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

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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.

WHAT YOU NEED TO KNOW

Change Request (CR) 10441 informs MACs about updates to the ASC payment system for January 2018. Be sure your billing staffs are aware of these changes.

BACKGROUND

CR10441 includes changes to and billing instructions for various payment policies implemented in the January 2018 ASC payment system update and also includes updates to the Healthcare Common Procedure Coding System (HCPCS).

This notification includes 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), and the CY 2018 ASC Payment Rates for Covered Surgical and Ancillary Services (ASCFS file). No ASC Code Pair file is being issued with this notice.

ASC payment rates under the ASC payment system are generally established using payment rate information in the hospital Outpatient Prospective Payment System (OPPS) or the Medicare Physician Fee Schedule (MPFS). The payment files associated with CR10441 reflect the most recent changes to CY 2018 OPPS and CY 2018 MPFS payments.

The changes in CR10441 are as follows:

1. a. New Device Pass-Through Policies

Section 1833(t)(6)(B) of the Social Security Act (the Act) requires that, under the OPPS,

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categories of devices be eligible for transitional pass-through payments for at least two (2), but not more than three (3) years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that the Centers for Medicare & Medicaid Services (CMS) creates additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices. This policy was implemented in the 2008 revised ASC payment system. Therefore, additional payments may be made to the ASC for covered ancillary services, including certain implantable devices with pass-through status under the Outpatient Prospective Payment System (OPPS).

Effective January 1, 2018, there are no device categories eligible for pass-through payment. However, an existing device described by HCPCS code C2623 (*Catheter, transluminal angioplasty, drug coated, non laser*) was recently approved by Food and Drug Administration (FDA) for a new indication, specifically the treatment of patients with Dysfunctional Arteriovenous (AV) fistulae.

Accordingly, in this January 2018 update, devices described by HCPCS code C2623 are eligible for pass-through status retroactive to August 25, 2017, when the device is billed with Current Procedural Terminology (CPT) code 36902 (*Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty*) or CPT code 36903 (*Insertion of needle and/or catheter into dialysis circuit and insertion of stent in dialysis segment, with imaging including radiological supervision and interpretation*).This device pass through status will be applied retroactively from August 25, 2017, through December 31, 2017.

1. b. Device Offset from Payment for Device Category

Section 1833(t)(6)(D)(ii) of the Act requires that CMS deduct from pass-through payments for devices an amount that reflects the portion of the Ambulatory Payment Classifications (APC) payment amount. With respect to device code C2623, CMS has previously determined that the costs associated with C2623 are not reflected in the APC payment amount. Therefore, CMS is not applying a device offset to the retroactive pass-through payments for C2623. Retroactive pass-through payments for services furnished on August 25, 2017, through December 31, 2017, without deduction, will only apply when HCPCS code C2623 is billed with CPT codes 36902 or 36903.

2. New Separately Payable Procedure Code, Effective January 1, 2018

Effective January 1, 2018, new HCPCS code C9748 has been created as described in Table 1.

Table 1 – New Separately Payable Procedure Code, Effective January 1, 2018

HCPCS Code	Short Descriptor	Long Descriptor	ASC PI
C9748	Prostatic rf water vapor tx	Transurethral destruction of prostate tissue; by radiofrequency water vapor (steam) thermal therapy	G2

3. Drugs, Biologicals, and Radiopharmaceuticals

a. New CY 2018 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

For CY 2018, several new HCPCS codes have been created for reporting drugs and biologicals in the ASC payment system, where there have not previously been specific codes available. These new codes are listed in Table 2.

Table 2 – New CY 2018 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

HCPCS Code	Short Descriptor	Long Descriptor	ASC PI
C9014	Injection, cerliponase alfa	Injection, cerliponase alfa, 1 mg	K2
C9015	C-1 esterase, haegarda	Injection, c-1 esterase inhibitor (human), Haegarda, 10 units	K2
C9016	Inj, triptorelin ext rel	Injection, triptorelin extended release, 3.75 mg	K2
C9024	Inj, daunorubicin-cytarabine	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine	K2
C9028	Inj. inotuzumab ozogamicin	Injection, inotuzumab ozogamicin, 0.1 mg	K2
C9029	Injection, guselkumab	Injection, guselkumab, 1 mg	K2
J0606	Inj, etelcalcetide, 0.1 mg	Injection, etelcalcetide, 0.1 mg	K2

HCPCS Code	Short Descriptor	Long Descriptor	ASC PI
J1555	Inj cuvitru, 100 mg	Injection, immune globulin (cuvitru), 100 mg	K2
J7211	Inj, kovaltry, 1 i.u.	Injection, factor viii, (antihemophilic factor, recombinant), (kovaltry), 1 i.u.	K2
J7345	Aminolevulinic acid, 10% gel	Aminolevulinic acid hcl for topical administration, 10% gel, 10 mg	K2
J9203	Gemtuzumab ozogamicin 0.1 mg	Injection, gemtuzumab ozogamicin, 0.1 mg	K2
Q2040	Tisagenlecleucel car-pos t	Tisagenlecleucel, up to 250 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per infusion	K2

b. Other Changes to CY 2018 HCPCS and CPT Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals

Many HCPCS and CPT codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS and CPT code descriptors that will be effective in CY 2018. In addition, several temporary HCPCS C-codes have been deleted, effective December 31, 2017, and replaced with permanent HCPCS codes in CY 2018. ASCs should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the CY 2018 HCPCS and CPT codes.

