CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2378	**Date: December 29, 2011**
	Change Request 7682

SUBJECT: January 2012 Update of the Ambulatory Surgery Center Payment System (ASC)

I. SUMMARY OF CHANGES: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the January 2012 ASC payment system update. This Recurring Update Notification applies to chapter 14, section 10.

EFFECTIVE DATE: January 1, 2012
IMPLEMENTATION DATE: January 3, 2012

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) and/or Carriers:
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: 2378	Date: December 29, 2011	Change Request: 7682

SUBJECT: January 2012 Update of the Ambulatory Surgery Center Payment System (ASC)

EFFECTIVE DATE: January 1, 2012
IMPLEMENTATION DATE: January 3, 2012

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the January 2012 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).

Included in this notification are CY 2012 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 2012 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 reflect the most recent changes to CY 2012 MPFS payment.

B. Policy:

1. New Device Pass-Through Category and Device Offset from Payment

Additional payments may be made to the ASC for covered ancillary services, including certain implantable devices with pass-through status under the outpatient prospective payment system (OPPS). Section 1833(t)(6)(B) of the Social Security Act (the Act) requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that we create additional categories for transitional pass-through payment of new medical devices not described by current or expired categories of devices. This policy was implemented in the 2008 revised ASC payment system.

CMS is establishing one new HCPCS device pass-through category as of January 1, 2012 for the OPPS and the ASC payment systems. Table 1 below provides a listing of new coding and payment information concerning the new device category for transitional pass-through payment. HCPCS code C1886 (Catheter, extravascular tissue ablation, any modality (insertable)) is assigned ASC PI=J7 (OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced).

Table 1 – New Device Pass-Through Code

HCPCS	Short Descriptor	Long Descriptor	Payment Indicator Effective 1/1/2012
C1886	Catheter, ablation	Catheter, extravascular tissue ablation, any modality (insertable)	J7

a. Device Offset from Payment for Pass-Through HCPCS Code C1840 (Lens, intraocular (telescopic)

CMS has determined that it is able to identify a portion of the OPPS payment associated with the cost of HCPCS code C1840 for the insertion procedure described by new HCPCS code C9732 (Insertion of ocular telescope prosthesis including removal of crystalline lens). Therefore, ASC payment for the nondevice facility resources for the insertion procedure will be based upon the nondevice portion of the related OPPS payment weight for HCPCS code C9732. The ASC Code Pair File will be used to establish the reduced ASC payment amount for HCPCS code C9732 only when billed with HCPCS code C1840.

b. Billing Instructions for C9732 and C1840

Pass-through category C1840 (Lens, intraocular (telescopic)), is to be billed and paid for as a pass-through device only when provided with C9732 (Insertion of ocular telescope prosthesis including removal of crystalline lens) beginning on and after the effective date for C9732 of January 1, 2012.

2. New Procedure Codes

CMS is establishing two new HCPCS procedure codes effective January 1, 2012. The following table provides a listing of the descriptor and payment indicator for these new codes.

Table 2 – New HCPCS Procedure Codes

HCPCS	Effective Date	Short Descriptor	Long Descriptor	CY2012 PI
C9732	01-01-12	Insert ocular telescope pros	Insertion of ocular telescope prosthesis including removal of crystalline lens	G2
G0448	01-01-12	Place perm pacing cardiovert	Insertion or replacement of a permanent pacing cardioverter-defibrillator system with transvenous lead(s) single or dual chamber with insertion of pacing electrode, cardiac venous system, for left ventricular pacing	J8

3. Cardiac Resynchronization Therapy Payment for CY 2012

Effective for services furnished on or after January 1, 2012, cardiac resynchronization therapy involving an implantable cardioverter defibrillator (CRT-D) will be recognized as a single, composite service combining implantable cardioverter defibrillator procedures (described by CPT code 33249 (Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator)) and pacing electrode insertion procedures (described by CPT code 33225 (Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (including upgrade to dual chamber system))) when performed on the same date of service in an ASC. The payment rate for CRT-D services in ASCs will be based on the OPPS payment rate applicable to APC 0108 and ASCs will use the HCPCS Level II G-code G0448 (Insertion or replacement of a permanent pacing cardioverter-defibrillator system with transvenous lead(s) single or dual chamber with insertion of pacing electrode, cardiac venous system, for left ventricular pacing) for proper reporting when the procedures described by CPT codes 33225 and 33249 are performed on the same date of service. When these procedures are not performed on the same date of service, the ASC payment rate will be based on the standard APC assignment for each service and ASCs should report the appropriate CPT codes for the individual procedures.

