Hospital Regulatory Update 2014

The Outpatient Prospective Payment System (OPPS) is not intended to be a fee schedule, in which separate payment is made for each coded line item. However, the OPPS is currently a prospective payment system that packages some items and services, but not others. CMS' overarching goal is to make payments for all services covered under OPPS more consistent with those of a prospective payment system and less like those of a per-service fee schedule. For CY 2014, CMS will again base payments on geometric mean costs. Under this methodology, claims are selected for services paid under the OPPS and matched to the most recent cost report filed by the individual hospitals represented in the claims data.

CMS estimates that total payments, including the beneficiary cost-share, to the approximately 4,100 facilities paid under OPPS will be approximately $50.4 billion in CY 2014, an increase of just over $4 billion compared to CY 2013 payments. Outpatient hospital payment rates will increase by 1.7 percent and CMS will continue the statutory 2.0 percentage point reduction in payments for hospitals that fail to meet the hospital outpatient quality reporting (OQR) requirements. The CY 2013 conversion factor of $71.313 increases to $72.672 with the 1.7 percent increase, but for hospitals that fail to meet the OQR requirements, the conversion factor will drop to $71.219 in 2014.

CMS will also continue the policy of providing additional payments to cancer hospitals so that the hospitals' payment-to-cost ratio, with the adjustment, is equal to the weighted average for the other OPPS hospitals. And last, CMS will continue to make an outlier payment that equals 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment amount when both the 1.75 multiple threshold and the final fixed dollar threshold of $2,900 are met.

Packaging Update

Effective in CY 2014, CMS will unconditionally or conditionally package the following five categories of items and services:

- Drugs, biologicals, and radiopharmaceuticals used in a diagnostic test or procedure
- Drugs and biologicals when used as supplies in a surgical procedure
- Certain clinical diagnostic laboratory tests
- Procedures described by add-on codes
- Device removal procedures.

However, CMS added that given the frequency of drug administration services in the hospital outpatient department and their use in such a wide variety of different drug treatment protocols for various diseases in all types of hospitals, further study of the payment methodology for these services is warranted at this time. Therefore, CMS did not finalize the proposal to package drug administration add-on codes for CY 2014.

In order to improve the accuracy and transparency of payment for certain device-dependent services, CMS is finalizing the policy to establish 29 comprehensive APCs to prospectively pay for the most costly hospital outpatient device-dependent services, but will delay the implementation of this policy until CY 2015. A comprehensive APC, by definition, will provide a single payment that includes the primary service and all adjunct services performed to support the delivery of the primary service. For services that trigger a comprehensive APC payment, the comprehensive APC will treat all individually reported codes on the claim as representing components of the comprehensive service, resulting in a single prospective payment for the comprehensive service. Hospitals will continue to report procedure codes for all services performed, but will receive a single payment for the total service. According to the 2014 final OPPS rule:

Typically beneficiaries understand the primary procedure to be the OPPS service they receive, and do not generally consider that the other HCPCS codes are separate services. For example, beneficiaries believe that a single service includes procedures such as "getting my gall bladder removed" or "getting a pacemaker." We believe that defining certain services within OPPS in terms of a single comprehensive service delivered to the beneficiary improves transparency for the beneficiary, for physicians, and for hospitals by creating a common reference point with similar meaning for all three groups and using the comprehensive service concept that already identifies these same services when they are performed in an inpatient environment.

In addition to services currently packaged, CMS intends to include ancillary services (status indicator X), certain clinical diagnostic laboratory tests, and drugs that function as supplies when used in a surgical procedure. CMS agrees that hospitals should have time to prepare for a comprehensive payment structure, and the delay in implementation until CY 2015 will allow more

time to operationalize the changes necessary to process comprehensive payments. CMS will also take advantage of this delay to request additional public comments on this packaging methodology.

Hospital Clinic Visit

Since April 7, 2000, CMS has instructed hospitals to report facility resources for clinic and emergency department hospital outpatient visits using the CPT evaluation and management (E/M) codes and to develop internal hospital guidelines for reporting the appropriate visit level. Because there was no national set of hospital visit guidelines, CMS has traditionally stated that internal guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the codes. Citing difficulty with the development of national guidelines, accommodating a variety of patient populations and service mix, no single approach to facility visit coding has been evident. According to the 2014 Final Rule:

While we agree that the proposed clinic APC encompasses a range of visits for beneficiaries with different medical issues, we believe that the spectrum of hospital resources provided during an outpatient hospital clinic visit is appropriately captured and reflected in the single level payment for clinic visits. We also believe that a single visit code is consistent with a prospective payment system, where payment is based on an average estimated relative cost for the service, although the cost of individual cases may be more or less costly than the average.

