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January 2020 Update of the Ambulatory Surgical Center (ASC) Payment System

MLN Matters Number: MM11607 | Related Change Request (CR) Number: 11607
Related CR Release Date: December 27, 2019 | Effective Date: January 1, 2020
Related CR Transmittal Number: R4485CP | Implementation Date: January 6, 2020

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

CR 11607 informs MACs about updates to the ASC payment system for Calendar Year (CY) 2019 and describes changes to and billing instructions for various payment policies in the January 2020 ASC payment system update. This notification also includes updates to the HCPCS. Be sure your billing staffs are aware of these changes.

BACKGROUND

CY 2020 payment rates for separately payable procedures/services, drugs and biologicals, including descriptors for newly created Common Procedural Terminology (CPT) and Level-II HCPCS codes, are included in CR 11607. A January 2020 ASC Fee Schedule (ASCFS) File, January 2020 ASC Payment Indicator (ASC PI) File, a January 2020 ASC Drug File, and a January 2020 ASC Code Pair file are issued with CR 11607. The January 2020 changes are as follows:

1. New Device Pass-Through Categories

Section 1833(t)(6)(B) of the Social Security Act (the Act) requires that, under the Outpatient Prospective Payment System (OPPS), categories of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that the Centers for Medicare & Medicaid Services (CMS) create 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

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the OPPS.

CMS is establishing five new device pass-through categories effective January 1, 2020. Table 1 describes these categories.

Table 1. – New Device Pass-Through Codes Effective January 1, 2020

HCPCS Code	Short Descriptor	Long Descriptor	ASC PI
C1734	Orth/devic/drug bn/bn,tis/bn	Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue-to bone (implantable)	J7
C1824	Generator, CCM, implant	Generator, cardiac contractility modulation (implantable)	J7
C1839	Iris prosthesis	Iris prosthesis	J7
C1982	Cath, pressure,valve-occlu	Catheter, pressure-generating, one-way valve, intermittently occlusive	J7
C2596	Probe, robotic, water-jet	Probe, image-guided, robotic, waterjet ablation	J7

Device Offset from Payment

Section 1833(t)(6)(D)(ii) of the Act requires that CMS deducts from pass-through payments for devices in the OPPS an amount that reflects the device portion of the Ambulatory Payment Classification (APC) payment amount. This deduction is known as the device offset, or the portion(s) of the APC amount that is associated with the cost of the pass-through device. The device offset from payment represents a deduction from pass-through payments for the applicable pass-through device. This policy was implemented in the 2008 revised ASC payment system.

We have determined that there are device offset amounts associated with four of the new device pass-through categories effective January 1, 2020, that are included in Table 1.

We have determined the device offset amounts for OPPS APC 5115 (Level 5 Musculoskeletal Procedures) and OPPS APC 5116 (Level 6 Musculoskeletal Procedures) that are associated with the costs of the device category described by HCPCS code C1734. The device in the category described by C1734 should always be billed with one of the following CPT codes in the ASC setting:

- CPT code 27870 (Arthrodesis, ankle, open) which is assigned to OPPS APC 5115 for CY 2020
- CPT code 28705 (Arthrodesis; pantalar) which is assigned to OPPS APC 5116 for (CY) 2020
- CPT code 28715 (Arthrodesis; triple) which is assigned to OPPS APC 5115 for (CY) 2020

- CPT code 28725 (Arthrodesis; subtalar) which is assigned to OPPS APC 5115 for (CY) 2020

We have determined the device offset amount for OPPS APC 5231 (Level 1 ICD and Similar Procedures) that is associated with the cost of the device category described by HCPCS code C1824. The device in the category described by C1824 should always be billed in the ASC setting with CPT code 0408T (Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator with transvenous electrodes), which is assigned to OPPS APC 5231 for CY 2020.

We have determined the device offset amount for OPPS APC 5193 (Level 3 Endovascular Procedures) that is associated with the cost of the device category described by HCPCS code C1982. The device in the category described by C1982 should always be billed in the ASC setting with CPT Code 37243 (Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction), which is assigned to OPPS APC 5193 for CY 2020.