4. Billing for Drugs, Biologicals, and Radiopharmaceuticals

a. Reporting HCPCS Codes for All Drugs, Biologicals, and Radiopharmaceuticals

ASCs are strongly encouraged to report charges for all separately payable drugs and biologicals, using the correct HCPCS codes for the items used. ASCs billing for these products must make certain that the reported units of service for the reported HCPCS codes are consistent with the quantity of the drug or biological that was used in the care of the patient. ASCs should not report HCPCS codes and separate charges for drugs and biologicals that receive packaged payment through the payment for the associated covered surgical procedure.

We remind ASCs that under the ASC payment system if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used in the care of the patient. The mixing together of two or more products does not constitute a "new" drug as regulated by the Food and Drug Administration (FDA) under the New Drug Application (NDA) process. In these situations, ASCs are reminded that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, Unclassified drug or biological, is for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned.

Unless otherwise specified in the long description, HCPCS descriptions refer to the non-compounded, FDA-approved final product. If a product is compounded and a specific HCPCS code does not exist for the compounded product, the ASC should include the charge for the compounded product in the charge for the surgical procedure performed. Instructions for downloading the ASC DRUG file updates are included in the business requirements section below. HCPCS payment updates are posted to the CMS website quarterly at: http://www.cms.gov/ASCPayment/11_Addenda_Updates.asp#TopOfPage

b. Drugs and Biologicals with Payment Based on Average Sales Price (ASP) Effective January 1, 2012

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, 2012, payment rates for many covered ancillary drugs and biologicals have changed from the values published in the CY 2012 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 2011. In cases where adjustments to payment rates are necessary, the updated payment rates will be incorporated in the January 2012 release of the ASC DRUG file. CMS is not publishing the updated payment rates in this Change Request implementing the January 2012 update of the ASC payment system. However, the updated payment rates effective January 1, 2012 for covered ancillary drugs and biologicals can be found in the January 2012 update of the ASC Addendum BB on the CMS Website.

c. New CY 2012 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

For CY 2012, several new HCPCS codes have been created for reporting drugs and biologicals in the ASC setting, where there have not previously been specific codes available. These new codes are listed in Table 3 below.

Table 3 – New CY 2012 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2012 HCPCS Code	CY 2012 Long Descriptor	CY 2012 P I
A9585	Injection gadobutrol, 0.1 ml	N1

C9287	Injection, brentuximab vedotin, 1 mg	K2
C9366	EpiFix, per square centimeter	K2
J0257	Injection, alpha 1 proteinase inhibitor (human), (glassia), 10 mg	K2
J7180	Injection, factor xiii (antihemophilic factor, human), 1 i.u.	K2
J7326	Hyaluronan or derivative, gel-one, for intra-articular injection, per dose	K2
J8561	Everolimus, oral, 0.25 mg	K2
Q4122	Dermacell, per square centimeter	K2

d. Other Changes to CY 2012 HCPCS for Certain Drugs, Biologicals, and Radiopharmaceuticals

Many HCPCS and CPT codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS and CPT code descriptors that will be effective in CY 2012. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2011 and replaced with permanent HCPCS codes in CY 2012. ASCs should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the active CY 2012 HCPCS and CPT codes.

Table 4 below notes those drugs, biologicals, and radiopharmaceuticals that have undergone changes in either their HCPCS codes, their long descriptors, or both. Each product's CY 2011 HCPCS code and CY 2011 long descriptor are noted in the two left hand columns, with the CY 2012 HCPCS code and long descriptor are noted in the adjacent right hand columns.