Table 3 notes those drugs, biologicals, and radiopharmaceuticals that have undergone changes in their HCPCS/CPT code, their long descriptor, or both. Each product's CY 2017 HCPCS/CPT code and long description is included.

Table 3 – Other CY 2018 HCPCS and CPT Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals

CY 2017 HCPCS Code	CY 2017 Long Descriptor	CY 2018 HCPCS Code	CY 2018 Long Descriptor
C9490	Injection, bezlotoxumab, 10 mg	J0565	Injection, bezlotoxumab, 10 mg

CY 2017 HCPCS Code	CY 2017 Long Descriptor	CY 2018 HCPCS Code	CY 2018 Long Descriptor
C9484	Injection, eteplirsen, 10 mg	J1428	Injection, eteplirsen, 10 mg
C9486	Injection, granisetron extended release, 0.1 mg	J1627	Injection, granisetron, extended-release, 0.1 mg
Q9986	Injection, hydroxyprogesterone caproate (Makena), 10 mg	J1726	Injection, hydroxyprogesterone caproate (Makena), 10 mg
C9489	Injection, nusinersen, 0.1 mg	J2326	Injection, nusinersen, 0.1 mg
C9494	Injection, ocrelizumab, 1 mg	J2350	Injection, ocrelizumab, 1 mg
Q9989	Ustekinumab, for Intravenous Injection, 1 mg	J3358	Ustekinumab, for intravenous injection, 1 mg
C9140	Injection, Factor VIII (antihemophilic factor, recombinant) (Afstyla), 1 I.U.	J7210	Injection, factor viii, (antihemophilic factor, recombinant), (Afstyla), 1 i.u.
C9483	Injection, atezolizumab, 10 mg	J9022	Injection, atezolizumab, 10 mg
C9491	Injection, avelumab, 10 mg	J9023	Injection, avelumab, 10 mg
C9485	Injection, olaratumab, 10 mg	J9285	Injection, olaratumab, 10 mg

c. Drugs and Biologicals with Payments Based on Average Sales Price (ASP), Effective January 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 radiopharmaceuticals is made 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.

Effective January 1, 2018, payment rates for many drugs and biologicals have changed from the

values published in the CY 2018 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2017. In cases where adjustments to payment rates are necessary, CMS is not publishing the updated payment rates in CR10441.

However, all ASC payable drugs and biologicals, effective January 1, 2018, including those that were updated as a result of the new ASP calculations are in the January 2018 ASC Addendum BB at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html.

d. 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 payments 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 contractor adjustment of the previously processed claims.

e. Biosimilar Biological Product Payment Policy

Effective January 1, 2018, the payment rate for biosimilars approved for payment in the ASC payment system will be the same as the payment rate in the OPPS and physician office setting, calculated as the ASP of the biosimilar(s) described by the HCPCS code + 6 percent of the ASP of the reference product. Payment will be made at the single ASP + 6 percent rate.

As a reminder, ASC claims for separately paid biosimilar biological products are required to include the modifier that identifies the manufacturer of the specific product. The modifier does not affect payment determination, but is used to distinguish between biosimilar products that appear in the same HCPCS code, but are made by different manufacturers. Any changes to the billing requirements for biosimilar biological products will be issued to ASCs in a future transmittal.

f. Skin-Substitute Assignments to High-Cost and Low-Cost Groups for CY 2018

The payment for skin-substitute products that do not qualify for hospital OPPS pass-through status are 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.

Table 4 lists the skin-substitute products and their assignment as either a high-cost or a low-cost skin substitute product, when applicable. ASCs should not separately bill for packaged skin substitutes (ASC PI=N1). Note that:

- 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 code 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 code 15271-15278.

Note: All of the skin substitute products listed in this table are packaged and should not be separately billed by ASCs.

Table 4 – Skin-Substitute Assignments to High-Cost and Low-Cost Groups for CY 2018

HCPCS Code	2018 Short Descriptor	ASC PI	CY 2018 High/Low Assignment
C9363	Integra meshed bil wound mat	N1	High
Q4100	Skin substitute, nos	N1	Low
Q4101	Apligraf	N1	High
Q4102	Oasis wound matrix	N1	Low
Q4103	Oasis burn matrix	N1	High
Q4104	Integra bmwd	N1	High
Q4105	Integra drt or omnigraft	N1	High
Q4106	Dermagraft	N1	High
Q4107	Graftjacket	N1	High
Q4108	Integra matrix	N1	High
Q4110	Primatrix	N1	High
Q4111	Gammagraft	N1	Low

