



**News Flash** – As a result of the Affordable Care Act (ACA), claims with dates of service on or after January 1, 2010, received later than one calendar year beyond the date of service will be denied by Medicare. For full details, see the MLN Matters® article, MM6960, at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6960.pdf> on the Centers for Medicare & Medicaid Services website.

MLN Matters® Number: MM7008 **Revised**

Related Change Request (CR) #: 7008

Related CR Release Date: June 25, 2010

Effective Date: July 1, 2010

Related CR Transmittal #: R1991CP

Implementation Date: July 6, 2010

## July 2010 Update to the Ambulatory Surgical Center (ASC) Payment System

**Note:** This article was updated on December 7, 2012, to reflect current Web addresses. This article was previously revised to reflect a new Change Request (CR) that was released on June 25, 2010. The new CR added information on the payment indicator adjustment for HCPCS 90670 (page 3) and corrected the Long Descriptor for C9264 (page 4). The transmittal number, CR release date and web address for the CR was also changed. All other information remains the same.

### Provider Types Affected

Providers (ASCs) submitting claims payable under the Ambulatory Surgical Center (ASC) Payment System to Medicare contractors (carriers and Medicare Administrative Contractors (MAC)) for services provided to Medicare beneficiaries are affected.

### Provider Action Needed

This article, based on Change Request (CR) 7008, which is a Recurring Update Notification that describes changes to, and billing instructions for, payment policies implemented in the July 2010 ASC payment system update. You should note that this instruction provides information on eight newly created Healthcare Common Procedure Coding System (HCPCS) codes that will be added to the ASC list of

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covered surgical procedures and seven newly created HCPCS codes that will be added to the ASC list of covered ancillary services effective July 1, 2010.

Also, CR 7008 notes that the payment rates for three HCPCS codes (C9258, C9262, and J1540) were incorrect in the April 2010 ASC DRUG file. Medicare contractors will adjust as appropriate claims for these three HCPCS codes brought to their attention that have dates of service on or after April 1, 2010 through July 1, 2010, and were originally processed prior to the installation of the revised April 2010 ASC DRUG File. Ensure that your billing staffs are aware of this update.

## Background

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CR 7008 describes changes to, and billing instructions for, payment policies implemented in the July 2010 ASC payment system update. Final policy under the revised ASC payment system 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 in April 9, 2008, the Centers for Medicare & Medicaid Services (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. CR 7008 provides information on eight newly created HCPCS codes that will be added to the ASC list of covered surgical procedures and seven newly created HCPCS codes that will be added to the ASC list of covered ancillary services effective July 1, 2010.

### *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.

ASCs are reminded 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.

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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 quarterly at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html> on the CMS website.

***New HCPCS Codes for Drugs and Biologicals that are Separately Payable under the ASC Payment System Effective July 1, 2010***

Seven new HCPCS codes have been created for drugs that are payable as covered ancillary services for dates of service on and after July 1, 2010. The new HCPCS codes, the long descriptors, the short descriptors, and payment indicators are identified in Table 1 below. The new separately payable drug and biological codes and their payment rates are included in the July 2010 ASC DRUG file.

**Table 1- New Drugs and Biologicals Separately Payable under the ASC Payment System Effective July 1, 2010**

| HCPCS Code | Long Descriptor   | Short Descriptor              | Payment Indicator Effective 7/1/10 |
|------------|---|-------------------------------|------------------------------------|
| C9264      | Injection, tocilizumab, 1 mg  | Tocilizumab injection         | K2                                 |
| C9265      | Injection, romidepsin, 1 mg   | Romidepsin injection          | K2                                 |
| C9266      | Injection, collagenase clostridium histolyticum, 0.1 mg                       | Collagenase clostridium histo | K2                                 |
| C9267      | Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO | Injection, Wilate             | K2                                 |
| C9268      | Capsaicin, patch, 10cm2   | Capsaicin patch               | K2                                 |
| C9367      | Skin substitute, Endoform Dermal Template, per square centimeter              | Endoform Dermal Template      | K2                                 |
| Q2025*     | Fludarabine phosphate, oral, 1 mg   | Oral Fludarabine phosphate    | K2                                 |

\* C9262 is discontinued after June 30, 2010, and replaced by Q2025 effective July 1, 2010.