Table 4 – Other CY 2012 HCPCS Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2011 HCPCS Code	CY 2011 Long Descriptor	CY 2012 HCPCS Code	CY 2012 Long Descriptor
C9270	Injection, immune globulin (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg	J1557	Injection, immune globulin, (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg
C9272	Injection, denosumab, 1 mg	J0897	Injection, denosumab, 1 mg
C9273	Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion	Q2043*	Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion
C9274	Crotalidae Polyvalent Immune Fab (Ovine), 1 vial	J0840	Injection, crotalidae polyvalent immune fab (ovine), up to 1 gram
C9276	Injection, cabazitaxel, 1 mg	J9043	Injection, cabazitaxel, 1 mg
C9277	Injection, alglucosidase alfa (Lumizyme), 1 mg	J0221	Injection, alglucosidase alfa, (lumizyme), 10 mg
C9278**	Injection, incobotulinumtoxin A, 1 unit	J0588	Injection, incobotulinumtoxin A, 1 unit
Q2040**	Injection, incobotulinumtoxin A, 1 unit	J0588	Injection, incobotulinumtoxin A, 1 unit
C9280	Injection,eribulin mesylate, 1 mg	J9179	Injection, eribulin mesylate, 0.1 mg

CY 2011 HCPCS Code	CY 2011 Long Descriptor	CY 2012 HCPCS Code	CY 2012 Long Descriptor
C9281	Injection, pegloticase, 1 mg	J2507	Injection, pegloticase, 1 mg
C9282	Injection, ceftaroline fosamil, 10 mg	J0712	Injection, ceftaroline fosamil, 10 mg
C9283	Injection, acetaminophen, 10 mg	J0131	Injection, acetaminophen, 10 mg
C9284	Injection, ipilimumab, 1 mg	J9228	Injection, ipilimumab, 1 mg
C9365	Oasis Ultra Tri-Layer matrix, per square centimeter	Q4124	Oasis ultra tri-layer wound matrix, per square centimeter
C9406	Iodine I-123 ioflupane, diagnostic, per study dose, up to 5 millicuries	A9584	Iodine i-123 ioflupane, diagnostic, per study dose, up to 5 millicuries
J0220	Injection, alglucosidase alfa, 10 mg	J0220	Injection, alglucosidase alfa, 10 mg, not otherwise classified
J0256	Injection, alpha 1 - proteinase inhibitor - human, 10 mg	J0256	Injection, alpha 1 proteinase inhibitor (human), not otherwise specified, 10mg
J1561	'Injection, immune globulin, (Gamunex), intravenous, non-lyophilized (e.g. liquid), 500 mg	J1561	Injection, immune globulin, (Gamunex/Gamunex-c/Gammaked), non-lyophilized (e.g., liquid), 500 mg
Q2044	Injection, belimumab, 10 mg	J0490	Injection, belimumab, 10 mg
Q2042	Injection, hydroxyprogesterone caproate, 1 mg	J1725	Injection, hydroxyprogesterone caproate, 1 mg
J7130	Hypertonic saline solution, 50 or 100 meq, 20 cc vial	J7131	Hypertonic saline solution, 1 ml
Q2041	Injection, von willebrand factor complex (human), wilate, 1 i.u. vwf:rco	J7183	Injection, von willlebrand factor complex (human), wilate, 1 i.u. vwf:rco
Q1079	Ondansetron hydrochloride 8 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	Q0162	Ondansetron 1 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen

*HCPCS code Q2043 was effective July 1, 2011 ** HCPCS code C9278 was replaced with HCPCS code Q2040 effective April 1, 2011. HCPCS code Q2040 was subsequently replaced with HCPCS code J0588, effective January 1, 2012.

e. Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2011 through December 31, 2011

The payment rates for two HCPCS codes were incorrect in the October 2011 ASC Drug file. The corrected payment rates are listed in Table 5 below and have been included in the revised October 2011 ASC Drug file, effective for services furnished on October 1, 2011, through implementation of the January 2012 update.

Suppliers who think they may have received an incorrect payment between October 1, 2011, and December 31, 2011, may request contractor adjustment of the previously processed claims.

Table 5 – Updated payment Rates for Certain HCPCS Codes Effective October 1, 2011 through December 31, 2011

HCPCS Code	Short Descriptor	Corrected Payment Rate
J9600	Porfimer sodium injection	$19,143.46
Q4121	Theraskin	$20.77

f. Correct Reporting of Biologicals When Used As Implantable Devices

When billing for a biological for which the HCPCS code describes a separately payable pass-through product that is only surgically implanted or inserted, 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.

ASCs are reminded that HCPCS codes describing skin substitutes (Q4100 – Q4130) should only be reported when used with one of the CPT codes describing application of a skin substitute (15271-15278). These Q codes for skin substitutes should not be billed when used with any other procedure besides the skin substitute application procedures.

