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July 2019 Update of the Ambulatory Surgical Center (ASC) Payment System

MLN Matters Number: MM11328
Related Change Request (CR) Number: 11328
Related CR Release Date: June 14, 2019
Effective Date: July 1, 2019
Related CR Transmittal Number: R4319CP
Implementation Date: July 1, 2019

PROVIDER TYPES AFFECTED

This MLN Matters Article is for physicians, providers, and suppliers billing Medicare Administrative Contractors (MACs) for services subject to the Ambulatory Surgical Center (ASC) payment system and provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR11328 contains the changes to and billing instructions for various payment policies implemented in the July 2019 ASC payment system update. This notification also includes updates to HCPCS. Make sure your billing staffs are aware of these updates.

BACKGROUND

CR11328 includes Calendar Year (CY) 2019 payment rates for separately payable procedures/services, drugs, and biologicals, including descriptors for newly created CPT and Level II HCPCS codes for drugs and biologicals (ASC DRUG) files. The CR also conveys a July 2019 Ambulatory Surgical Center Payment Indicator (ASC PI) File, and a July 2019 Ambulatory Surgical Center Fee Schedule (ASCFS). The Centers for Medicare & Medicaid Services (CMS) is not issuing an ASC Code Pair file with this CR.

1. New CPT Category III Codes Effective July 1, 2019

Similar to the vaccine codes, the American Medical Association (AMA) releases the CPT Category III codes twice per year: in January, for implementation beginning the following July, and in July, for implementation beginning the following January.

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Effective July 1, 2019, the CMS is implementing five (5) CPT Category III codes in the ASC payment system that the AMA released in January 2019 for implementation on July 1, 2019. These codes, along with their short and long descriptors, and their ASC PIs are shown in Table 1 below. These codes are also included in the July 2019 ASC addenda, which is posted on the CMS website.

Table 1 – New CPT Category III Codes Effective July 1, 2019

CPT Code	Short Descriptor	Long Descriptor	ASC PI
0548T*	Tprnl balo cntnc dev bi	Transperineal periurethral balloon continence device; bilateral placement, including cystoscopy and fluoroscopy	J8
0549T	Tprnl balo cntnc dev uni	Transperineal periurethral balloon continence device; unilateral placement, including cystoscopy and fluoroscopy	J8
0550T	Tprnl balo cntnc dev rmvl ea	Transperineal periurethral balloon continence device; removal, each balloon	G2
0551T	Tprnl balo cntnc dev adjmt	Transperineal periurethral balloon continence device; adjustment of balloon(s) fluid volume	R2
0558T	Ct scan f/biomchn ct alys	Computed tomography scan taken for the purpose of biomechanical computed tomography analysis	Z2

*HCPCS code C9746 (Transperineal implantation of permanent adjustable balloon continence device, with cystourethroscopy, when performed and/or fluoroscopy, when performed), which was effective July 1, 2017, is deleted June 30, 2019, and replaced with CPT code 0548T, effective July 1, 2019.

2. Drugs and Biologicals

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective July 1, 2019

For CY 2019, payment for nonpass-through drugs and biologicals continues to be made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug or biological. Also, in CY 2019, a single payment of ASP + 6 percent continues to be made for Outpatient Prospective Payment System (OPPS) pass-through drugs, and biologicals to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective July 1, 2019, are in the July 2019 update of ASC

Addendum BB at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-payment/ASCPayment/11_Addenda_Updates.html.

b. New Established HCPCS Codes for Separately Payable Drugs and Biologicals as of July 1, 2019

Ten new separately payable drug and biological HCPCS codes will be established on July 1, 2019. Eight of the products are new. J7208 will replace HCPCS code C9141. Another HCPCS code, J9030, will replace HCPCS code J9031. The new codes are listed in Table 2 below. HCPCS codes C9141 and J9031 will be deleted effective June 30, 2019.

Table 2 – New Established HCPCS Codes for Separately Payable Drugs and Biologicals, as of July 1, 2019

New HCPCS Codes	Old HCPCS Codes	Short Descriptor	Long Descriptor	ASC PI
J9036		Inj., belrapzo/bendamustine	Injection, bendamustine hydrochloride, (Belrapzo/bendamustine), 1 mg	K2
J7208	C9141	Inj. jivi 1 iu	Injection, factor viii, (antihemophilic factor, recombinant), pegylated-aucl, (jivi), 1 i.u.	K2
J9356		Inj. herceptin hylecta, 10mg	Injection, trastuzumab, 10 mg and Hyaluronidase-oysk	K2
J9030	J9031	Bcg live intravesical 1mg	BCG live intravesical instillation, 1 mg	K2
C9047		Injection, caplacizumab-yhdp	Injection, caplacizumab-yhdp, 1 mg	K2
C9048		Dexamethasone ophth insert	Dexamethasone, lacrimal ophthalmic insert, 0.1 mg	K2
C9049		Injection, tagraxofusp-erzs	Injection, tagraxofusp-erzs, 10 mcg	K2
C9050		Injection, emapalumab-lzsg	Injection, emapalumab-lzsg, 1 mg	K2
C9051		Injection, omadacycline	Injection, omadacycline, 1 mg	K2
C9052		Injection, ravulizumab-cwv	Injection, ravulizumab-cwvz, 10 mg	K2

c. Descriptor Change for the HCPCS code J9355, Effective July 1, 2019

Effective July 1, 2019, the descriptors for the HCPCS code J9355 are updated. Both the old and new descriptors are located in table 3 below.

Table 3 – Descriptor Change for the HCPCS code J9355, Effective July 1, 2019

HCPCS Code	Old Short Descriptor	New Short Descriptor	Old Long Descriptor	New Long Descriptor
J9355	Trastuzumab injection	Inj trastuzumab excl biosimi	Injection, trastuzumab, 10 mg	Injection, trastuzumab, excludes biosimilar, 10 mg

d. Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates

Some drugs and biologicals with payment rates based on the ASP methodology may have their payment rates corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payment rates will be accessible on the first date of the quarter at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Restated-Payment-Rates.html.

Suppliers who think they may have received an incorrect payment for drugs and biologicals impacted by these corrections may request their MAC to adjust the previously processed claims.

3. Payment Indicator Revision for Flu Vaccine CPT Code 90689

Currently, CPT code 90689 is assigned to status indicator "E1" in the OPPS to indicate that the vaccine is not paid by Medicare when submitted on outpatient claims (any outpatient bill type). This policy is also applicable to ASCs. However, as noted in Change Request 10871 (Quarterly Influenza Virus Vaccine Code Update - January 2019), Transmittal 4141, dated September 27, 2018, effective for claims with dates of service on or after January 1, 2019, CPT 90689 will be payable by Medicare.

The vaccine is packaged in the ASC payment system; therefore, CMS is revising the status indicator to "L1" (L1: Influenza vaccine; pneumococcal vaccine. Packaged item/service; no separate payment made.) for CPT code 90689 retroactive to January 1, 2019. Please note that packaged codes should not be separately billed by ASCs. Refer to Table 4 below for the code descriptors and payment indicator assignment.

Table 4 – Payment Indicator Revision for Flu Vaccine CPT Code 90689

CPT Code	Short Descriptor	Long Descriptor	ASC PI
90689	Vacc iiv4 no prsrv 0.25ml im	Influenza virus vaccine, quadrivalent (iiv4), inactivated, adjuvanted, preservative free, 0.25 ml dosage, for intramuscular use	L1

4. Coverage Determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the ASC payment system does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. MACs determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

ADDITIONAL INFORMATION

The official instruction, CR11328, issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4319CP.pdf.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
July 16, 2019	Initial article released.