



Do you have your NPI? National Provider Identifiers (NPIs) will be required on claims sent on or after May 23, 2007. Every health care provider needs to get an NPI. Learn more about the NPI and how to apply for an NPI by visiting <http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/index.html> on the CMS website.

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**Note:** This article was updated on November 8, 2012, to reflect current Web addresses. All other information remains unchanged. This article was previously revised on July 17, 2006, to include an additional web address in the "Additional Information" section. This address houses Part B Drug information and the quarterly ASP Medicare Drug Pricing Files.

## July 2006 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective July 1, 2006, and Revisions to January 2006 and April 2006 Quarterly ASP Medicare Part B Drug Pricing Files

### Provider Types Affected

Physicians, providers, and suppliers who submit Part A or Part B Fee-for-Service claims to Medicare contractors (fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs), and carriers including durable medical equipment regional carriers (DMERCs)) for services.

### Provider Action Needed



#### STOP – Impact to You

CR5110 provides notice of the updated payment allowance limits for Medicare Part B drugs, effective July 1, 2006 through September 30, 2006, as well as revised payment files for the January 2006, and April 2006 Quarterly ASP Medicare Part B Drug Pricing Files.



#### CAUTION – What You Need to Know

Certain Medicare Part B drug payment limits have been revised and the Centers for Medicare & Medicaid Services (CMS) updates the payment allowance

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quarterly. The revised payment limits included in the revised ASP and Not Otherwise Classified (NOC) payment files supersede the payment limits for these codes in any publication published prior to CR5110.



### GO – What You Need to Do

Make certain that your billing staffs are aware of this change.

## Background

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According to Section 303(c) of the Medicare Modernization Act of 2004 (MMA), CMS will update the payment allowances for Medicare Part B drugs on a quarterly basis.

As mentioned in previous articles (see MM4319 at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM4319.pdf>), beginning January 1, 2005, Part B drugs (that are not paid on a cost or prospective payment basis) are paid based on **106 percent** of the average sales price (ASP).

Pricing for compounded drugs is performed by the local Medicare contractor.

### *ESRD Drugs*

Additionally, in 2006, all ESRD drugs furnished by both independent and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPSS, are paid based on the ASP methodology.

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis.

Beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP.

Beginning January 1, 2006, the payment allowance limits for all ESRD drugs when separately billed by freestanding and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPSS, will be paid based on **106 percent** of the ASP. CMS will update the payment allowance limits quarterly.

### *Exceptions*

There are exceptions to these general rules and those exceptions are outlined in MLN Matters article MM4319, which can be viewed at

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<http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM4319.pdf> on the CMS website.

With regard to the exceptions listed in MM4319, note that the payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded.

The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP, unless the drug is compounded.

### ***Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir***

Physicians (or other authorized practitioners) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to do so. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir, is determined under the ASP methodology.

Note that the use of the implantable pump or reservoir must be found medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

If a physician or other practitioner is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if:

- The medication administered is accepted as a safe and effective treatment of the patient's illness or injury;
- There is a medical reason that the medication cannot be taken orally; and
- The skills of the nurse are needed to infuse the medication effectively.

### ***How the ASP Is Calculated***

The ASP is calculated using data submitted to CMS by manufacturers on a quarterly basis and each quarter:

- The revised January 2006 payment allowance limits apply to dates of service January 1, 2006, through March 31, 2006.
- The revised April 2006 payment allowance limits apply to dates of service April 1, 2006, through June 30, 2006.
- The July 2006 payment allowance limits apply to dates of service July 1, 2006, through September 30, 2006.

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The absence or presence of a HCPCS (Healthcare Common Procedure Coding System) code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The carrier processing your claim will make these determinations.

## Additional Information

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The *Medicare Claims Processing Manual*, Publication 100-04, Chapter 17, Drugs and Biologicals, contains information that is pertinent to MM5110. It is located at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf> on the CMS website.

Quarterly Part B Drug Pricing files and information are also available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html> on the CMS website.

CR5110 is the official instruction issued to your Medicare carrier/FI/RHHI/DMERC regarding changes mentioned in this article. CR5110 may be found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R974CP.pdf> on the CMS website.

If you have questions, please contact your Medicare carrier/FI/RHHI/DMERC 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.

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