5. ASC Quality Measures

In Transmittal 934, issued August 1, 2011, CMS announced that the G codes tied to the M5 PI indicator would be effective 1/1/2012. CMS intends to include these HCPCS and further clarification in the April 2012 ASC quarterly update.

6. Billing for Thermal Anal Lesions by Radiofrequency Energy

For CY 2012, the CPT Editorial Panel created new CPT code 0288T (Anoscopy, with delivery of thermal energy to the muscle of the anal canal (eg, for fecal incontinence)) to describe the procedure associated with radiofrequency energy of thermal anal lesions. Prior to CY 2012, this procedure was described by HCPCS code C9716 (Creations of thermal anal lesions by radiofrequency energy). In Addendum B of the CY 2012 OPPS/ASC final rule, both HCPCS code C9716 and 0288T were assigned to specific APCs. Specifically, HCPCS code C9716 was assigned to APC 0150 (Level IV Anal/Rectal Procedures) and CPT code 0288T was assigned to APC 0148 (Level I Anal/Rectal Procedures). Because HCPCS code C9716 is described by CPT

code 0288T, we are deleting HCPCS code C9716 on December 31, 2011, since it will be replaced with CPT code 0288T effective January 1, 2012. In addition, we are reassigning CPT code 0288T from APC 0148 to APC 0150 effective January 1, 2012. Table 6 below lists the final ASC payment indicator for HCPCS codes C9716 and 0288T. The ASCPI file will reflect this deletion with PI=D5 for C9716 effective 1/1/2012.

Table 6. – CY 2012 ASC Payment Indicator for HCPCS Codes C9716 and 0288T

HCPCS Code	Short Descriptor	CY 2012 PI
C9716	Radiofrequency energy to anu	D5
0288T	Anoscopy w/rf delivery	G2

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

For CY 2012, 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 A, 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 B, below, and the associated implantation procedure code is listed in Attachment A. In addition, contractors will reduce the payment for implantation procedures listed in Attachment A 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 B, the ASC must append the modifier "FC" to the associated implantation procedure code if the procedure is listed in Attachment A. 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.

8. Coverage Determinations

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

9. Attachments

Three 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: **CY2012 ASC COVERED SURGICAL PROCEDURES AND ANCILLARY SERVICES THAT ARE NEWLY PAYABLE IN ASCs**

Attachment B**: CY 2012 ASC PROCEDURES TO WHICH THE NO COST/FULL CREDIT AND PARTIAL CREDIT DEVICE ADJUSTMENT POLICY APPLIES**

Attachment C: **CY 2012 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	
7682.1	Contractors shall download the January 2012 ASCFS from the CMS mainframe. FILENAME: MU00.@BF12390.ASC.CY12.FS.JAN.R.V1230 **NOTE: The January 2012 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.** **NOTE: Date of retrieval will be provided in a separate email communication from CMS**	X			X						All EDCs
7682.2	Contractors shall modify the procedure code file and TOS tables for HCPCS codes 77424, 77425, C1886, C9728, and C9732 for DOS on/after January 1, 2012 **NOTE: Attachment A lists all CY2012 newly payable ASC covered surgical and ancillary services. HCPCS codes 77424, 77425, C1886, C9728, and C9732 do not appear on the 2012 HCPCS file with the YY designation.**	X			X						All EDCs
7682.2.1	CWF shall assign TOS F for HCPCS codes 77424, 77425, C1886, C9728, and C9732 for claims with DOS on and after January 1, 2012.									X	
7682.3	Contractors and CWF, as appropriate, shall remove the TOS F records for HCPCS J2265, Q4123, Q4125, Q4126, Q4127, Q4128, Q4129 to prevent claims from incorrectly processing as ASC approved services for DOS on/after January 1, 2012	X			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: Codes J2265, Q4123, Q4125, Q4126, Q4127, Q4128 and Q4129 were incorrectly listed in the 2012 HCPC file with a YY ASC indicator. These codes are not valid ASC codes.										
7682.4	Medicare contractors shall download and install the January 2012 ASC DRUG file. FILENAME: MU00.@BF12390.ASC.CY12.DRUG.JAN.R.V1221 **NOTE: Date of retrieval will be provided in a separate email communication from CMS**	X			X						All EDCs
7682.5	Medicare contractors shall download and install the January 2012 ASC PI file. FILENAME: MU00.@BF12390.ASC.CY12.PI.JAN.R.V1230 **NOTE: Date of retrieval will be provided in a separate email communication from CMS.**	X			X						All EDCs
7682.6	Medicare contractors shall download and install a revised October 2011 ASC DRUG file. FILENAME: MU00.@BF12390.ASC.CY11.DRUG.OCT.R.V1221 **NOTE: Date of retrieval will be provided in a separate email communication from CMS**	X			X						All EDCs
7682.7	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service on or after October 1, 2011 and ; 2) Were originally processed prior to the installation of the revised October 2011 ASC DRUG File.	X			X						COBC
7682.8	Medicare contractors shall download and utilize the January 2012 ASC CODE PAIR file to perform maintenance required to create the code audit(s).	X			X						All EDCs COBC