HCPCS Code	2018 Short Descriptor	ASC PI	CY 2018 High/Low Assignment
Q4115	Alloskin	N1	Low
Q4116	Alloderm	N1	High
Q4117	Hyalomatrix	N1	Low
Q4121	Theraskin	N1	High
Q4122	Dermacell	N1	High
Q4123	Alloskin	N1	High
Q4124	Oasis tri-layer wound matrix	N1	Low
Q4126	Memoderm/derma/tranz/integup	N1	High
Q4127	Talymed	N1	High
Q4128	Flexhd/allopatchhd/matrixhd	N1	High
Q4131	Epifix or epicord	N1	High
Q4132	Grafix core, grafixpl core	N1	High
Q4133	Grafix prime grafix pl prime	N1	High
Q4134	Hmatrix	N1	Low
Q4135	Mediskin	N1	Low
Q4136	Ezderm	N1	Low
Q4137	Amnioexcel or biodexcel, 1cm	N1	High
Q4138	Biodfence dryflex, 1cm	N1	High
Q4140	Biodfence 1cm	N1	High
Q4141	Alloskin ac, 1cm	N1	High
Q4143	Repriza, 1cm	N1	High
Q4146	Tensix, 1 cm	N1	High
Q4147	Architect ecm px fx 1 sq cm	N1	High
Q4148	Neox rt or clarix cord	N1	High

HCPCS Code	2018 Short Descriptor	ASC PI	CY 2018 High/Low Assignment
Q4150	Allowrap ds or dry 1 sq cm	N1	High
Q4151	Amnioband, guardian 1 sq cm	N1	High
Q4152	Dermapure 1 square cm	N1	High
Q4153	Dermavest, plurivest sq cm	N1	High
Q4154	Biovance 1 square cm	N1	High
Q4156	Neox 100 or clarix 100	N1	High
Q4157	Revitalon 1 square cm	N1	High
Q4158	Neox 100 or clarix 100	N1	High
Q4159	Neox 100 or clarix 100	N1	High
Q4160	Neox 100 or clarix 100	N1	High
Q4161	Bio-Connekt per square cm	N1	High
Q4163	Woundex, bioskin, per sq cm	N1	High
Q4164	Helicoll, per square cm	N1	High
Q4165	Keramatrix, per square cm	N1	Low
Q4166	Cytal, per square cm	N1	Low
Q4167	Truskin, per square cm	N1	Low
Q4169	Artacent wound, per square cm	N1	High
Q4170	Cygnus, per square cm	N1	Low
Q4172*	Puraply or puraply am	N1	High
Q4173	Palingen or palingen xplus	N1	High
Q4175	Miroderm	N1	High
Q4176*	Neopatch, per sq centimeter	N1	Low
Q4178*	Floweramniopatch, per sq cm	N1	Low
Q4179*	Flowerderm, per sq cm	N1	Low

HCPCS Code	2018 Short Descriptor	ASC PI	CY 2018 High/Low Assignment
Q4180*	Revita, per sq cm	N1	Low
Q4181*	Amnio wound, per square cm	N1	Low
Q4182*	Transcyte, per sq centimeter	N1	Low

Note: HCPCS codes Q4176, Q4178, Q4179, Q4180, Q4181, and Q4182 were assigned to the low-cost group in CY 2018 OPPS/ASC final rule with comment period. Pass-through status for HCPCS code Q4172 ended on December 31, 2017.

4. Section 4011 of the 21st Century Cures Act

Section 4011 of the 21st Century Cures Act created a new subsection (t) in Section 1834 of the Act that requires CMS to make available to the public a searchable Internet website that compares estimated payment and beneficiary liability for an appropriate number of items and services paid under the OPPS and the ASC Payment System. Consistent with this statute, CMS plans to first make this website available during CY 2018.

CMS believes that making available a comparison for all services that receive separate payment under both the OPPS and ASC payment system would be most useful to the public, with regards to displaying the comparison for an “appropriate number of such items and services.” CMS believes that displaying the national unadjusted payments and copayment amounts will allow the user to make a meaningful comparison between the systems for items and services paid under both systems. CMS may consider providing payment and copayment comparisons at the locality or provider level for future years.

Along with the comparison information that CMS will make available to the public in accordance with the requirements of Section 4011, CMS also plans to include a disclaimer statement that notes some of the payment policy differences in each care setting and describes the limitations of the comparison tool, to provide users with some context for why there might be potential differences. In the case of the OPPS copayments, CMS plans to include an additional indicator where the service is likely to be capped at the Part A inpatient deductible, based on the unadjusted copayments, under the OPPS coinsurance rules.

5. July ASCFS Technical Record Correction CMS is including a revised July ASCFS record to provide a technical correction to the record for 0474T, position 38, on the ASCFS record layout. The original indicator was incompatible with this code. No additional instructions are being provided to MACs at this time.

6. 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, CR10441, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3939CP.pdf.

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

DOCUMENT HISTORY

Date of Change	Description
January 2, 2017	Initial article released.