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July 2018 Update of the Ambulatory Surgical Center (ASC) Payment System

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Related Change Request (CR) Number: 10788
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Related CR Transmittal Number: R4076CP
Implementation Date: July 2, 2018

Note: This article was revised on June 28, 2018, to reflect an updated Change Request. To reflect those changes this article modified Section 2.b and the related Table 1. It also added Section 2e and 2f with corresponding Table 3. The CR Release Date, transmittal number and link to the transmittal also changed. All other information remains the same.

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for Ambulatory Surgical Centers (ASCs) billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10788 informs MACs about updates to the ASC payment system for July 2018. Be sure your billing staffs are aware of these changes.

BACKGROUND

Change Request (CR) 10788 describes changes to and billing instructions for various payment policies implemented in the July 2018 ASC payment system update. As appropriate, this notification also includes updates to the Healthcare Common Procedure Coding System (HCPCS). Included in CR10788 are Calendar Year (CY) 2018 payment rates for separately payable drugs and biologicals, including descriptors for newly created Level II HCPCS codes for drugs and biologicals (ASC DRUG) files. The CR also includes a July 2018 ASC payment rates for covered surgical and ancillary services (ASCFS) update file. CR10788 is not issuing a No ASC Code Pair file. The key changes are as follows:

1. Bilateral Indicator for HCPCS Code C9749

In the April 2018 Outpatient Prospective Payment System (OPPS) update (Transmittal 4005, CR10515, dated March 20, 2018), the Centers for Medicare & Medicaid Services (CMS) announced the establishment of HCPCS code C9749 (Repair of nasal vestibular lateral wall

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stenosis with implant(s)), effective April 1, 2018. CMS is clarifying that this code describes an inherently bilateral procedure, and that for unilateral procedures; ASCs need to report either modifier 73 or 74. Modifiers 73 and 74 are only used to indicate discontinued procedures for which anesthesia is planned or provided.

2. Drugs, Biologicals, and Radiopharmaceuticals

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective April 1, 2018

For CY 2018, payment for non-pass-through drugs, biologicals, and therapeutic radiopharmaceuticals 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, biological, or therapeutic radiopharmaceutical. In addition, in CY 2018, a single payment of ASP + 6 percent continues to be made for pass-through drugs, biologicals, and therapeutic radiopharmaceuticals 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, 2018, and drug price restatements are available in the July 2018 update of ASC Addendum BB, which is at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html.

b. July 2018 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals Effective July 1, 2018

Seven new HCPCS codes have been created for reporting drugs and biologicals in the ASC payment system effective July 1, 2018, where there have not previously been specific codes available. These new codes are listed in Table 1.

Table 1 — July 2018 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals Effective July 1, 2018

HCPCS Code	Long Descriptor	Short Descriptor	ASC PI
C9030	Injection, copanlisib, 1 mg	Inj copanlisib	K2
C9032	Injection, voretigene neparvovec-rzyl, 1 billion vector genome	Voretigene neparvovec-rzyl	K2
Q5105	Injection, epoetin alfa, biosimilar, (Retacrit) (for esrd on dialysis), 100 units	Inj Retacrit esrd on dialysi	K2
Q5106	Injection, epoetin alfa, biosimilar, (Retacrit) (for non-esrd use), 1000 units	Inj Retacrit non-esrd use	K2

HCPCS Code	Long Descriptor	Short Descriptor	ASC PI
Q9991	Injection, buprenorphine extended-release (Sublocade), less than or equal to 100 mg	Buprenorph xr 100 mg or less	K2
Q9992	Injection, buprenorphine extended-release (Sublocade), greater than 100 mg	Buprenorphine xr over 100 mg	K2
Q9995	Injection, emicizumab-kxwh, 0.5 mg	inj. emicizumab-kxwh, 0.5 mg	K2

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

Some drugs and biologicals based on ASP methodology may have payment rates that are 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 http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html.

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

d. Other Changes to CY 2018 HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals Effective July 1, 2018

Effective July 1, 2018, HCPCS code Q9993 (Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg) will replace HCPCS code C9469 (Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg). The ASC Payment Indicator will remain K2, “Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.” These codes are listed in Table 2.