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	
	FILENAME: MU00.@BF12390.ASC.CY12.CPAIR.JAN.R.V1223 **NOTE: Date of retrieval will be provided in a separate email communication from CMS**										
7682.8.1	For procedure codes processed to payment with the ASC Code Pair file, contractors shall use the following messages: Medicare Summary Notice (MSN) 30.1 – The approved amount is based on a special payment method. Claim Adjustment Reason Code 59 - Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	X			X						All EDCs COBC
7682.9	Contractors shall deny claims when both CPT 33249 and CPT 33225 are billed on the same date of service beginning with DOS January 1, 2012	X			X						All EDCs COBC
7682.9.1	Contractors shall use CARC #231 when denying these services. The message is as follows: Mutually exclusive procedures cannot be done in the same day/setting. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present." Medicare Summary Notice (MSN) 18.18 - Medicare does not pay for this service separately since payment of it is included in our allowance for other services you received on the same day.	X			X						All EDCs COBC
7682.10	Contractors shall end date C9716 in their systems effective December 31, 2011.	X			X					X	All EDCs COBC
7682.11	Contractors shall make January 2012 ASCFS fee data	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	
	for their ASC payment localities available on their web sites.										

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	
7682.12	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:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
7682.2	Attachment A

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

Attachment A: CY2012 ASC COVERED SURGICAL PROCEDURES AND ANCILLARY SERVICES THAT ARE NEWLY PAYABLE IN ASCs

Attachment B**:** CY 2012 ASC PROCEDURES TO WHICH THE NO COST/FULL CREDIT AND PARTIAL CREDIT DEVICE ADJUSTMENT POLICY APPLIES

Attachment C: CY 2012 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 *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or 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 3

Attachment A

CY2012 ASC COVERED SURGICAL PROCEDURES AND ANCILLARY SERVICES THAT ARE NEWLY PAYABLE IN ASCs

CY 2012 HCPCS	CY 2012 Short Descriptor	CY 2012 Long Descriptor
15271	Skin sub graft trnk/arm/leg	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area
15272	Skin sub graft t/a/l add-on	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)
15273	Skin sub grft t/arm/lg child	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children
15274	Skn sub grft t/a/l child add	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15275	Skin sub graft face/nk/hf/g	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area
15276	Skin sub graft f/n/hf/g addl	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)
15277	Skn sub grft f/n/hf/g child	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children
15278	Skn sub grft f/n/hf/g ch add	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)
15777	Acellular derm matrix implt	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk) (List separately in addition to code for primary procedure)
20527	Inj dupuytren cord w/enzyme	Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)

