



News Flash – Did you know that your local Medicare contractor (carrier, fiscal intermediary, or Medicare Administrative Contractor (MAC)) is a valuable source of news and information regarding Medicare business in your specific practice location? Through their electronic mailing lists, your local contractor can quickly provide you with information pertinent to your geographic area, such as local coverage determinations, local provider education activities, etc. If you have not done so already, you should go to your local contractor website and sign up for their listserv or e-mailing list. Many contractors have links on their home page to take you to their registration page to subscribe to their listserv. If you do not see a link on the homepage, just search their site for “listserv” or “e-mail list” to find the registration page. If you do not know the Web address of your contractor’s homepage, it is available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

MLN Matters Number: MM6424

Related Change Request (CR) #: 6424

Related CR Release Date: March 13, 2009

Effective Date: April 1, 2009

Related CR Transmittal #: R104BP, R1698CP

Implementation Date: April 6, 2009

Note: This article was updated on December 20, 2012, to reflect current Web addresses. All other information remains unchanged.

April 2009 Update to the Ambulatory Surgical Center (ASC) Payment System; Summary of Payment Policy Changes/Manual Revisions

See the MLN Matters® article MM6630 at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM6630.pdf> for an update on a correction regarding liability for intraocular lenses in the ASC Payment Indicator File.

Provider Types Affected

ASCs that submit claims to Medicare Administrative Contractors (MACs) and carriers, for services provided to Medicare beneficiaries paid under the ASC payment system

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Provider Action Needed

This article is based on Change Request (CR) 6424 which describes changes to, and billing instructions for, payment policies implemented in the April 2009 ASC update. This update provides updated payment rates for selected separately payable drugs and biologicals and provides rates and descriptors for newly created Level II Healthcare Common Procedure Coding System (HCPCS) codes for drugs and biologicals. Be sure your billing staff is aware of these changes. Be sure billing staff know of these changes.

Background

CR 6424 describes changes to, and billing instructions for, payment policies implemented in the April 2009 ASC payment system update. Final policy under the revised ASC payment system, as set forth in the final rule CMS-1517-F, 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 the update notification (Transmittal R1488CP, CR5994) issued 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 6424 provides an updated payment rate for a current HCPCS drug code, a payment rate and descriptor for a newly created HCPCS drug code and a corrected payment rate for another HCPCS drug code.

In CR 6424, CMS issues instructions to their contractors to modify their systems to include new payment rates for some separately payable drugs and biologicals. CR 6424 also includes updates to the *Medicare Benefit Policy Manual*, Chapter 15, section(s) 260.1 and the *Medicare Claims Processing Manual*, Chapter 14, section(s) 10.1. The revised language in these manuals clarifies CMS policy related to potential changes in Medicare certification status by ASCs that are operated by hospitals and is intended to prohibit such an entity from switching from one payment method to another to maximize revenues.

Key Points of CR 6424

CR 6424 provides the following key points of information:

- CMS reminds 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

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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.

- One new HCPCS drug code has been created that is payable for dates of service on or after April 1, 2009. The new HCPCS code is C9249, the long descriptor is Injection, certolizumab pegol, 1 mg, and the payment indicator (PI) is K2.
- Corrections to the ASC PI and payment rate for HCPCS code J3300 (Injection, triamcinolone acetonide, preservative free, 1 mg) effective January 1, 2009 were included in the January 26, 2009, Federal Register. The short descriptor is Triamcinolone A inj PRS-free, the PI is K2 and the payment rate is \$3.18. ASCs may submit a claim(s) to receive separate payment for this HCPCS code when the service was originally provided as a packaged service to the surgical procedure during the affected dates of service.
- For dates of service beginning April 1, 2009, HCPCS code C9247 (Injection, iobenguane, I-123, diagnostic) is eligible for separate payment under the ASC payment system when it is provided integral to a covered surgical procedure. The short descriptor for HCPCS code C9247 is Inj, iobenguane, I-123, dx and the updated PI is K2.
- ASCs are reminded of the correct reporting of drugs and biologicals when used as implantable devices and the correct reporting of units for drugs.
- The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) extended the requirement for CMS to pay hospitals for brachytherapy sources for the period of July 1, 2008 through December 31, 2009, at the hospital's charges adjusted to costs. ASC payment policy is to make payment at the OPPS rate for brachytherapy sources when a prospective rate is available. Consistent with the MIPPA, there is no prospective rate under the OPPS for the period July 1, 2008 through December 31, 2009. Therefore, for those dates of service payment to ASCs for brachytherapy sources will be made at contractor-priced amounts, consistent with ASC payment policy when no OPPS prospective rate is available.

Additional Information

If you have questions, please contact your Medicare MAC or FI 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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The official instruction (CR6424) was issued to your Medicare MAC and/or FI in two transmittals, which are <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1698CP.pdf> and <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R104BP.pdf> on the CMS website.

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