CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2305	**Date: September 15, 2011**
	Change Request 7547

Transmittal 2290, dated August 26, 2011, is being rescinded and replaced by Transmittal 2305, dated September 15, 2011 to correct the Table 1 label and other related label references in the policy section of the Recurring Update Notification. All other information remains the same.

SUBJECT: October 2011 Update of the Ambulatory Surgery Center (ASC) Payment System

I. SUMMARY OF CHANGES: This Recurring Update Notification describes changes to, and billing instructions for, payment policies implemented in the October 2011 ASC payment system update. This Recurring Update Notification applies to chapter 14, section 10.

EFFECTIVE DATE: October 1, 2011
IMPLEMENTATION DATE: October 3, 2011

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-

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. ATTACHMENT:

Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub.100-04	Transmittal: 2305	Date: September 15, 2011	Change Request: 7547

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SUBJECT: October 2011 Update of the Ambulatory Surgery Center (ASC) Payment System

Effective Date: **October 1, 2011**

Implementation Date: October 3, 2011

I. GENERAL INFORMATION

A. Background:

This Recurring Update Notification describes changes to, and billing instructions for, payment policies implemented in the October 2011 ASC payment system update per Chapter 14, section 10. 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 three newly created HCPCS codes that will be added to the ASC list of covered ancillary services effective October 1, 2011. No new HCPCS codes are being added to the ASC list of covered surgical procedures for October 1, 2011.

In this Change Request (CR), CMS is issuing instructions to contractors to modify their systems to accept the October 2011 ASC Fee Schedule (ASCFS), October 2011 ASC Payment Indicator (PI) file, the October 2011 ASC DRUG file, and the updated July 2011 ASC DRUG files and to ensure that the updated files properly interface with all other ASC module programming. 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. New HCPCS Level II Codes that are Separately Payable under the ASC Payment System Effective October 1, 2011

Two new HCPCS Level II codes have been created as payable ancillary procedures that are payable for dates of service on and after October 1, 2011. The new HCPCS codes, the long descriptors, the short descriptors, and payment indicators are identified in Table 1 below.

Table 1 -- HCPCS Level II Codes Implemented as of October 1, 2011

HCPCS Code	Long Descriptor	Short Descriptor	Payment Indicator Effective 10/1/2011
C1830	Powered bone marrow biopsy needle	Powered bone marrow bx needle	J7
C1840	Lens, intraocular (telescopic)	Telescopic intraocular lens	J7

2. Billing for Drugs, Biologicals, and Radiopharmaceuticals

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.

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 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 Web site quarterly at: http://www.cms.gov/ASCPayment/11_Addenda_Updates.asp#TopOfPage

a. 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. ASCs should not bill the units based on the way the implantable biological is packaged, stored, or stocked. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the implantable biological. Therefore, before submitting Medicare claims for biologicals that are used as implantable devices, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

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.

b. 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 HCPCS long 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, 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 Pub.100-04, Medicare Claims Processing Manual, Chapter 17, Section 40, CMS encourages ASCs to use drugs efficiently and in a clinically appropriate manner. However, CMS also recognizes 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.

3. New HCPCS Code for Drugs and Biologicals Separately Payable under the ASC Payment System Effective October 1, 2011

One new drug and biological has been granted ASC payment status effective October 1, 2011. This item, along with the long and short descriptors, and payment indicator is identified in Table 2 below.

Table 2: New Drug and Biological Separately Payable under the ASC Payment System Effective October 1, 2011

HCPCS Code	Long Descriptor	Short Descriptor	ASC PI
C9286	Injection, belatacept, 1 mg	Injection, belatacept	K2

NOTE: HCPCS code C9286 is a new code effective October 1, 2011.

4. Updated Payment Rate for HCPCS Code J9185 Effective July 1, 2011, through September 30, 2011

The payment rate for HCPCS code J9185 was incorrect in the July 2011 ASC Drug file. The corrected payment rate is listed in Table 3 below and has been included in the revised July 2011 ASC DRUG file effective for services furnished on July 1, 2011, through implementation of the October 2011 update. Suppliers who think they may have received an incorrect payment between July 1, 2011, and September 30, 2011, may request contractor adjustment of the previously processed claims.

Table 3 – Updated Payment Rates for HCPCS Code J9185 Effective July 1, 2011, through September 30, 2011

HCPCS Code	Short Descriptor	ASC Payment	ASC PI
J9185	Fludarabine phosphate inj	$104.52	K2

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

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	
7547.1	Medicare contractors shall download and install the October 2011 ASCFS file FILENAME: MU00.@BF12390.ASC.CY11.FS.OCT.Q.V0902 **Confirmation and date of retrieval will be provided in a separate email communication from CMS.**	X			X						COBC All EDCs
7547.2	Medicare contractors shall download and install the October 2011 ASC PI file FILENAME: MU00.@BF12390.ASC.CY11.PI.OCT.Q.V0909 **Confirmation and date of retrieval will be provided in a separate email communication from CMS.**	X			X						COBC All EDCs
7547.3	Medicare contractors shall download and install the October 2011 ASC DRUG file. FILENAME: MU00.@BF12390.ASC.CY11.DRUG.OCT.Q.V0921 **Date of retrieval will be provided in a separate email communication from CMS**	X			X						COBC All EDCs
7547.4	Medicare contractors shall download and install the revised July 2011 ASC DRUG file. FILENAME: MU00.@BF12390.ASC.CY11.DRUG.JUL.Q.V0921 **Date of retrieval will be provided in a separate email communication from CMS**	X			X						COBC All EDCs

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	
7547.4.1	Medicare contractors shall adjust as appropriate claims brought to their attention that: 1) Have dates of service on or after July 1, 2011, through September 30, 2011, and ; 2) Were originally processed prior to the installation of the revised July 2011 ASC DRUG File.	X			X						COBC All EDCs
7547.5	CWF shall assign Type of Service (TOS) F for C1830, C1840, and C9286 for dates of service beginning October 1, 2011.									X	
7547.6	Contractors shall modify the procedure code file and TOS tables for HCPCS code C1830, C1840, and C9286.	X			X						
7547.7	Contractors shall accept C1830, C1840, and C9286 for claims with a DOS beginning October 1, 2011.	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	
7547.8	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	X			X						COBC

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	
	scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	None

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

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): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: 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.

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.