26341	Manipulat palm cord post inj	Manipulation, palmar fascial cord (ie, Dupuytren's cord), post enzyme injection (eg, collagenase), single cord
29582	Apply multlay comprs upr leg	Application of multi-layer venous wound compression system, below knee; thigh and leg, including ankle and foot, when performed
29583	Apply multlay comprs upr arm	Application of multi-layer venous wound compression system, below knee; upper arm and forearm
29584	Appl multlay comprs arm/hand	Application of multi-layer venous wound compression system, below knee; upper arm, forearm, hand, and fingers
33221	Insert pulse gen mult leads	Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular with existing multiple leads
33227	Remove&replace pm gen singl	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system
33228	Remv&replc pm gen dual lead	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system
33229	Remv&replc pm gen mult leads	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system
33230	Insrt pulse gen w/dual leads	Insertion of single or dual chamber pacing cardioverter-defibrillator pulse generator only; with existing dual leads
33231	Insrt pulse gen w/mult leads	Insertion of single or dual chamber pacing cardioverter-defibrillator pulse generator only; with existing multiple leads
33262	Remv&replc cvd gen sing lead	Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; single lead system
33263	Remv&replc cvd gen dual lead	Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; dual lead system
33264	Remv&replc cvd gen mult lead	Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; multiple lead system
37201	Transcatheter therapy infuse	Transcatheter therapy, infusion for thrombolysis other than coronary
37202	Transcatheter therapy infuse	Transcatheter therapy, infusion other than for thrombolysis, any type (eg, spasmolytic, vasoconstrictive)
37207	Transcath iv stent open	Transcatheter placement of an intravascular stent(s), (non-coronary vessel), open; initial vessel
37208	Transcath iv stent/open addl	Transcatheter placement of an intravascular stent(s), (non-coronary vessel), open; each additional vessel (list separately in addition to code for primary procedure)
38232	Bone marrow harvest autolog	Bone marrow harvesting for transplantation; autologous
49082	Abd paracentesis	Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance
49083	Abd paracentesis w/imaging	Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance
49084	Peritoneal lavage	Peritoneal lavage, including imaging guidance, when performed
59074	Fetal fluid drainage w/us	Fetal fluid drainage (eg, vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance

62369	Anal sp inf pmp w/reprg&fill	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill
62370	Anl sp inf pmp w/mdreprg&fil	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring physician's skill)
64633	Destroy cerv/thor facet jnt	Destruction by neurolytic agent, paravertebral facet joint nerve(s); cervical or thoracic, single facet joint
64634	Destroy c/th facet jnt addl	Destruction by neurolytic agent, paravertebral facet joint nerve(s); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)
64635	Destroy lumb/sac facet jnt	Destruction by neurolytic agent, paravertebral facet joint nerve(s); lumbar or sacral, single facet joint
64636	Destroy l/s facet jnt addl	Destruction by neurolytic agent, paravertebral facet joint nerve(s); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)
74174	Ct angio abd&pelv w/o&w/dye	Computed tomographic angiography, abdomen and pelvis; with contrast material(s), including noncontrast images, if performed, and image postprocessing
78226	Hepatobiliary system imaging	Hepatobiliary system imaging, including gallbladder when present
78227	Hepatobil syst image w/drug	Hepatobiliary system imaging, including gallbladder when present with pharmacologic intervention, including quantitative measurement(s) when performed
78579	Lung ventilation imaging	Pulmonary ventilation imaging (eg, aerosol or gas)
78582	Lung ventilat&perfus imaging	Pulmonary ventilation (eg, aerosol or gas) and perfusion imaging
78597	Lung perfusion differential	Quantitative differential pulmonary perfusion, including imaging when performed
78598	Lung perf&ventilat diferentl	Quantitative differential pulmonary perfusion and ventilation (eg, aerosol or gas), including imaging when performed
0282T	Periph field stimul trial	Percutaneous or open implantation of neurostimulator electrode array(s), subcutaneous (peripheral subcutaneous field stimulation), including imaging guidance, when performed, cervical, thoracic or lumbar; for trial, including removal at the conclusion of trial period
0283T	Periph field stimul perm	Percutaneous or open implantation of neurostimulator electrode array(s), subcutaneous (peripheral subcutaneous field stimulation), including imaging guidance, when performed, cervical, thoracic or lumbar; permanent, with implantation of a pulse generator
0284T	Periph field stimul revise	Revision or removal of pulse generator or electrodes, including imaging guidance, when performed, including addition of new electrodes, when performed
0288T	Anoscopy w/rf delivery	Anoscopy, with delivery of thermal energy to the muscle of the anal canal (eg, for fecal incontinence)

