MLN Matters®
Information for Medicare Fee-for-Service Health Care Professionals

News Flash - Medicare paid over $92 million in incentives for 2008 under the Physician Quality Reporting Initiative (PQRI). More than 85,000 physicians and other eligible professionals who successfully reported quality-related data to Medicare under the 2008 PQRI received these payments, which were well above the $36 million paid in 2007. The number of eligible professionals who earned an incentive payment increased by one-third from 2007, when 56,700 eligible professionals earned an incentive payment. More information about the PQRI program, including participation guidance and the criteria to qualify for an incentive payment is available at *http://www.cms.gov/PQRI* on the CMS website.

MLN Matters Number: MM6866 | Related Change Request (CR) #:6866

Related CR Release Date: April 6, 2010 | Effective Date: April 1, 2010

Related CR Transmittal #: R1943CP | Implementation Date: April 5, 2010

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

Provider Types Affected

Providers 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, are affected.

Provider Action Needed

This article is based on Change Request (CR) 6866 which describes changes to, and billing instructions for, payment policies implemented in the April 2010 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.

Background

This Recurring Update Notification describes changes to, and billing instructions for, payment policies implemented in the April 2010 ASC payment system update. Final policy under the revised ASC payment system, as set forth in Medicare

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Program, Revised Payment System Policies for Services Furnished in 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 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. CR6866 provides information on six newly created HCPCS codes that will be added to the ASC list of covered ancillary procedures effective April 1, 2010. You may review CR5994 at *http://www.cms.gov/MLNMattersArticles/downloads/MM5994.pdf* on the CMS website.

Key Points in CR 6866

- 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 two or more drugs and biological products are being mixed together to facilitate their concurrent administration, the ASC should report the quantity of each product (reported by HCPCS codes) that is separately payable in the ASC used in the care of the patient.
- 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.
- 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. Note: Unless otherwise specified in the long description, HCPCS descriptions refer to the non-compounded, FDA-approved final product

New HCPCS Drug Codes Separately Payable under the ASC Payment System as of April 1, 2010

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Six new HCPCS codes have been created effective April 1, 2010. These new HCPCS codes, their descriptors, and ASC payment indicators are listed in Table 1 below.

Table 1

New Drugs and Biologicals Separately Payable under the ASC Payment System as of April 1, 2010

HCPCS Code	Long Descriptor	Payment Indicator
C9258*	Injection, telavancin, 10 mg	K2
C9259*	Injection, pralatrexate, 1 mg	K2
C9260*	Injection, ofatumumab, 10 mg	K2
C9261*	Injection, ustekinumab, 1 mg	K2
C9262*	Fludarabine phosphate, oral, 1 mg	K2
C9263*	Injection, ecallantide, 1 mg	K2

*Indicates that the HCPCS code is new and effective April 1, 2010

Updated Payment Rate for HCPCS Code J9031 Effective January 1, 2009, through March 31, 2009

The payment rate for HCPCS code J9031 was incorrect in the January 2009 ASC DRUG file. The corrected payment rate is listed in Table 2 below and has been included in the revised January 2009 ASC DRUG file effective for services furnished on January 1, 2009 through implementation of the April 2009 update. Suppliers who think they may have received an incorrect payment between January 1, 2009, and March 31, 2009, may request contractor adjustment of the previously processed claims.

Table 2

Updated Payment Rate for HCPCS Code J9031 Effective January 1, 2009 through March 31, 2009

HCPCS Code	Payment Indicator	Short Descriptor	Corrected Payment Rate
J9031	K2	Bcg live intravesical vac	$118.96

Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2009, through December 31, 2009

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The payment rates for four HCPCS codes were incorrect in the October 2009 ASC DRUG file. The corrected payment rates are listed in Table 3 below and have been included in the revised October 2009 ASC DRUG file effective for services furnished on October 1, 2009 through implementation of the January 2010 update. Suppliers who think they may have received an incorrect payment between October 1, 2009, and December 31, 2009, may request contractor adjustment of the previously processed claims.

Table 3

Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2009, through December 31, 2009

HCPCS Code	Payment Indicator	Short Descriptor	Corrected Payment Rate
J2278	K2	Ziconotide injection	$6.38
J2323	K2	Natalizumab injection	$7.97
J1458	K2	Galsulfase injection	$333.49
90371	K2	Hep b ig, im	$113.78

Correct Reporting of Drugs and Biologicals When Used As Implantable Devices

When billing for a biological for which the HCPCS code describes a product that is solely surgically implanted or inserted, and that is separately payable under the ASC payment system, the ASC should report the HCPCS code for the product. If the implanted biological is packaged, that is, not eligible for separate payment under the ASC payment system, the ASC should not report the biological product HCPCS code.

When billing for a biological for which the HCPCS code describes a product that either may be surgically implanted or inserted or otherwise applied in the care of a patient, ASCs should not report the HCPCS code for the product when the biological is used as an implantable device (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures. Under the ASC payment system, ASCs are provided a packaged payment for surgical procedures that includes the cost of supportive items. When using biologicals during surgical procedures as implantable devices, ASCs may include the charges for these items in their charge for the procedure.

Correct Reporting of Units for Drugs

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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.
- 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.

Note: Providers take note that if your claims were processed prior to the installation of the revised April 2009 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, 2009, through March 31, 2009.

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Additional Information

For complete details regarding this Change Request, please see the official instruction (CR6866) issued to your Medicare FI or carrier at *http://www.cms.gov/Transmittals/downloads/R1943CP.pdf* on the CMS website. If you have questions, please contact your Medicare Carrier or, FI at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.

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