We continue to believe discontinuing the use of the five levels of HCPCS visit codes for clinic visits will reduce hospitals' administrative burden by eliminating the need for them to develop and apply for their own internal guidelines to differentiate among five levels of resource use for every clinic visit they provide... We note that the level of CPT® code is not the only method for assessing patient acuity. Diagnosis coding and the type and frequency of other services billed on a visit claim also communicate patient acuity.

As a result, CMS has finalized its proposal to replace the current five levels of visit codes for hospital technical clinic visits with a single new Level II HCPCS code representing a single level of payment for clinic visits:

- **G0463**: Hospital outpatient clinic visit for assessment and management of a patient.

This visit code will be reported for new patients and established patients and is assigned to new APC 0634 with a payment rate based on the total mean costs of Level 1 through Level 5 clinic visit codes.

Supervision

CMS has established that direct supervision is required for hospital outpatient therapeutic services covered and paid by Medicare in hospitals, as well as in provider-based departments of hospitals. In the 2010 OPPS rule, CMS finalized a technical correction to the title and text of the applicable regulations (42 CFR 410.27) to clarify that this supervision standard applies in Critical Access Hospitals (CAHs), as well as other hospitals. In response to concerns expressed by CAHs and small rural community hospitals that they would have difficulty meeting this standard, CMS instructed all Medicare contractors not to evaluate or enforce the supervision requirements for therapeutic services provided to outpatients in CAHs while the agency revisited the supervision policy during future rulemaking cycles.

In subsequent calendar years, the OPPS Panel met to consider and advise CMS regarding stakeholder requests for changes in the required level of supervision of individual hospital outpatient therapeutic services. Based on the panel's recommendations, CMS has modified supervision requirements to shift some services to a general supervision requirement. Most comments received on the 2014 proposed rule requested that CMS continue to extend the enforcement of direct supervision or even develop policies exempting CAHs and small rural hospitals from the requirement for direct supervision, citing insufficient staff and difficulty in recruiting physicians and nonphysician practitioners. These commenters believe that if enforced, the CAHs will have to limit their hours of operation for chemotherapy, other intravenous infusions, and radiation oncology.

Effective Jan. 1, 2013, CMS accepted recommendations of the OPPS Panel on Supervision Levels for Select Services. The agency states that it intends to adopt recommendations from the OPPS Panel to update the supervision level of the following oncology services to general supervision:[1]

- **36000:** Introduction of needle or intracatheter, vein.
- **36591:** Collection of blood specimen from a completely implantable venous access device.
- **36592:** Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified.
- **96360:** Intravenous infusion, hydration; initial, 31 minutes to 1 hour.
- **96361:** Intravenous infusion, hydration; each additional hour.
- **96521:** Refilling and maintenance of portable pump.
- **96523:** Irrigation of implanted venous access device for drug delivery systems.

In the 2014 OPPS final rule, CMS states that it continues to believe that direct supervision is the appropriate level of supervision for most hospital outpatient therapeutic services. As a result, effective Jan. 1, 2014, the instruction for Medicare contractors to not enforce supervision requirements in CAHs or small rural hospitals will expire. This means that all hospitals, including CAHs and small rural hospitals, may only provide chemotherapy, therapeutic drug administration, and radiation therapy when all direct supervision requirements are met, including the immediate availability of a qualified physician or nonphysician practitioner who is able to provide assistance and direction, clinically appropriate to redirect the service or provide additional orders.

Scope of Practice

Under current policy, CMS generally defers to hospitals to ensure that state scope of prac-

tice and other state rules relating to healthcare delivery are followed, such that these services are performed only by qualified personnel in accordance with all applicable laws and regulations. After consideration of public comments received, CMS is amending the conditions of payment for therapeutic "incident-to" hospital (including CAH) outpatient services to explicitly require that individuals furnishing these services be in compliance with state law. It is important to note that this final policy does not impose any new requirements on hospitals that bill Medicare because practitioners and other personnel furnishing services already are required to comply with the laws of the state in which the services are furnished. This regulatory change simply adopts the existing requirements as a condition of payment under Medicare. The 2014 OPPS rule adds:

Codifying this requirement provides the Federal government with a clear basis to deny Medicare payment when services are not furnished in accordance with applicable State law, as well as to ensure that Medicare pays for services furnished to beneficiaries only when the services meet the requirements imposed by the States to regulate health care delivery for the health and safety of their citizens.

