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MLN Matters Number: MM6095 **Related Change Request (CR) #: 6095**

Related CR Release Date: June 20, 2008 **Effective Date: July 1, 2008**

Related CR Transmittal #: R1540CP **Implementation Date: July 7, 2008**

July 2008 Update to the Ambulatory Surgical Center (ASC) Payment System; Summary of Payment Policy Changes

Provider Types Affected

Providers (ASCs) who submit claims to Medicare Administrative Contractors (A/B MACs) and carriers, for services provided to Medicare beneficiaries paid under the ASC payment system.

Provider Action Needed

This article is based on Change Request (CR) 6095 which describes changes to, and billing instructions for, payment policies implemented in the July 2008 ASC update. This update provides updated payment rates for selected separately payable drugs and biologicals, descriptors for newly created Level II Healthcare Common Procedure Coding System (HCPCS) codes for drugs and biologicals, and payment rates and descriptors for three newly created Category III Common Procedural Terminology (CPT) codes that are added to the list of payable procedures. Code deletions are also identified in this notification. Be sure billing staff is aware of these changes.

Key Points of CR6095

Billing for Drugs and Biologicals

The Centers for Medicare & Medicaid Services (CMS) strongly encourages ASCs to report charges for all separately payable drugs and biologicals, using the correct HCPCS codes for the items used. ASCs billing for these products should make certain that the reported units of service of the reported HCPCS code 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.

Remember that under the Outpatient Prospective Payment System (OPPS), 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 report an appropriate unlisted code such as J9999 or J3490.

Drugs and Biologicals with Payment Based on Average Sales Price (ASP) Effective July 1, 2008

- Payments for separately payable drugs and biologicals based on the ASP will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates for previous quarter(s) are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the July 2008 release of the ASC DRUG FILE.
- Your Medicare contractors will make available to the ASCs the list of any newly added codes and previous quarter payment rate changes as identified in CR6095.
- Providers take note that, if your claims were processed prior to the installation of the revised January or April 2008 ASC Drug file, your Medicare AB/MAC or carrier will adjust, as appropriate, claims you bring to their attention that have dates of service on or after January 1, 2008 but prior to July 1, 2008.

New HCPCS Drugs and Biologicals Separately Payable under the ASC Payment System Effective July 1, 2008

The four HCPCS codes that are newly payable in ASCs and their descriptors are listed in Table 1 below.

Table 1

New Drugs and Biologicals Separately Payable under the ASC Payment System as of July 1, 2008

HCPCS Code	Short Descriptor
C9242	Injection, fosaprepitant
C9356	TendoGlide Tendon Prot, cm2
C9357	Flowable Wound Matrix, 1 cc
C9358	SurgiMend, per 0.5cm2

The payment rates for these drugs in Table 1 are included in the July 2008 update of the ASC Addendum BB which will be posted at the end of June at http://www.cms.gov/ASCPayment/04_CMS-1517-F.asp .

No HCPCS codes are being deleted from the ASC DRUG file for July 2008.

Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2008 through March 31, 2008

The payment rates for several HCPCS codes were incorrect in the January 2008 ASC DRUG file. The corrected payment rates are listed below in Table 2 and have been included in the revised January 2008 ASC DRUG file, effective for services furnished on January 1, 2008 through March 31, 2008. Your Medicare contractor will adjust Claims affected by these corrections if you bring such claims to their attention.

Table 2

Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2008, through March 31, 2008

HCPCS	Short Descriptor	ASC Payment Indicator	Corrected Payment Rate
90675	Rabies vaccine, im	K2	150.27
J2820	Sargramostim injection	K2	25.02
J9010	Alemtuzumab injection	K2	549.29
J9015	Aldesleukin/single use vial	K2	764.56
J9226	Supprelin LA implant	K2	14694.12

Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2008 through June 30, 2008

The payment rates for several HCPCS codes were incorrect in the April 2008 ASC DRUG file. The corrected payment rates are listed below in Table Three and have been corrected in the revised April 2008 ASC DRUG file effective for services furnished on April 1, 2008 through June 30, 2008. Your Medicare contractor will adjust Claims affected by these corrections if you bring such claims to their attention.

Table 3

Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2008 through June 30, 2008

HCPCS	Short Descriptor	ASC Payment Indicator	Corrected Payment Rate
J2323	Natalizumab injection	K2	7.51
J2778	Ranibizumab inj	K2	406.18
J3350	Urea Injection	K2	23.23
J3488	Reclast injection	K2	216.61

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 full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor.

- For example, if the drug's HCPCS code descriptor specifies 6 mg, and 6 mg of the drug were administered to the patient, the units billed should be 1.
- As another example, if the drug's HCPCS descriptor specifies 50 mg and 200 mg of the drug were administered to the patient, the units billed should be 4.
- ASCs should not bill the units based on how 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, 10 units should be reported on the bill, even though only 1 vial was administered.

