CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1991	**Date: June 25, 2010**
	Change Request 7008

Transmittal 1984, dated June 11, 2010, is rescinded and replaced by Transmittal 1991, dated June 25, 2010. This instruction is to include the following changes to the policy section: (1) payment indicator adjustment for HCPCS 90670 and; (2) Long Descriptor correction to C9264. All other information remains the same.

SUBJECT: July 2010 Update to the Ambulatory Surgical Center (ASC) Payment System

I. SUMMARY OF CHANGES: This Recurring Update Notification describes changes to, and billing instructions for, payment policies implemented in the July 2010 ASC payment system update as contained in the Pub. 100-04, Chapter 14.

EFFECTIVE DATE: July 1, 2010
IMPLEMENTATION DATE: July 6, 2010

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Recurring Update Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1991	Date: June 25, 2010	Change Request: 7008

Transmittal 1984, dated June 11, 2010, is rescinded and replaced by Transmittal 1991, dated June 25, 2010. This instruction is to include the following changes to the policy section: (1) payment indicator adjustment for HCPCS 90670 and; (2) Long Descriptor correction to C9264. All other information remains the same.

SUBJECT: July 2010 Update of the Ambulatory Surgical Center (ASC) Payment System

Effective Date: July 1, 2010

Implementation Date: July 6, 2010

I. GENERAL INFORMATION

A. Background:

This Recurring Update Notification describes changes to, and billing instructions for, payment policies implemented in the July 2010 ASC payment system update. Final policy under the revised ASC payment system, as set forth in Medicare Program; Revised Payment System Policies for Services Furnished in Ambulatory Surgical Centers (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 Transmittal R1488CP (CR5994), 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. This instruction provides information on eight newly created HCPCS codes that will be added to the ASC list of covered surgical procedures and seven newly created HCPCS codes that will be added to the ASC list of covered ancillary services effective July 1, 2010.

In this Change Request (CR), we are issuing instructions to contractors to modify their systems to accept the July 2010 ASC Fee Schedule (ASCFS), the July 2010 ASC Payment Indicator (PI) file, the July 2010 ASC DRUG file, and the updated April 2010 ASC DRUG file and to ensure that the updated files properly interface with all other ASC module programming. The July 2010 ASCFS is an updated file only. The July 2010 ASC PI file is a full replacement file. All of the ASC DRUG files are full replacement files that include payment rates for all separately payable drugs and biologicals applicable to the calendar quarter.

B. Policy:

1. 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 for the reported HCPCS codes 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.

We remind 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 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. Instructions for downloading the ASC DRUG file updates are included in the business requirements section below.

HCPCS payment updates are posted to the CMS website quarterly at:
http://www.cms.hhs.gov/ASCPayment/11_Addenda_Updates.asp#TopOfPage

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. Units should be reported in multiples of the units included in the HCPCS descriptor.

When billing for a biological for which the HCPCS code describes a product that may be either 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

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 description for the drug code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be 1. As another example, if the description for the drug code is 50 mg, but 200 mg of the drug was administered to the patient, the units billed should be 4. ASCs should not bill the units based on the way 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, hospitals should bill 10 units, 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.

As discussed in Chapter 17, Section 40 of the Medicare Claims Processing Manual, Pub.100-04, we encourage ASCs to use drugs efficiently and in a clinically appropriate manner. However, we also recognize that ASCs

may discard some drug and biological product when administering from a single use vial or package. In that circumstance, Medicare pays for the amount of drug or biological discarded as well as the dose administered, up to the amount of the drug or biological as indicated on the vial or package label. Multi-use vials are not subject to payment for discarded amounts of drug or biological.

a. New HCPCS Codes for Drugs and Biologicals that are Separately Payable under the ASC Payment System Effective July 1, 2010

Seven new HCPCS codes have been created for drugs that are payable as covered ancillary services for dates of service on and after July 1, 2010. The new HCPCS codes, the long descriptors, the short descriptors, and payment indicators are identified in Table 1 below.

The new separately payable drug and biological codes and their payment rates are included in the July 2010 ASC DRUG file.

Table 1- New Drugs and Biologicals Separately Payable under the ASC Payment System Effective July 1, 2010.

HCPCS Code	Long Descriptor	Short Descriptor	Payment Indicator Effective 7/1/10
C9264	Injection, tocilizumab, 1 mg	Tocilizumab injection	K2
C9265	Injection, romidepsin, 1 mg	Romidepsin injection	K2
C9266	Injection, collagenase clostridium histolyticum, 0.1 mg	Collagenase clostridum histo	K2
C9267	Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO	Injection, Wilate	K2
C9268	Capsaicin, patch, 10cm2	Capsaicin patch	K2
C9367	Skin substitute, Endoform Dermal Template, per square centimeter	Endoform Dermal Template	K2
Q2025*	Fludarabine phosphate, oral, 1 mg	Oral Fludarabine phosphate	K2

* C9262 is discontinued after June 30, 2010 and replaced by Q2025 effective July 1, 2010

b. Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2010 through June 30, 2010

The payment rates for three HCPCS codes were incorrect in the April 2010 ASC DRUG file. The corrected payment rates are listed in Table 2 below and have been included in the revised April 2010 ASC DRUG file effective for services furnished on April 1, 2010 through implementation of the July 2010 update. Suppliers who think they may have received an incorrect payment between April 1, 2010 and June 30, 2010 may request contractor adjustment of the previously processed claims.