Off-Campus Provider-Based Departments

In the CY 2014 proposed rule, CMS solicited comments regarding a potential new claims modifier or other data element that would designate services furnished in an off-campus provider-based department. According to CMS, research literature and popular press have documented the increased trend toward hospital acquisition of physician practices, integration of those practices as a department of the hospital, and the resulting increase in the delivery of physician services in a hospital setting. When a Medicare beneficiary receives outpatient services in a hospital, the total payment amount for outpatient services made by Medicare is generally higher than the total payment amount made by Medicare when a physician furnishes those same services in a freestanding clinic or in a physician's office. CMS received a number of comments and recommendations regarding methods for collecting detailed information and stated that it will continue to consider approaches to collecting data on services furnished in off-campus provider-based departments.

Quality Measures & EHRs

CMS also adopted four new quality measures for the Hospital Outpatient Quality Reporting (OQR) Program CY 2016 payment determinations. Three of these measures will require the collection of aggregate data (numerators, denominators, and exclusions) and submission via an online web-based tool located on the CMS website. The other hospital acquired infection quality measure will be submitted through the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network. Last, two quality measures will be removed and administrative procedures will be codified.

CMS is also revising regulations to provide a special method for making hospital-based determinations for 2014 only in the cases of those eligible professionals (EPs) who reassign their benefits to Method II CAHs. Previously, CMS has been unable to make electronic health record payments to these EPs for their CAH II claims, or to take those claims into consideration in making hospital-based determinations because of system limitation.

Radiation Oncology Services

CMS previously proposed to conditionally package all codes assigned the ancillary service status indicator "X" for CY 2014. Conditional packaging meant that if a service with an X status was reported on the same service date as a significant procedure, the X status code would not be separately reimbursed. However, after a review of public comments received, CMS has decided not to conditionally package all of these codes, which included simulations and a number of other radiation oncology services. However, the agency indicated that these ancillary services would be reviewed in future years to determine which may be appropriate for packaging.

CMS also indicated a concern with hospital pricing for several different services, including the high-dose rate (HDR) brachytherapy source billed for each brachytherapy treatment. According to the 2014 OPPS rule:

As we have stated in previous OPPS/ASC proposed and final rules, we agree that HDR brachytherapy sources such as HDR Iridium-192 have a fixed active life and must be replaced every 90 days. As a result, hospitals' per-treatment cost for the source would be dependent on the number of treatments furnished per source. The source cost must be amortized over the life of the source. Therefore, when establishing their charges for HDR Iridium-192, we expect hospitals to project the number of treatments that would be provided over the life of the source and establish their charges for the source accordingly. After consideration of public comments we received, we are finalizing our proposal to continue to set the payment rates for brachytherapy sources using our established prospective payment methodology, which is based on geometric mean costs.

This means that hospitals should ensure that charges for procedure code **C1717** (brachytherapy source, high-dose rate Iridium 192, per source) accurately reflect cost of the reusable source for each patient treatment.

Beginning in CY 2008, CMS began providing a single payment allowance under a Composite APC for low-dose rate (LDR) prostate brachytherapy. At least two procedure codes are used to report the composite treatment service because there are separate codes that describe placement of the needles (code **55875**, transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy) and the application of the brachytherapy (code **77778**, interstitial radiation source application, complex). These codes are generally present together on claims for the same date of service and the same operative session. For CY 2014, CMS will continue to pay for LDR prostate brachytherapy using Composite APC 8001, with a geometric mean cost of approximately $3,858.

Beginning in CY 2014, CMS will conditionally or unconditionally package certain procedures described by an add-on code. According to CMS, procedures described by add-on codes represent an extension or continuation of a primary procedure, which means that they are typically supportive, dependent, or adjunctive to a primary service. The primary code defines the purpose and typical scope of the patient encounter and the add-on code describes incremental work. As a result, the following new code will be packaged when billed by the hospital:

- **+77293:** Respiratory motion management simulation. (List separately in addition to code for primary procedure.)

