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The *Ambulatory Surgical Center Fee Schedule Fact Sheet*, which provides general information about the Ambulatory Surgical Center (ASC) Fee Schedule, ASC payments, and how ASC payment amounts are determined, is now available in downloadable format from the Centers for Medicare & Medicaid Services Medicare Learning Network at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/index.html on the CMS website and is also available in print format. To place your order for the printed version, visit *http://www.cms.gov/mlngeninfo/*, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page."

MLN Matters Number: MM5994
Related Change Request (CR) #: 5994
Related CR Release Date: April 9, 2008
Effective Date: April 1, 2008
Related CR Transmittal #: R1488CP
Implementation Date: April 7, 2008

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

Note: This article was updated on July 12, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 5994 which describes changes to, and billing instructions for, payment policies implemented in the April 2008 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.

Key Points

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 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.
- If commercially available drug and biological products are being mixed together to facilitate their concurrent administration, the ASC should report the quantity of each product (reported by HCPCS code) that is separately payable in the ASC used in the care of the patient. Alternatively, if the ASC is compounding drugs that are not a mixture of commercially available products, but are a different product that has no applicable HCPCS code, the payment is packaged and no HCPCS coding is required. In these situations, ASCs should not report HCPCS code C9399. HCPCS code C9399, Unclassified drug or biological, is for new drugs and biologicals that are approved by the Food and Drug Administration (FDA) on or after January 1, 2004, for which a HCPCS code has not been assigned.

Drugs and Biologicals with Payment Based on Average Sales Price (ASP) Effective April 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 quarters (January 2008) are necessary based on the most recent ASP submissions, the Centers for Medicare & Medicaid Services (CMS) will incorporate changes to the payment rates in the April 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 CR5994.
- Providers take note that if your claims were processed prior to the installation of the revised January 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 April 1, 2008.

New HCPCS Drug Codes Separately Payable under the ASC Payment System as of April 1, 2008

Four new HCPCS codes have been created effective April 1, 2008. These new HCPCS codes and their descriptors are listed in Table 1 below.

Table 1
New Drugs Separately Payable under the ASC Payment System as of April 1, 2008

HCPCS Code	Long Descriptor
C9241	Injection, doripenem, 10 mg
Q4096	Injection, Von Willebrand Factor Complex, human, Ristocetin Cofactor (Not otherwise specified), per I.U. VWF:RCO,
Q4097	Injection, immune globulin (Privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg
Q4098	Injection, iron dextran, 50 mg

The payment rates for the drugs in Table 1 can be found in the April 2008 update of the ASC Addendum BB which will be posted on the CMS Web site at the end of March.

HCPCS Drug Codes No Longer Payable under the ASC Payment System Effective April 1, 2008

The following drug codes have been deleted and are no longer payable by Medicare, effective April 1, 2008.

Table 2
Drugs HCPCS codes no longer eligible for payment under Medicare as of April 1, 2008

HCPCS Code	Long Descriptor	ASC Payment Status
J1751	Injection, iron dextran 165, 50 mg	Not payable by Medicare
J1752	Injection, iron dextran 267, 50 mg	Not payable by Medicare

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.

Additional Information

To see the official instruction (CR5994) issued to your Medicare Carrier or A/B MAC refer to http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1488CP.pdf on the CMS website.

If you have questions, please contact your Medicare A/B MAC or carrier 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.