Table 2-Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2010 through June 30, 2010

HCPCS	Short Descriptor	ASC Payment	ASC PI

Code		Rate	
C9258	Telavancin injection	$2.12	K2
C9262	Fludarabine phosphate, oral	$8.18	K2
J1540	Gamma globulin 9 CC inj	$141.64	K2

c. Adjustment to Payment Indicator for HCPCS Code 90670 Effective April 1, 2010

Effective April 1, 2010, the payment for HCPCS code 90670 (Pneumococcal conjugate vaccine, 13 valent, for intramuscular use) will change from ASC PI=Y5 (non-surgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made) to ASC PI=K2 (Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate). The payment rate effective April 1, 2010 is: $106.70. Suppliers who think they may have received an incorrect payment determination between April 1, 2010 and June 30, 2010 may request contractor adjustment of the previously processed claims.

2. New Category III CPT Codes that are Separately Payable under the ASC Payment System Effective July 1, 2010

Seven new Category III CPT codes have been created for payable surgical procedures that are payable for dates of service on and after July 1, 2010. The new HCPCS codes, the long descriptors, the short descriptors, and payment indicators are identified in Table 3 below.

The new separately payable codes and their payment rates are included in the July 2010 ASCFS file.

Table 3- New Category III CPT Codes that are Separately Payable under the ASC Payment System Effective July 1, 2010

HCPCS Code	Long Descriptor	Short Descriptor	Payment Indicator Effective 7/1/10
0226T	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed	Anosc high resol dx +-coll	R2*
0227T	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)	Anosc high resol dx w/bx	R2*
0228T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; single level	US tfrml edrl inj crv/t 1lvl	G2
0229T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; each additional level (List separately in addition to code for primary procedure)	US tfrml edrl inj crv/t +lvl	G2
0230T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; single level	US tfrml edrl inj l/s 1lvl	G2

0231T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; each additional level (List separately in addition to code for primary procedure)	US tfrml edrl inj l/s +lvl	G2
0232T	Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed	Inj plsm img guid hrvstg&prep	R2*

*Denotes Temporary Office-Based Status

Several codes have been identified as having temporary office-based status. CMS will not establish permanent office-based status for these new Category III CPT codes until sufficient volume and utilization data become available to assess accurately that each procedure is performed predominantly in physicians' offices. See the CY 2010 OPPS/ASC November 20, 2009 final rule (74 FR 60605) for a more detailed discussion of temporary office-based status.

3. New HCPCS Code that is Separately Payable under the ASC Payment System Effective March 23, 2010

One new HCPCS code has been created for a payable surgical procedure that is payable for dates of service on and after March 23, 2010 as a result of a recent CMS national coverage decision (NCD). For further information on the NCD, refer to CR 6953. The new HCPCS code, the long descriptor, the short descriptor, and payment indicator is identified in Table 4 below.

The new separately payable code and its payment rate is included in the July 2010 ASCFS file.

Table 4- New HCPCS Code that is Separately Payable under the ASC Payment System Effective March 23, 2010

HCPCS Code	Long Descriptor	Short Descriptor	Payment Indicator Effective 3/23/10
C9800	Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies	Dermal filler inj px/suppl	R2*

*Denotes Temporary Office-Based Status

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)						
		A/B	DME	FI	CAR	RHH	Shared-System Maintainers	OTHER

		MAC	MAC		RIER	I	FISS	MCS	VMS	CWF	
7008.1	Medicare contractors shall download the July 2010 ASCFS from the CMS mainframe. FILENAME: MU00.@BF12390.ASC.CY10.FS.JUL.L.V0614 **Date of retrieval will be provided in a separate email communication from CMS**	X			X						All EDCs
7008.2	Medicare contractors shall download and install the July 2010 ASC PI file FILENAME: MU00.@BF12390.ASC.CY10.IND.JUL.L.V0614 **Date of retrieval will be provided in a separate email communication from CMS**	X			X						
7008.3	Medicare contractors shall download and install the July 2010 ASC DRUG file. FILENAME: MU00.@BF12390.ASC.CY10.DRUG.JUL.L.V0622 **Date of retrieval will be provided in a separate email communication from CMS**	X			X						All EDCs
7008.4	Medicare contractors shall download and install a revised April 2010 ASC DRUG file. FILENAME: MU00.@BF12390.ASC.CY10.DRUG.APR.L.V0622 **Confirmation and date of retrieval will be provided in a separate email communication from CMS**	X			X						All EDCs
7008.4.1	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service on or after April 1, 2010 prior to July 1, 2010 and ; 2) Were originally processed prior to the installation of the revised April 2010 ASC DRUG File.	X			X						
7008.5	Contractors shall make July 2010 ASCFS fee data for their ASC payment localities available on their web sites.	X			X						
7008.6	Contractors shall modify the procedure code file and TOS tables for HCPCS codes 0226T- 0232T, C9264-C9268, C9367, and Q2025.	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7008.7	CWF shall assign TOS F for 0226T- 0232T, C9264-C9268, C9367, and Q2025 for claims with DOS on or after July 1, 2010.									X	
7008.8	Contractors shall modify the procedure code file and TOS tables for HCPCS code C9800	X			X						
7008.8.1	Contractors shall accept C9800 for claims with a DOS on or after March 23, 2010.	X			X						
7008.9	CWF shall add TOS F to C9800 effective March 23, 2010.									X	
7008.10	Medicare contractors shall send notification of successful receipt via email to price_file_receipt@cms.hhs.gov stating the name of the file received and the entity for which it was received (e.g., carrier name and number).	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7008.11	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	the Medicare program correctly.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): ASC Payment Policy: Chuck Braver at chuck.braver@cms.hhs.gov or 410-786-6719.
Carrier/ AB MAC Claims Processing Issues: Yvette Cousar at yvette.cousar@cms.hhs.gov or 410-786-2160.

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

Section A: For *Carriers:*
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.