This means that the hospital will report the add-on code with the correct primary procedure (code **77295**, 3D radiation planning, or code **77301**, IMRT computer planning), but there will be no separate payment for this service.

Effective Jan. 1, 2012, two new procedure codes were added for intraoperative radiation treatment delivery. Code **77424** describes a single treatment by X-ray (photons) and code **77425** describes a single treatment by electrons. For CY 2014, these codes will remain in **APC 0065**, but the APC will be renamed "IORT, MRgFUS, and MEG" with an estimated payment rate of $1,715. In the 2014 proposed rule, CMS noted that both of these codes include the placement and removal of an applicator into the breast, as well as the delivery of radiation therapy. Numerous comments were received, including statements that HCPCS code **C9726** (placement and removal of applicator into breast for radiation therapy) represented the cost of the applicator and hospital costs related to the surgeon's placement of the applicator. Based on the comments received, CMS will not delete this HCPCS code; however, the code will be redefined as "Placement and removal (if performed) of applicator into breast for intraoperative radiation therapy, add-on to primary breast procedure." In addition, this will be an add-on code for which payment is packaged into the reimbursement for the primary procedure. As a result, hospitals will continue to report this code, but there will be no separate reimbursement for this procedure.

Since CY 2007, there have been both HCPCS Level II codes and CPT procedure codes for stereotactic radiosurgery (SRS) and SBRT treatment. According to the OPPS final rule:

However, SRS techniques and equipment have evolved and expanded over time. In light of these developments and our understanding of current SRS technology and clinical practice, we have reexamined the HCPCS G-codes and CPT codes for SRS with the intent of identifying the codes that would best capture the significant differences between the various procedures while eliminating unnecessary complexity, redundancy, and outdated distinctions that no longer represent meaningful distinctions for purposes of OPPS payment. Based on our review of the current SRS technology, we understand that most current linac-based SRS technology incorporates some type of robotic feature. Therefore we believe that it is no longer necessary to continue to distinguish robotic versus non-robotic linac-based SRS through the HCPCS G-codes.

CMS added that they intend to refrain from creating supplemental HCPCS G-codes or C-codes that describe attributes of a particular device under the assumption of more precise coding. Of importance, the agency does not want to risk unintentionally creating a competitive advantage for a particular technology through the establishment of codes that may not be based on the most complete understanding of the clinical science of treatment delivery.

As a result, CMS replaced the HCPCS Level II G-codes (**G0173**, **G0251**, **G0339**, and **G0340**) with CPT procedure codes effective Jan. 1, 2014. The status indicators for the HCPCS codes have been updated to B (alternative code may be available) since the Medicare Physician Fee Schedule (PFS) may continue to use these codes in a "carrier priced" capacity. In response to comments received, CMS provided the following coding guidance for the replacement CPT codes **77371**, **77372**, and **77373**:

CPT code **77371** *is to be used only for single session cranial SRS cases performed with a Cobalt-60 device, and CPT code* **77372** *is to be used only for single session cranial SRS cases performed with a linac-based device. The term "cranial" means that the pathological lesion(s) that are the target of the radiation is located in the patient's cranium or head. The term "single session" means that the entire intracranial lesion or lesions that comprise the patient's diagnosis are treated in their entirety during a single treatment session on a single day.*

CPT code **77372** *is never to be used for the first fraction or any other fraction of fractionated treatment. CPT code* **77372** *is to be used only for single session cranial linac-based SRS treatment. Fractionated SRS treatment is an SRS delivery service requiring more than a single session of SRS treatment for a cranial lesion, up to a total of no more than five fractions, and one to five fractions (but no more than five) for non-cranial lesions.*

CPT code **77373** *is to be used for any fraction (including the first fraction) in any series of fractionated treatments, regardless of the anatomical location of the lesion or lesions being radiated. Fractionated cranial SRS treatment is any cranial SRS delivery service that exceeds one treatment session and fractionated non-cranial SRS treatment is any non-cranial SRS delivery service, regardless of the number of fractions, but never more than five. Therefore, CPT code* **77373** *is the exclusive code (and the use of no other SRS treatment delivery code is permitted) for any and all fractionated SRS treatment services delivered anywhere in the body, including but not limited to, the cranium or head.*

In addition, CMS has assigned code **77371** (radiation treatment delivery, SRS, complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt-60 based) and **77372** (radiation treatment delivery, SRS, complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based) to **APC 0067**, which has been renamed "Level II Stereotactic Radiosurgery."

