodium /30 MG	$15.61
J2850	Inj secretin synthetic human	$26.97
J9065	Inj cladribine per 1 MG	$24.12
J9178	Inj, epirubicin hcl, 2 mg	$2.06
J9185	Fludarabine phosphate inj	$112.61
J9200	Floxuridine injection	$42.31
J9206	Irinotecan injection	$4.23
J9208	Ifosfomide injection	$30.95
J9209	Mesna injection	$4.96
J9211	Idarubicin hcl injection	$40.09
J9263	Oxaliplatin	$4.37
J9293	Mitoxantrone hydrochl / 5 MG	$44.07

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. Units should be reported in multiples of the units included in the HCPCS descriptor. ASCs should not bill the units based on the way the implantable biological is packaged, stored, or stocked. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the implantable biological. Therefore, before submitting Medicare claims for biologicals that are used as implantable devices, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

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.

As discussed in Pub.100-04, Medicare Claims Processing Manual, Chapter 17, Section 40, CMS encourages ASCs to use drugs efficiently and in a clinically appropriate manner. However, CMS also recognizes that ASCs may discard some drug and biological product when administering from a single use vial or package. In that circumstance, Medicare pays for the amount of drug or biological discarded as well as the dose administered, up to the amount of the drug or biological as indicated on the vial or package label. Multi-use vials are not subject to payment for discarded amounts of drug or biological.

h. Waiver of Cost- Sharing for Preventive Services

The Affordable Care Act waives any copayment and deductible that would otherwise apply for the defined set of preventive services to which the U.S. Preventive Services Task Force (USPSTF) has given a grade of A or B, including copayment for screening colonoscopies and screening flexible sigmoidoscopies, effective for services furnished on and after January 1, 2011. Further information on the implementation of waiver of cost- sharing for preventive services as prescribed by the Affordable Care Act will be included in a separate CR that will be released shortly.

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

For CY 2011, 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.

j. 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: CY2011 ASC COVERED SURGICAL PROCEDURES AND ANCILLARY SERVICES THAT ARE NEWLY PAYABLE IN ASCs

Attachment B**:** CY 2011 ASC PROCEDURES TO WHICH THE NO COST/FULL CREDIT AND PARTIAL CREDIT DEVICE ADJUSTMENT POLICY APPLIES

Attachment C: CY 2011 DEVICES FOR WHICH THE "FB" OR "FC" MODIFIER MUST BE REPORTED WITH THE ASC 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	
7275.1	Contractors shall download the January 2011 ASCFS from the CMS mainframe. FILENAME: MU00.@BF12390.ASC.CY11.FS.JAN.N.V1222 Note: The January 2011 ASCFS includes all updates	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	
	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**										
7275.2	Contractors shall incorporate updates to the Core Based Statistical Area (CBSA) into ASCFS module programming.	X			X						
7275.2.1	Contractors shall modify their systems to incorporate the CBSA updates for jurisdictional ASCs in Bradenton, FL, Sarasota, FL, Venice, FL, and North Port, FL for dates of service beginning January 1, 2011. **From:** CBSA 14600 **To:** CBSA 35840	X			X						
7275.2.2	Contractors shall modify their systems to incorporate the CBSA update for jurisdictional ASCs in Fort Walton Beach, FL, Crestview, FL, and Destin, FL for dates of service beginning January 1, 2011. **From:** CBSA 23020 **To:** CBSA 18880	X			X						
7275.2.3	Contractors shall modify their systems to incorporate the CBSA update for jurisdictional ASCs in Weirton-Steubenville, WV-OH for dates of service beginning January 1, 2011. **From:** CBSA 48260 **To:** CBSA 44600	X			X						
7275.3	Medicare contractors shall download and install the January 2011 ASC DRUG file. FILENAME: MU00.@BF12390.ASC.CY11.DRUG.JAN.N.V1221 **Date of retrieval will be provided in a separate email communication from CMS**	X			X						All EDCs
7275.4	Medicare contractors shall download and install a revised July 2010 ASC DRUG file. FILENAME: MU00.@BF12390.ASC.CY10.DRUG.JUL.N.V1221 **Date of retrieval will be provided in a separate email communication from CMS**	X			X						All EDCs
7275.4.1	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service on or after July 1, 2010	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	
	prior to October 1, 2010 and ; 2) Were originally processed prior to the installation of the revised July 2010 ASC DRUG File.										
7275.5	Medicare contractors shall download and install the January 2011 ASC PI file FILENAME: MU00.@BF12390.ASC.CY11.PI.JAN.N.V1222 **Confirmation and date of retrieval will be provided in a separate email communication from CMS.**	X			X						All EDCs
7275.6	Contractors shall make January 2011 ASCFS fee data for their ASC payment localities available on their web sites.	X			X					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	
7275.7	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: CY2011 ASC COVERED SURGICAL PROCEDURES AND ANCILLARY SERVICES THAT ARE NEWLY PAYABLE IN ASCs