0301T	Mw therapy for breast tumor	Destruction/reduction of malignant breast tumor with externally applied focused microwave, including interstitial placement of disposable catheter with combined temperature monitoring probe and microwave focusing sensocatheter under ultrasound thermotherapy guidance
A9584	Iodine i-123 ioflupane	Iodine i-123 ioflupane, diagnostic, per study dose, up to 5 millicuries
C1886	Catheter, ablation	Catheter, extravascular tissue ablation, any modality (insertable)
C9287	Inj, brentuximab vedotin	Injection, brentuximab vedotin, 1 mg
C9366	EpiFix wound cover	EpiFix, per square centimeter
C9732	Insert ocular telescope pros	Insertion of ocular telescope prosthesis including removal of crystalline lens
G0365	Vessel mapping hemo access	Vessel mapping of vessels for hemodialysis access (services for preoperative vessel mapping prior to creation of hemodialysis access using an autogenous hemodialysis conduit, including arterial inflow and venous outflow)
G0448	Place perm pacing cardiovert	Insertion or replacement of a permanent pacing cardioverter-defibrillator system with transvenous lead(s) single or dual chamber with insertion of pacing electrode, cardiac venous system, for left ventricular pacing
J0131	Acetaminophen injection	Injection, acetaminophen, 10 mg
J0221	Lumizyme injection	Injection, alglucosidase alfa, (lumizyme), 10 mg
J0257	Glassia injection	Injection, alpha 1 proteinase inhibitor (human), (glassia), 10 mg
J0490	Belimumab injection	Injection, belimumab, 10 mg
J0588	Incobotulinumtoxin a	Injection, incobotulinumtoxin A, 1 unit
J0712	Ceftaroline fosamil inj	Injection, ceftaroline fosamil, 10 mg
J0840	Crotalidae poly immune fab	Injection, crotalidae polyvalent immune fab (ovine), up to 1 gram
J0897	Denosumab injection	Injection, denosumab, 1 mg
J1557	Gammaplex injection	Injection, immune globulin, (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg
J1725	Hydroxyprogesterone caproate	Injection, hydroxyprogesterone caproate, 1 mg
J2507	Pegloticase injection	Injection, pegloticase, 1 mg
J7180	Factor XIII anti-hem factor	Injection, factor xiii (antihemophilic factor, human), 1 i.u.
J7183	Wilate injection	Injection, von willlebrand factor complex (human), wilate, 1 i.u. vwf:rco
J7326	Gel-one	Hyaluronan or derivative, gel-one, for intra-articular injection, per dose
J8561	Oral everolimus	Everolimus, oral, 0.25 mg
J9043	Cabazitaxel injection	Injection, cabazitaxel, 1 mg
J9179	Eribulin mesylate injection	Injection, eribulin mesylate, 0.1 mg
J9228	Ipilimumab injection	Injection, ipilimumab, 1 mg

Q4122	Dermacell	Dermacell, per square centimeter
Q4124	Oasis tri-layer wound matrix	Oasis ultra tri-layer wound matrix, per square centimeter

Attachment B

CY 2012 ASC PROCEDURES TO WHICH THE NO COST/FULL CREDIT AND PARTIAL CREDIT DEVICE ADJUSTMENT POLICY APPLIES

CPT Code	Short Descriptor	CY 2012 Device Offset Amount for No Cost/ Full Credit Case	CY 2012 Device Offset Amount for Partial Credit Case
0282T	Periph field stimul trial	$2,446.18	$1,223.09
0283T	Periph field stimul perm	$20,927.71	$10,463.86
24361	Reconstruct elbow joint	$5,704.94	$2,852.47
24363	Replace elbow joint	$5,704.94	$2,852.47
24366	Reconstruct head of radius	$5,704.94	$2,852.47
25441	Reconstruct wrist joint	$5,704.94	$2,852.47
25442	Reconstruct wrist joint	$5,704.94	$2,852.47
25446	Wrist replacement	$5,704.94	$2,852.47
27446	Revision of knee joint	$5,704.94	$2,852.47
33206	Insertion of heart pacemaker	$5,594.14	$2,797.07
33207	Insertion of heart pacemaker	$5,594.14	$2,797.07
33208	Insertion of heart pacemaker	$7,126.42	$3,563.21
33212	Insertion of pulse generator	$4,829.70	$2,414.85
33213	Insertion of pulse generator	$5,412.94	$2,706.47
33214	Upgrade of pacemaker system	$7,126.42	$3,563.21
33221	Insert pulse gen mult leads	$5,412.94	$2,706.47
33224	Insert pacing lead & connect	$7,126.42	$3,563.21
33225	Lventric pacing lead add-on	$7,126.42	$3,563.21
33227	Remove&replace pm gen singl	$4,829.70	$2,414.85
33228	Remv&replc pm gen dual lead	$5,412.94	$2,706.47
33229	Remv&replc pm gen mult leads	$5,412.94	$2,706.47
33230	Insrt pulse gen w/dual leads	$21,295.23	$10,647.62
33231	Insrt pulse gen w/mult leads	$21,295.23	$10,647.62
33240	Insert pulse generator	$21,295.23	$10,647.62
33249	Eltrd/insert pace-defib	$25,747.79	$12,873.90