Procedure code **77373** is assigned to **APC 0066**, which is now titled "Level I Stereotactic Radiosurgery." In response to questions regarding single fraction treatment, CMS stated that it believes the high degree of clinical similarity for the Cobalt-60 and linac-based treatments support grouping these services together.

Medical Oncology & Hematology Services

Based on the OPPS final rule for CY 2014, payment for the acquisition and pharmacy overhead costs of separately payable drugs and biologicals that do not have pass-through status will be set at the statutory default of average sales price (ASP) plus 6 percent. According to CMS, the ASP+6 percent payment amount for separately payable drugs and biologicals requires no further adjustment and represents the combined acquisition and pharmacy overhead payment for drugs and biologicals for CY 2014. In addition, CMS finalized the proposed policy to continue to establish payment rates for blood and blood products using a blood-specific cost-to-charge methodology.

Section 1833 of the Social Security Act permits CMS to make pass-through payments for a period of at least two, but not more than three, years after the product's first payment as a hospital outpatient service under Medicare Part B. The long-standing practice has been to provide pass-through payment for a period of two to three years, with expiration of pass-through status proposed and finalized through the annual rulemaking process. CMS included a list of the drugs for which pass-through status expired on Dec. 31, 2013, in the final rule (see Table 3, page 20).

In addition to drugs and biologicals with expired pass-through status, other medications and substances were approved for pass-through during CY 2014. Payment for drugs and biologicals with pass-through status under the OPPS is currently made at

the physician's office payment rate of ASP+6 percent. If ASP data are not available for a radiopharmaceutical, CMS will provide pass-through payment at wholesale acquisition cost (WAC)+6 percent. And, if WAC information is also not available, CMS will provide payment for the pass-through radiopharmaceutical at 95 percent of its more recent average wholesale price (AWP). Table 4 (page 21) shows the drugs and biologicals that will continue or have been granted pass-through status as of January 2014.

Under the comprehensive service APCs that will be effective for CY 2015, drugs supplied to the patient to fill the reservoir of a pump at the time of pump implantation will be considered adjunctive to the procedure. As reviewed on page 16, costs of costly adjunctive services will be included proportionally into the cost estimation for the primary service. CMS confirmed that drugs used to fill pumps at the time of a comprehensive pump insertion procedure will be considered to be ancillary and supportive to the primary procedure and packaged as part of the comprehensive APC payment regardless of whether the drug was previously packaged within the OPPS payment, was previously separately paid under the OPPS, or was previously paid according to a Durable Medical Equipment fee schedule.

Ambulatory Surgical Center Update

For CY 2014, CMS is increasing payment rates under the Ambulatory Surgical Center (ASC) payment system by 1.2 percent. The final ASC conversion factor for ASCs that meet all quality reporting requirements is $43.471 and for ASCs that do not meet the quality reporting requirements, the conversion factor is $42.612. Based on this update, CMS estimates that total payments to ASCs in CY 2014, including beneficiary cost-share, will be approximately $3.992 billion. This represents an increase of about $143 million compared to CY 2013 payments.

CMS received no comments on the proposal to update the ASC list of ancillary services to reflect the proposed payment status for the same services under the OPPS in CY 2014. For example, a covered ancillary service that was separately paid under the revised ASC payment system in CY 2013 may be proposed for packaged status under CY 2014 OPPS and, therefore, also under the ASC payment system for CY 2014. In the absence of public comments, CMS is finalizing, without modification, the proposal to update the ASC list of covered ancillary services to reflect the payment status for the same services under the OPPS.