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.

Payment for Brachytherapy Sources as of July 1, 2008

The Medicare, Medicaid, and SCHIP Extension Act of 2007 requires CMS to pay for brachytherapy sources for the period of January 1 through June 30, 2008 at hospitals' charges adjusted to costs. Consistent with CMS policy to pay ASCs at contractor-priced rates if prospective OPPS rates are not available for brachytherapy sources, for the period January 1 through June 30, 2008, ASCs are paid at contractor-priced rates for these sources. The prospective payment rates for each source, which are listed in Addendum BB to CMS CY 2008 final rule dated November 27, 2007, will be used for payment from July 1 through December 31, 2008. These payment rates are also included in the revised ASCFS effective for dates of service beginning July 1, 2008. The "H7" payment indicators assigned to brachytherapy source HCPCS codes in the April 2008 Addendum BB on the CMS website will change to "H2" to reflect the policy to pay for brachytherapy sources at prospectively determined rates, as in Addendum BB published with the CY 2008 OPPS/ASC final rule with comment period.

The HCPCS codes for separately payable brachytherapy sources, long descriptors, and payment indicators for CY 2008 are listed in Table 4 below.

Note that when billing for stranded sources, providers should bill the number of units of the appropriate source HCPCS C-code according to the number of brachytherapy sources in the +

will be available in Addendum BB posted on the CMS website at the end of June.

Table 4

Comprehensive List of Brachytherapy Sources Payable as of July 1, 2008

CPT/ HCPCS	Short Descriptor	Payment Indicator
A9527	Iodine I-125 sodium iodide	H2
C1716	Brachytx, non-str, Gold-198	H2
C1717	Brachytx, non-str, HDR Ir-192	H2
C1719	Brachytx, NS, Non-HDRIr-192	H2
C2616	Brachytx, non-str, Yttrium-90	H2
C2634	Brachytx, non-str, HA, I-125	H2
C2635	Brachytx, non-str, HA, P-103	H2
C2636	Brachy linear, non-str,P-103	H2
C2638	Brachytx, stranded, I-125	H2
C2639	Brachytx, non-stranded, I-125	H2
C2640	Brachytx, stranded, P-103	H2
C2641	Brachytx, non-stranded, P-103	H2

CPT/ HCPCS	Short Descriptor	Payment Indicator
C2642	Brachytx, stranded, C-131	H2
C2643	Brachytx, non-stranded,C-131	H2
C2698	Brachytx, stranded, NOS	H2
C2699	Brachytx, NOS	H2

Category III CPT Codes

CMS is implementing three new Category III CPT Codes that are appropriate for payment in ASCs, effective July 1, 2008. The new Category III codes and their ASC payment indicators are shown in Table 5 below. Payment rates for these services can be found in Addendum AA of the July 2008 ASC Update that will be posted on the CMS Web site at the end of June. These new Category III CPT codes and their payment rates are included in the July release of the ASC Fee Schedule.

Table 5

Category III CPT Codes Implemented as ASC Covered Surgical Procedures as of July 1, 2008

HCPCS	Short Descriptor	SI
0190T	Place intraoc radiation src	G2
0191T	Insert ant segment drain int	G2
0192T	Insert ant segment drain ext	G2

ASC Payment for Office-Based Procedures and Radiology Services

ASC payment for office-based procedures and radiology services are made at the lesser of the non facility practice expense (PE) relative value units (RVU) amount under the Medicare Physician Fee Schedule or the ASC rate for the service calculated according to the standard ASC methodology. The provisions of Section 109(b) of the Medicare, Medicaid and SCHIP Extension Act of 2007 expire after June 30, 2008 and, therefore, the MPFS payment rates for July 1 through December 31, 2008 will be those issued by CMS in the MPFS final rule (72 FR 66410). The changes to those rates result in changes to rates for some covered office-based surgical procedures and covered ancillary radiology services paid under the ASC payment system.

Beginning July 1, 2008, ASC payment amounts for office-based procedures and radiology services will be equal to the rates displayed in Addenda AA and BB to the OPPS/ASC final rule with comment period (72 FR 66945 and 67165) and will be included in Addenda AA and BB

that will be posted on the CMS website at the end of June. These revised rates are included in the July release of the ASCFS

Additional Information

To see the official instruction (CR6095) issued to your Medicare Carrier or A/B MAC visit http://www.cms.gov/Transmittals/downloads/R1540CP.pdf . Your Medicare contractor will make the July 2008 ASC fee schedule data for their localities available on their website.

If you have questions, please contact your Medicare Carrier or A/B MAC at their toll-free number which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html .