CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1740	**Date: MAY 22, 2009**
	Change Request 6496

NOTE: Transmittal 1740, dated May 22, 2009 is being re-communicated to correct the file name in Business Requirement (BR) 6496.4 of the attachment. The Transmittal Number, Date Issued and all other information remain the same.

Subject: July 2009 Update to the ASC Payment System; Summary of Payment Policy Changes

I. SUMMARY OF CHANGES: This Recurring Update Notification describes changes to, and billing instructions for, payment policies implemented in the July 2009 ASC payment system update. In this Change Request (CR), we are issuing instructions to contractors to modify their systems to accept the July 2009 ASCFS, the July 2009 ASC PI file, and the updated January and July ASC DRUG files and to ensure that the updated files properly interface with all other ASC module programming. This RUN applies to IOM Chapter 14.

New / Revised Material
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

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

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1740	Date: May 22, 2009	Change Request: 6496

NOTE: Transmittal 1740, dated May 22, 2009 is being re-communicated to correct the file name in Business Requirement (BR) 6496.4 of the attachment. The Transmittal Number, Date Issued and all other information remain the same.

SUBJECT: July 2009 Update to the ASC Payment System; Summary of Payment Policy Changes

Effective Date: July 1, 2009

Implementation Date: July 6, 2009

I. GENERAL INFORMATION

A. Background:

This Recurring Update Notification describes changes to, and billing instructions for, payment policies implemented in the July 2009 ASC payment system update. Final policy under the revised ASC payment system, as set forth in Medicare Program; Revised Payment System Policies for Services Furnished in Ambulatory Surgical Centers (ASCs), beginning in CY 2008, (72 FR 42470), requires that ASC payment rates for covered separately payable drugs and biologicals be consistent with the payment rates under the Medicare hospital outpatient prospective payment system (OPPS). Those rates are updated quarterly. Therefore, beginning with Transmittal 1488, (CR 5994) issued April 9, 2008, CMS has issued quarterly updates to ASC payment rates for separately paid drugs and biologicals. CMS also updates the lists of covered surgical procedures and covered ancillary services to include newly created HCPCS codes, as appropriate. This instruction provides the new HCPCS codes for 12 separately payable drugs and biologicals and two new Category III CPT codes for surgical procedures that will be added to the ASC list of covered surgical procedures effective July 1, 2009.

The policies related to the CMS updates to the ASC payment system are included in the 2008 ASC payment system instructions: Transmittal 1325 (CR5680), issued August 29, 2007, Transmittal 1415 (CR5885), issued January 18, 2008 and Transmittal 1616 (CR6184), issued October 17, 2008.

In this Change Request (CR), we are issuing instructions to contractors to modify their systems to accept the July 2009 ASCFS, the July 2009 ASC PI file, and the updated January and July ASC DRUG files and to ensure that the updated files properly interface with all other ASC module programming. The July 2009 ASC PI file and the January and July 2009 ASC DRUG files are full replacement files and the July 2009 ASCFS file contains only changes. The drug files include payment rates for all separately payable drugs and biologicals and the ASC PI file includes the payment indicators for payable and non-payable ASC services.

B. Policy:

1. Billing for Drugs and Biologicals

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.

Updated drug payment rates effective July 1, 2009 are included in the July 1, 2009 updated ASC Addendum BB that will be posted on the CMS Web site at the end of June.

Instructions for downloading the ASC DRUG file updates are included in the business requirements section below.

a. **New HCPCS Drug and Biological Codes that are Separately Payable under the ASC Payment System as of July 1, 2009**

Twelve new HCPCS drug codes have been created that are payable for dates of service on or after July 1, 2009. The new HCPCS codes, the long descriptors, and payment indicators (PIs) are identified in Table 1 below. These new separately payable drug and biological codes and their payment rates are included in the July ASC DRUG file.

Table 1- New Drugs and Biologicals Separately Payable under the ASC Payment System Effective July 1, 2009.