Attachment B**:** CY 2011 ASC PROCEDURES TO WHICH THE NO COST/FULL CREDIT AND PARTIAL CREDIT DEVICE ADJUSTMENT POLICY APPLIES

Attachment C: CY 2011 DEVICES FOR WHICH THE “FB” OR “FC” MODIFIER MUST BE REPORTED WITH THE ASC PROCEDURE CODE WHEN FURNISHED AT NO COST OR WITH FULL OR PARTIAL CREDIT

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

CY2011 ASC COVERED SURGICAL PROCEDURES AND ANCILLARY SERVICES THAT ARE NEWLY PAYABLE IN ASCs

HCPCS Code	Short Descriptor
0238T	Trluml perip athrc iliac art
0249T	Ligation hemorrhoid w/us
0250T	Insert bronchial valve
0251T	Remov bronchial valve addl
0252T	Bronchscpc rmvl bronch valve
0253T	Insert aqueous drain device
11045	Deb subq tissue add-on
11046	Deb musc/fascia add-on
11047	Deb bone add-on
29914	Hip arthro w/femoroplasty
29915	Hip arthro acetabuloplasty
29916	Hip arthro w/labral repair
31295	Sinus endo w/balloon dil
31296	Sinus endo w/balloon dil
31297	Sinus endo w/balloon dil
31634	Bronch w/balloon occlusion
37204	Transcatheter occlusion
37210	Embolization uterine fibroid
37220	Iliac revasc
37221	Iliac revasc w/stent
37222	Iliac revasc add-on
37223	Iliac revasc w/stent add-on
43753	Tx gastro intub w/asp
43754	Dx gastr intub w/asp spec
43755	Dx gastr intub w/asp specs
43756	Dx duod intub w/asp spec
43757	Dx duod intub w/asp specs
49327	Lap ins device for rt
49418	Insert tun ip cath perc
50593	Perc cryo ablate renal tum
52649	Prostate laser enucleation
53860	Transurethral rf treatment
57156	Ins vag brachytx device
64566	Neuroeltrd stim post tibial
64568	Inc for vagus n elect impl
64569	Revise/repl vagus n eltrd
64570	Remove vagus n eltrd
64611	Chemodenerv saliv glands
65778	Cover eye w/membrane

65779	Cover eye w/membrane stent
66174	Translum dil eye canal
66175	Trnslum dil eye canal w/stnt
74176	Ct angio abd & pelvis
74177	Ct angio abd&pelv w/contrast
74178	Ct angio abd & pelv 1+ regns
76881	Us xtr non-vasc complete
76882	Us xtr non-vasc lmtd
C9274	Crotalidae Poly Immune Fab
C9275	Hexaminolevulinate HCl
C9276	Cabazitaxel injection
C9277	Lumizyme, 1 mg
C9278	Incobotulinumtoxin A
C9279	Injection, ibuprofen
J0515	Inj benztropine mesylate
J0597	C-1 esterase, berinert
J0638	Canakinumab injection
J0775	Collagenase, clost hist inj
J1290	Ecallantide injection
J1559	Hizentra injection
J1786	Imuglucerase injection
J2170	Mecasermin injection
J2358	Olanzapine long-acting inj
J2426	Paliperidone palmitate inj
J3095	Televancin injection
J3262	Tocilizumab injection
J3310	Perphenazine injeciton
J3350	Urea injection
J3357	Ustekinumab injection
J3385	Velaglucerase alfa
J7184	Wilate injection
J7196	Antithrombin recombinant
J7309	Methyl aminolevulinate, top
J7312	Dexamethasone intra implant
J7335	Capsaicin 8% patch
J8510	Oral busulfan
J8562	Oral fludarabine phosphate
J9265	Paclitaxel injection
J9302	Ofatumumab injection
J9307	Pralatrexate injection
J9315	Romidepsin injection
J9351	Topotecan injection
Q4118	Matristem micromatrix
Q4121	Theraskin