Table 2 – Other Changes to CY 2018 HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals Effective July 1, 2018

HCPCS Code	Long Descriptor	Short Descriptor	ASC PI	Effective Date	Termination Date
C9469	Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg	Inj triamcinolone acetonide	K2	04/01/2018	06/30/2018

HCPCS Code	Long Descriptor	Short Descriptor	ASC PI	Effective Date	Termination Date
Q9993	Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg	Inj., triamcinolone ext rel	K2	07/01/2018	

e. New Biosimilar Biological Products Effective July 1, 2018

Two new HCPCS codes will be created for reporting Retacrit, (epoetin alfa-epbx) as a biosimilar to Epogen/Procrit (epoetin alfa) for the treatment of anemia caused by chronic kidney disease, chemotherapy, or use of zidovudine in patients with HIV infection. Retacrit is also approved for use before and after surgery to reduce the chance that red blood cell transfusions will be needed because of blood loss during surgery. The codes, descriptors, and ASC payment indicators are separately listed in Table 3, and are effective for services furnished on or after July 1, 2018. Payment for each of these codes can be found in Addendum BB of the July 2018 ASC addenda that are posted on the CMS website.

Table 3 - New Biosimilar Biological Products Effective July 1, 2018

HCPCS Code	Long Descriptor	Short Descriptor	ASC PI
Q5105	Injection, epoetin alfa, biosimilar, (Retacrit) (for esrd on dialysis), 100 units	Inj Retacrit esrd on dialysi	K2
Q5106	Injection, epoetin alfa, biosimilar, (Retacrit) (for non-esrd use), 1000 units	Inj Retacrit non-esrd use	K2

f. Drugs and Biologicals with a Change in Status Indicator

Two drugs, specifically, HCPCS codes J9216 and Q2049, have a change in status indicator from “K2” to not separately payable, effective July 1, 2018, since we do not have pricing information for either drug code.

3. **Category III CPT Code Effective July 1, 2018**

The AMA releases Category III CPT codes twice per year:

- In January, for implementation beginning the following July
- In July, for implementation beginning the following January

For the July 2018 update, CMS is implementing one Category III CPT code that the AMA released in January 2018 for implementation on January 1, 2018. The ASC payment indicator for this code is shown in Table 4. The payment rate for this service is in Addendum BB of the July 2018 ASC addenda at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html.

Table 4 – Category III CPT Codes Effective July 1, 2018

CPT Code	Long Descriptor	Short Descriptor	ASC PI
0508T	Pulse-echo ultrasound bone density measurement resulting in indicator of axial bone mineral density, tibia	Pls echo us b1 dns meas tib	Z2

4. Reassignment of Skin Substitute Product from the Low-Cost Group to the High-Cost Group

The payment for skin substitute products that do not qualify for hospital OPPS pass-through status is packaged into the OPPS payment for the associated skin substitute application procedure. This policy is also implemented in the ASC payment system. The skin substitute products are divided into two groups: 1) High-cost skin substitute products and 2) Low-cost skin substitute products for packaging purposes.

The skin substitute product listed in Table 5 has been reassigned from the low-cost skin substitute group to the high-cost skin substitute group based on updated pricing information.

Note: This skin substitute product is packaged and should not be separately billed by ASCs

Table 5 – Reassignment of Skin Substitute Product from the Low Cost Group to the High Cost Group Effective July 1, 2018

CY 2018 HCPCS Code	CY 2018 Short Descriptor	CY 2018 ASC PI	Low/High Cost Skin Substitute
Q4178	Floweramniopatch, per sq cm	N1	High

ASCs should not separately bill for packaged skin substitutes (ASC PI=N1). High-cost skin substitute products should only be used in combination with the performance of one of the skin application procedures described by CPT codes 15271-15278. Low-cost skin substitute products should only be used in combination with the performance of one of the skin application procedures described by HCPCS codes C5271-C5278. All OPPS pass-through skin substitute products (ASC PI=K2) should be billed in combination with one of the skin application procedures described by CPT codes 15271-15278.

5. 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. Medicare Administrative Contractors (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, CR10788, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4076CP.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
June 28, 2018	This article was revised to reflect an updated Change Request. To show those changes this article modified Section 2.b and the related Table 1. It also added Section 2e and 2f with corresponding Table 3. The CR Release Date, transmittal number and link to the transmittal also changed
June 1, 2018	Initial article released.