HCPCS	Long Descriptor	P I
C9250	Human plasma fibrin sealant, vapor-heated, solvent-detergent (Artiss), 2ml	K2
C9251	Injection, C1 esterase inhibitor (human), 10 units	K2
C9252	Injection, plerixafor, 1 mg	K2
C9253	Injection, temozolomide, 1 mg	K2
C9360	Dermal substitute, native, non-denatured collagen, neonatal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters	K2
C9361	Collagen matrix nerve wrap (NeuroMend Collagen Nerve Wrap), per 0.5 centimeter length	K2
C9362	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Strip),	K2

	per 0.5 cc	
C9363	Skin substitute, Integra Meshed Bilayer Wound Matrix, per square centimeter	K2
C9364	Porcine implant, Permacol, per square centimeter	K2
Q2023	Injection, factor viii (antihemophilic factor, recombinant) (Xyntha), per i.u.	K2
Q4115	Skin substitute, Alloskin, per square centimeter	K2
Q4116	Skin substitute, Alloderm, per square centimeter	K2

b. Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2009 through March 31, 2009

The payment rates for several HCPCS codes were incorrect in the January 2009 ASC DRUG file. The corrected payment rates are listed in Table 3 below and have been included in the revised January 2009 ASC DRUG file, effective for services furnished on January 1, 2009, through March 31, 2009. Suppliers who think they may have received an incorrect payment between January 1, 2009 and March 31, 2009 may voluntarily submit claims to their contractors for reprocessing.

Table 3-Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2009 through March 31, 2009

HCPCS Code	Short Descriptor	Payment Indicator	Corrected Payment Rate
J1441	Filgrastim 480 mcg injection	K2	$304.27
J1740	Ibandronate sodium injection	K2	$136.35
J2505	Injection, pegfilgrastim 6mg	K2	$2,135.12
J7513	Daclizumab, parenteral	K2	$341.09

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

ASCs are not to bill separately for drug and biological HCPCS codes when using these items as implantable devices (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures. As under the OPPS, ASCs are provided a packaged payment for surgical procedures that includes the cost of supportive items, including implantable devices without pass-through status. When using drugs and biologicals during covered surgical procedures as implantable devices, ASCs may include the charges for these items in their charge for the procedure.

d. 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 code descriptor specifies 50 mg, but 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. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

2. Category III CPT Codes

The AMA releases Category III CPT codes in January for implementation the following July 1, and in July, for implementation January 1 of the following year. As discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66834), we adopted a policy to implement through the July ASC quarterly update, the Category III codes that the AMA releases each January for implementation the following July 1, to ensure timely collection of data pertinent to the services described by the codes; to ensure patient access to the services the codes describe; and to eliminate potential redundancy between Category III CPT codes and some of the C-codes that are payable under the ASCFS as a result of their creation by CMS in response to applications for new technology services under the OPPS.

Therefore, we are implementing two new Category III CPT codes that we have determined are appropriate for payment in ASCs, effective July 1, 2009. The new Category III codes and their ASC payment indicators are shown in Table 4 below. Payment rates for these services can be found in the July 2009 updated ASC Addendum AA 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 ASCFS.

Table 4- Category III CPT Codes Implemented as ASC Covered Surgical Procedures as of July 1, 2009

HCPCS	Long Descriptor	P I
0200T	Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device (if utilized), one or more needles	G2
0201T	Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device (if utilized), two or more needles	G2

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	
6496.1	Medicare contractors shall download and install the July 2009 ASC DRUG file FILENAME: MU00.@BF12390.ASC.CY09.DRUG.JUL.G.V0623 **Date of retrieval will be provided in a separate email communication from CMS**	X			X						
6496.2	Medicare contractors shall download and install a revised January 2009 ASC DRUG file FILENAME: MU00.@BF12390.ASC.CY09.DRUG.JAN.G.V0623 **Date of retrieval will be provided in a separate email communication from CMS**	X			X						
6496.3	Medicare contractors shall download and install the July 2009 ASC PI file FILENAME: MU00.@BF12390.ASC.CY09.IND.V0623 **Date of retrieval will be provided in a separate email communication from CMS**	X			X						
6496.4	Medicare contractors shall download and install the July 2009 ASCFS file FILENAME: MU00.@BF12390.ASC.CY09.FS.V0616 **Date of retrieval will be provided in a separate email communication from CMS**	X			X						
6496.5	Contractors shall assign TOS F to HCPCS codes 0200T, 0201T, C9250, C9251, C9252, C9253, C9360, C9361, C9362, C9363,	X			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	
	C9364, Q2023, Q4115, and Q4116 for claims with DOS on or after July 1, 2009.										
6496.6	Contractors shall adjust, as appropriate, claims brought to their attention with the following HCPCS codes J1441, J1740, J2505, J7513, for claims with DOS on or after January 1, 2009 but before April 1, 2009.	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6496.7	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X			X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

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): Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs)*:

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.