For the Ambulatory Surgical Center Quality Reporting (ASCQR) Program, CMS is adopting three new quality measures for the CY 2016 payment determination. Aggregate data (numerators, denominators, and exclusions) will be collected on all ASC patients for these four chart-abstracted measures via an online web tool located on a CMS website. Effective for CY 2016, ASCs will also be required to establish a QualityNet account and security administrator, facility participation, a minimum threshold, and minimum volume for claims-based measures, and data collection

Table 3. Drugs & Biologicals with a Pass-Through Status that Expired Dec. 31, 2013

CY 2014 HCPCS CODE	CY 2014 LONG DESCRIPTOR	CY 2014 STATUS INDICATOR	CY 2014 APC
A9584	Iodine I-123 ioflupane, diagnostic, per study dose, up to 5 millicuries	**N**	**N/A**
C9285	Lidocaine 70 mg/tetracaine 70 mg, per patch	**N**	**9285**
J0131	Injection, acetaminophen, 10 mg	**N**	**9283**
J0485	Injection, belatacept, 1 mg	**K**	**9286**
J0490	Injection, belimumab, 10 mg	**K**	**1353**
J0638	Injection, canakinumab, 1 mg	**K**	**1311**
J0712	Injection, ceftaroline fosamil, 10 mg	**N**	**9282**
J1572	Injection, immune globulin, (flebogamma/flebogamma dif),intravenous, non-lyophilized (e.g., liquid), 500 mg	**K**	**0947**
J2507	Injection, pegloticase, 1 mg	**K**	**9281**
J7180	Injection, factor xiii (antihemophilic factor, human), 1 i.u.	**K**	**1416**
J9042	Injection, brentuximab vedotin, 1 mg	**K**	**9287**
J9179	Injection, eribulin mesylate, 0.1 mg	**K**	**1426**
J9228	Injection, ipilimumab, 10 mg	**K**	**9284**
Q4124	Oasis Ultra Tri-Layer matrix, per square centimeter	**N**	**9365**

and submission for new measures and for certain previously finalized measures. OI

References

1. CMS. CMS' Final Decisions on the August 2012 Recommendations of the Hospital Outpatient Payment Panel on Supervision Levels for Select Services. Available online at: *www.cms.gov/Regulations-and-Guidance/Guidance/FACA/Downloads/2012-Aug-Final-Supervision-Decisions.pdf.* Last accessed Dec. 3, 2013.

Table 4. Drugs & Biologicals with Pass-Through Status in CY 2014

CY 2013 HCPCS CODE	CY 2014 HCPCS CODE	CY 2014 LONG DESCRIPTOR	CY 2014 STATUS INDICATOR	CY 2014 APC
C1204	A9520	Technetium Tc 99m tilmanocept, diagnostic, up to 0.5 millicuries	G	1463
C9130	J1556	Injection, immune globulin (Bivigam), 500 mg	G	9130
C9131	J9354	Injection, ado-trastuzumab emtansine, 1 mg	G	9131
C9132	C9132	Prothrombin complex concentrate (human), KCentra, per i.u. of Factor IX activity	G	9132
C9290	C9290	Injection, bupivicaine liposome, 1 mg	G	9290
C9292	J9306	Injection, pertuzumab, 1 mg	G	9292
C9293	C9293	Injection, glucarpidase, 10 units	G	9293
C9294	J3060	Injection, taliglucerase alfa, 10 units	G	9294
C9295	J9047	Injection, carfilzomib, 1 mg	G	9295
C9296	J9400	Injection, ziv-aflibercept, 1 mg	G	9296
C9297	J9262	Injection, omacetaxine mepesuccinate, 0.01 mg	G	9297
C9298	J7316	Injection, ocriplasmin, 0.125 mg	G	9298
N/A	C9133	Factor ix (antihemophilic factor, recombinant) Rixubus, per i.u.	G	1467
N/A	C9441	Injection, ferric carboxymaltose, 1 mg	G	9441
N/A	C9497	Loxapine, inhalation powder, 10 mg	G	9497
N/A	J7508	Tacrolimus, Extended Release, Oral, 0.1 mg	G	1465
N/A	J9371	Injection, Vincristine Sulfate Liposome, 1 mg	G	1466
J0178	J0178	Injection, aflibercept, 1 mg vial	G	1420
J0716	J0716	Injection, centruroides (scorpion) immune f(ab)2, up to 120 mg	G	1431
J7315	J7315	Mitomycin, ophthalmic, 0.2 mg	G	1448
J9019	J9019	Injection, asparaginase (erwinaze), 1000 i.u.	G	9289
Q4122	Q4122	Dermacell, per square centimeter	G	1419
Q4127	Q4127	Talymed, per square centimeter	G	1449
Q4131	Q4131	Epifix, per square centimeter	G	9366
Q4132	Q4132	Grafix core, per square centimeter	G	9368
Q4133	Q4133	Grafix prime, per square centimeter	G	9369