CPT Code	Short Descriptor	CY 2012 Device Offset Amount for No Cost/ Full Credit Case	CY 2012 Device Offset Amount for Partial Credit Case
33262	Remv&replc cvd gen sing lead	$21,295.23	$10,647.62
33263	Remv&replc cvd gen dual lead	$21,295.23	$10,647.62
33264	Remv&replc cvd gen mult lead	$21,295.23	$10,647.62
33282	Implant pat-active ht record	$4,105.54	$2,052.77
53440	Male sling procedure	$4,508.35	$2,254.17
53444	Insert tandem cuff	$4,508.35	$2,254.17
53445	Insert uro/ves nck sphincter	$8,371.17	$4,185.59
53447	Remove/replace ur sphincter	$8,371.17	$4,185.59
54400	Insert semi-rigid prosthesis	$4,508.35	$2,254.17
54401	Insert self-contd prosthesis	$8,371.17	$4,185.59
54405	Insert multi-comp penis pros	$8,371.17	$4,185.59
54410	Remove/replace penis prosth	$8,371.17	$4,185.59
54416	Remv/repl penis contain pros	$8,371.17	$4,185.59
61885	Insrt/redo neurostim 1 array	$13,053.24	$6,526.62
61886	Implant neurostim arrays	$17,636.31	$8,818.16
62361	Implant spine infusion pump	$10,968.52	$5,484.26
62362	Implant spine infusion pump	$10,968.52	$5,484.26
63650	Implant neuroelectrodes	$2,446.18	$1,223.09
63655	Implant neuroelectrodes	$3,985.92	$1,992.96
63663	Revise spine eltrd perq aray	$2,446.18	$1,223.09
63664	Revise spine eltrd plate	$2,446.18	$1,223.09
63685	Insrt/redo spine n generator	$13,053.24	$6,526.62
64553	Implant neuroelectrodes	$2,446.18	$1,223.09

CPT Code	Short Descriptor	CY 2012 Device Offset Amount for No Cost/ Full Credit Case	CY 2012 Device Offset Amount for Partial Credit Case
64555	Implant neuroelectrodes	$2,446.18	$1,223.09
64561	Implant neuroelectrodes	$2,446.18	$1,223.09
64565	Implant neuroelectrodes	$2,446.18	$1,223.09
64568	Implant neuroelectrodes	$20,927.71	$10,463.86
64575	Implant neuroelectrodes	$3,985.92	$1,992.96
64580	Implant neuroelectrodes	$3,985.92	$1,992.96
64581	Implant neuroelectrodes	$3,985.92	$1,992.96
64590	Insrt/redo pn/gastr stimul	$13,053.24	$6,526.62
69714	Implant temple bone w/stimul	$5,704.94	$2,852.47
69715	Temple bne implnt w/stimulat	$5,704.94	$2,852.47
69717	Temple bone implant revision	$5,704.94	$2,852.47
69718	Revise temple bone implant	$5,704.94	$2,852.47
69930	Implant cochlear device	$24,250.95	$12,125.47

Attachment C

CY 2012 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

CY 2012 Device HCPCS Code	CY 2012 Short Descriptor
C1721	AICD, dual chamber
C1722	AICD, single chamber
C1762	Conn tiss, human(inc fascia)
C1763	Conn tiss, non-human
C1764	Event recorder, cardiac
C1767	Generator, neurostim, imp
C1771	Rep dev, urinary, w/sling
C1772	Infusion pump, programmable
C1776	Joint device (implantable)
C1777	Stent, non-coat/cov w/o del
C1778	Lead, neurostimulator
C1779	Lead, pmkr, transvenous VDD
C1781	Mesh (implantable)
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
C1895	Lead, AICD, endo dual coil
C1897	Lead, neurostim, test kit
C1898	Lead, pmkr, other than trans
C1900	Lead coronary venous
C2618	Probe, cryoablation
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

CY 2012 Device HCPCS Code	CY 2012 Short Descriptor
L8690	Aud osseo dev, int/ext comp