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

News Flash - News Flash - Flu Season Is Upon Us! Begin now to take advantage of each office visit as an opportunity to encourage your patients to get a flu shot. It's still their best defense against combating the flu this season. *(Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.)* And don't forget, health care personnel can spread the highly contagious flu virus to patients. Protect yourself. Don't Get the Flu. Don't Give the Flu. Get Your Flu Shot. Remember - Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of the influenza virus vaccine and its administration as well as related educational resources for health care professionals, please go to *http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf* on the CMS website.

MLN Matters Number: MM6205 | Related Change Request (CR) #: 6205

Related CR Release Date: October 3, 2008 | Effective Date: October 1, 2008

Related CR Transmittal #: R1611CP | Implementation Date: October 6, 2008

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

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6205 which describes changes to, and billing instructions for, payment policies implemented in the October 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 HCPCS codes for drugs and biologicals. Be sure billing staff is aware of these changes.

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Key Points of CR6205

Billing for Drugs and Biologicals

The Centers for Medicare & Medicaid Services (CMS) strongly encourages ASCs to report charges for all separately payable drugs and biologicals, using the correct Healthcare Common Procedure Coding System (HCPCS) codes for the items used. ASCs billing for these products should 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.

Remember 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. 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.

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.

Drugs and Biologicals with Payment Based on Average Sales Price (ASP) Effective October 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 quarter(s) are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the October 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 CR6205.

New HCPCS Drugs and Biologicals Separately Payable under the ASC Payment System Effective October 1, 2008

The three HCPCS codes that are newly payable in ASCs and their descriptors are listed in Table 1 below.

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Table 1

HCPCS	Long Descriptor	Payment Indicator
C9243	Injection, bendamustine hcl, 1 mg	K2
C9244	Injection, regadenoson, 0.4 mg	K2
C9359	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Putty, Integra OS Osteoconductive Scaffold Putty), per 0.5cc	K2

Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2008 through March 31, 2008

The payment rates for three HCPCS codes were incorrect in the January 2008 ASC DRUG file. The corrected payment rates are listed below in Table 2 and have been included in the revised January 2008 ASC DRUG file, effective for services furnished on January 1, 2008 through March 31, 2008. Your Medicare contractor will adjust claims affected by these corrections if you bring such claims to their attention.

Table 2

HCPCS Code	Short Descriptor	Corrected Payment Rate	Payment Indicator
J7324	Orthovisc inj per dose	$169.10	K2
J9015	Aldesleukin/single use vial	$757.34	K2
J9303	Panitumumab injection	$82.86	K2

Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2008 through June 30, 2008

The payment rates for three HCPCS codes were incorrect in the April 2008 ASC DRUG file. The corrected payment rates are listed below in Table 3 and have been corrected in the revised April 2008 ASC DRUG file effective for services furnished on April 1, 2008 through June 30, 2008. Your Medicare contractor will adjust Claims affected by these corrections if you bring such claims to their attention.

Table 3

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HCPCS Code	Short Descriptor	Corrected Payment Rate	Payment Indicator
J7324	Orthovisc inj per dose	$174.63	K2
J9303	Panitumumab injection	$82.83	K2
Q4096	VWF complex, not Humate-P	$0.65	K2

Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2008 through September 30, 2008

The payment rate for one HCPCS code was incorrect in the July 2008 ASC DRUG file. The corrected payment rate is listed below and has been corrected in the July 2008 ASC DRUG file, effective for services furnished on July 1, 2008 through September 30, 2008. Your Medicare contractor will adjust claims affected by these corrections if you bring such claims to their attention.

Table 4

HCPCS Code	Short Descriptor	Corrected Payment Rate	Payment Indicator
J7324	Orthovisc inj per dose	$175.85	K2

Correct Reporting of Drugs and Biologicals When Used As Implantable Devices

ASCs are reminded that with the exception of drugs and biologicals with pass-through status under the Outpatient Prospective Payment System (OPPS), ASCs are not to bill separately for drug and biological HCPCS codes when using these items as implantable devices (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures.

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 code descriptor specifies 50 mg, but 200 mg of the drug were administered to the patient, the units billed should be 4.

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- 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.
- The 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.

Payment for Office-based Procedures and Covered Ancillary Radiology Services

The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA),which may be reviewed at *http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3200* on the CMS website, requires that the Medicare physician fee schedule (MPFS) update originally applicable to dates of service January 1, 2008 through June 30, 2008 be extended through December 31, 2008. Consequently, ASC payments for some office-based procedures and covered ancillary radiology services, services for which payment is made at the lesser of the ASC rate or the MPFS non-facility Practical Expense Relative Value Unit (RVU) amount, are affected.

Payment for Brachytherapy Sources

The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) requires CMS to pay for brachytherapy sources for the period of July 1, 2008 through December 31, 2009, at hospitals' charges adjusted to costs. As a result of the legislative amendment, there is no prospective rate under the OPPS for that period. Contrary to the payment policy, payment indicators and payment rates included in previous guidance, including Addendum BB to the November 27, 2007 OPPS/ASC final rule, for dates of service July 1, 2008 through December 31, 2009, payment for brachytherapy sources will be made at contractor-priced amounts, consistent with payment policy for the revised ASC payment system when no OPPS prospective rate is available.

The HCPCS codes for separately paid brachytherapy sources, long descriptors and payment indicators are listed in Table 5 below.

Table 5

HCPCS Code	Long Descriptor	Payment Indicator
A9527	Iodine I-125, sodium iodide solution, therapeutic, per millicurie	H7

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HCPCS Code	Long Descriptor	Payment Indicator
C1716	Brachytherapy source, non-stranded, Gold-198, per source	H7
C1717	Brachytherapy source, non-stranded, High Dose Rate Iridium-192, per source	H7
C1719	Brachytherapy source, non-stranded, Non-High Dose Rate Iridium-192, per source	H7
C2616	Brachytherapy source, non-stranded, Yttrium-90, per source	H7
C2634	Brachytherapy source, non-stranded, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source	H7
C2635	Brachytherapy source, non-stranded, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source	H7
C2636	Brachytherapy linear source, non-stranded, Palladium-103, per 1MM	H7
C2638	Brachytherapy source, stranded, Iodine-125, per source	H7
C2639	Brachytherapy source, non-stranded, Iodine-125, per source	H7
C2640	Brachytherapy source, stranded, Palladium-103, per source	H7
C2641	Brachytherapy source, non-stranded, Palladium-103, per source	H7
C2642	Brachytherapy source, stranded, Cesium-131, per source	H7
C2643	Brachytherapy source, non-stranded, Cesium-131, per source	H7
C2698	Brachytherapy source, stranded, not otherwise specified, per source	H7
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source	H7

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Additional Information

If you have questions, please contact your Medicare MAC or carrier at their toll-free number which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.

To see the official instruction (CR6205) issued to your Medicare Carrier or MAC visit *http://www.cms.hhs.gov/Transmittals/downloads/R1611CP.pdf* on the CMS website. Your Medicare contractor will make the October 2008 ASC fee schedule data for their localities

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