CY 2011 ASC PROCEDURES TO WHICH THE NO COST/FULL CREDIT AND PARTIAL CREDIT DEVICE ADJUSTMENT POLICY APPLIES

HCPCS Code	Short Descriptor	CY 2011 Device Offset Amount for No Cost/ Full Credit Case	CY 2011 Device Offset Amount for Partial Credit Case
24361	Reconstruct elbow joint	$5,103.59	$2,551.80
24363	Replace elbow joint	$5,103.59	$2,551.80
24366	Reconstruct head of radius	$5,103.59	$2,551.80
25441	Reconstruct wrist joint	$5,103.59	$2,551.80
25442	Reconstruct wrist joint	$5,103.59	$2,551.80
25446	Wrist replacement	$5,103.59	$2,551.80
27446	Revision of knee joint	$5,103.59	$2,551.80
33206	Insertion of heart pacemaker	$5,537.76	$2,768.88
33207	Insertion of heart pacemaker	$5,537.76	$2,768.88
33208	Insertion of heart pacemaker	$6,990.08	$3,495.04
33212	Insertion of pulse generator	$4,801.04	$2,400.52
33213	Insertion of pulse generator	$5,507.37	$2,753.69
33214	Upgrade of pacemaker system	$6,990.08	$3,495.04
33224	Insert pacing lead & connect	$7,756.83	$3,878.42
33225	Lventric pacing lead add-on	$7,756.83	$3,878.42
33240	Insert pulse generator	$20,680.31	$10,340.16
33249	Eltrd/insert pace-defib	$23,470.54	$11,735.27
33282	Implant pat-active ht record	$3,829.02	$1,914.51
53440	Male sling procedure	$4,306.23	$2,153.12
53444	Insert tandem cuff	$4,306.23	$2,153.12
53445	Insert uro/ves nck sphincter	$8,310.78	$4,155.39
53447	Remove/replace ur sphincter	$8,310.78	$4,155.39
54400	Insert semi-rigid prosthesis	$4,306.23	$2,153.12
54401	Insert self-contd prosthesis	$8,310.78	$4,155.39
54405	Insert multi-comp penis pros	$8,310.78	$4,155.39
54410	Remove/replace penis prosth	$8,310.78	$4,155.39
54416	Remv/repl penis contain pros	$8,310.78	$4,155.39
61885	Insrt/redo neurostim 1 array	$12,623.45	$6,311.73
61886	Implant neurostim arrays	$16,562.29	$8,281.15
62361	Implant spine infusion pump	$10,827.72	$5,413.86
62362	Implant spine infusion pump	$10,827.72	$5,413.86
63650	Implant neuroelectrodes	$2,620.26	$1,310.13
63655	Implant neuroelectrodes	$3,966.04	$1,983.02
63685	Insrt/redo spine n generator	$12,623.45	$6,311.73
64553	Implant neuroelectrodes	$2,620.26	$1,310.13
64555	Implant neuroelectrodes	$2,620.26	$1,310.13
64560	Implant neuroelectrodes	$2,620.26	$1,310.13
64561	Implant neuroelectrodes	$2,620.26	$1,310.13
64565	Implant neuroelectrodes	$2,620.26	$1,310.13

HCPCS Code	Short Descriptor	CY 2011 Device Offset Amount for No Cost/ Full Credit Case	CY 2011 Device Offset Amount for Partial Credit Case
64568	Inc for vagus n elect impl	$19,443.05	$9,721.53
64575	Implant neuroelectrodes	$3,966.04	$1,983.02
64577	Implant neuroelectrodes	$3,966.04	$1,983.02
64580	Implant neuroelectrodes	$3,966.04	$1,983.02
64581	Implant neuroelectrodes	$3,966.04	$1,983.02
64590	Insrt/redo pn/gastr stimul	$12,623.45	$6,311.73
69714	Implant temple bone w/stimul	$5,103.59	$2,551.80
69715	Temple bne implnt w/stimulat	$5,103.59	$2,551.80
69717	Temple bone implant revision	$5,103.59	$2,551.80
69718	Revise temple bone implant	$5,103.59	$2,551.80
69930	Implant cochlear device	$26,479.07	$13,239.54

CY 2011 DEVICES FOR WHICH THE "FB" OR "FC" MODIFIER MUST BE REPORTED WITH THE ASC 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