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### ***Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2010 through June 30, 2010***

The payment rates for three HCPCS codes were incorrect in the April 2010 ASC DRUG file. The corrected payment rates are listed in Table 2 below and have been included in the revised April 2010 ASC DRUG file effective for services furnished on April 1, 2010 through implementation of the July 2010 update. Suppliers who think they may have received an incorrect payment between April 1, 2010 and June 30, 2010 may request their Medicare contractor to adjust the previously processed claims.

**Table 2-Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2010 through June 30, 2010**

| HCPCS Code | Short Descriptor            | ASC Payment Rate | ASC PI |
|------------|-----------------------------|------------------|--------|
| C9258      | Telavancin injection        | \$2.12           | K2     |
| C9262      | Fludarabine phosphate, oral | \$8.18           | K2     |
| J1540      | Gamma globulin 9 CC inj     | \$141.64         | K2     |

### ***Adjustment to Payment Indicator for HCPCS Code 90670 Effective April 1, 2010***

Effective April 1, 2010, the payment for HCPCS code 90670 (Pneumococcal conjugate vaccine, 13 valent, for intramuscular use) will change from ASC PI=Y5 (non-surgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made) to ASC PI=K2 (Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate). The payment rate effective April 1, 2010, is \$106.70. Suppliers who think they may have received an incorrect payment determination between April 1, 2010, and June 30, 2010, may request contractor adjustment of the previously processed claims.

### ***New Category III Current Procedural Terminology (CPT) Codes that are Separately Payable under the ASC Payment System Effective July 1, 2010***

Seven new Category III CPT codes have been created for payable surgical procedures that are payable for dates of service on and after July 1, 2010. The new HCPCS codes, the long descriptors, the short descriptors, and payment indicators are identified in Table 3 below. The new separately payable codes and their payment rates are included in the July 2010 ASCFS file.

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**Table 3- New Category III CPT Codes that are Separately Payable under the ASC Payment System Effective July 1, 2010**

| HCPCS Code | Long Descriptor   | Short Descriptor                 | Payment Indicator Effective 7/1/10 |
|------------|---|----------------------------------|------------------------------------|
| 0226T      | Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed                                | Anosc high resol dx<br>+coll     | R2*                                |
| 0227T      | Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)   | Anosc high resol dx<br>w/bx      | R2*                                |
| 0228T      | Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; single level  | US tfrml edrl inj crv/t<br>1lv   | G2                                 |
| 0229T      | Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; each additional level (List separately in addition to code for primary procedure) | US tfrml edrl inj crv/t<br>+lv   | G2                                 |
| 0230T      | Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; single level  | US tfrml edrl inj l/s<br>1lv     | G2                                 |
| 0231T      | Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; each additional level (List separately in addition to code for primary procedure)     | US tfrml edrl inj l/s<br>+lv     | G2                                 |
| 0232T      | Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed   | Inj plsm img guid<br>hrvstg&prep | R2*                                |

\*Denotes Temporary Office-Based Status

Several codes have been identified as having temporary office-based status. CMS will not establish permanent office-based status for these new Category III CPT codes until sufficient volume and utilization data become available to assess accurately that each procedure is performed predominantly in physicians' offices. See the CY 2010 OPPS/ASC November 20, 2009 final rule (74 FR 60605),

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available at <http://edocket.access.gpo.gov/2009/E9-26499.htm> on the Internet at page 60605, for a more detailed discussion of temporary office-based status.

***New HCPCS Code that is Separately Payable under the ASC Payment System Effective March 23, 2010***

One new HCPCS code has been created for a payable surgical procedure that is payable for dates of service on and after March 23, 2010, as a result of a recent CMS national coverage decision (NCD). For further information on the NCD, refer to CR 6953. The new HCPCS code, the long descriptor, the short descriptor, and payment indicator is identified in Table 4 below. The new separately payable code and its payment rate are included in the July 2010 ASCFS file.

**Table 4- New HCPCS Code that is Separately Payable under the ASC Payment System Effective March 23, 2010**

| HCPCS Code | Long Descriptor   | Short Descriptor              | Payment Indicator Effective 3/23/10 |
|------------|---|-------------------------------|-------------------------------------|
| C9800      | Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies | Dermal filler inj<br>px/suppl | R2*                                 |

\*Denotes Temporary Office-Based Status

## Additional Information

If you have questions, please contact your Medicare carrier and/or 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> on the CMS website.

The official instruction issued to your Medicare carrier and/or MAC, regarding this change, may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1991CP.pdf> on the CMS website.

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