We have determined the device offset amount for OPPS APC 5376 (Level 6 Urology and Related Services) that is associated with the cost of the device category described by HCPCS code C2596. The device in the category described by C2596 should always be billed in the ASC setting with CPT code 0421T (Transurethral waterjet ablation of prostate, including control of post-operative bleeding, including ultrasound guidance, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included when performed)), which is assigned to OPPS APC 5376 for CY 2020.

2. New Separately Payable Procedure Code Effective January 1, 2020

Effective January 1, 2020, new HCPCS code C9757 has been created as described in Table 2.

Table 2. – New Separately Payable Procedure Code Effective January 1, 2020

HCPCS Code	Short Descriptor	Long Descriptor	ASC PI
C9757	Spine/lumbar disk surgery	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and excision of herniated intervertebral disc, and repair of annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment, and image guidance; 1 interspace, lumbar	J8

3. New CY2020 HCPCS Codes for Separately Payable Drugs and Biologicals Effective January 1, 2020

For CY 2020, several new HCPCS codes have been created for reporting drugs and biologicals in the ASC setting, where there have not previously been specific codes available. These new codes are listed in Table 3.

Table 3. — New CY2020 HCPCS Codes for Separately Payable Drugs and Biologicals Effective January 1, 2020

HCPCS Code	Short Descriptor	Long Descriptor	CY 2020 SI
C9054	Injection, lefamulin	Injection, lefamulin (Xenleta), 1 mg	K2
C9055	Inj, brexanolone	Injection, brexanolone, 1mg	K2
J0642	Injection, khapzory, 0.5 mg	Injection, levoleucovorin (khapzory), 0.5 mg	K2
J7331	Synojoynt, inj., 1 mg	Hyaluronan or derivative, synojoynt, for intra-articular injection, 1 mg	K2
J7332	Inj., triluron, 1 mg	Hyaluronan or derivative, triluron, for intra-articular injection, 1 mg	K2

a. Changes to CY 2019 HCPCS and CPT Codes for Certain Drugs and Biologicals

Many HCPCS and CPT codes for drugs and biologicals have undergone changes in their descriptors that will be effective in CY 2020. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2019, and replaced with permanent HCPCS codes effective in CY 2020. ASCs should pay close attention to accurate billing for units of service consistent with the dosages contained in the descriptors of the active CY 2020 HCPCS and CPT codes. Table 4 notes certain ASC drugs and biologicals that have undergone changes in their HCPCS/CPT code, their long descriptor, or both.

Table 4. — Other CY 2020 HCPCS Code Changes for Certain Drugs and Biologicals

CY 2019 HCPCS Code	CY 2019 Long Descriptor	CY 2020 HCPCS Code	CY 2020 Short Descriptor	CY 2020 Long Descriptor
C9407	Iodine i-131 iobenguane, diagnostic, 1 millicurie	A9590	Iodine i-131 iobenguane 1mci	Iodine i-131 iobenguane, 1 millicurie
C9408	Iodine i-131 iobenguane, therapeutic, 1 millicurie	A9590	Iodine i-131 iobenguane 1mci	Iodine i-131 iobenguane, 1 millicurie

b. Drugs and Biologicals with Payments Based on Average Sales Price (ASP)

For CY 2020, 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. In addition, in CY 2019, a single payment of ASP + 6 percent continues to be made for 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 January 1, 2020, are in the January 2020 update of ASC Addendum BB at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html.

c. 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 MAC adjustment of the previously processed claims.

4. Skin Substitutes

a. Skin Substitute Procedure Edits

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 for packaging purposes:

1. High-cost skin substitute products
2. Low-cost skin substitute products.

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. Table 5 lists the skin substitute products and their assignment as either a high-cost or a low-cost skin substitute product, when applicable.

Note: ASCs should not separately bill for packaged skin substitutes (ASC PI=N1) since

packaged codes are not reportable under the ASC payment system.

Table 5. – Skin Substitute Assignments to High Cost and Low Cost Groups for CY2020

CY 2019 HCPCS Code	CY 2020 Short Descriptor	ASC PI	CY 2019 High/Low Cost Assignment	CY 2020 High/Low Cost Assignment
C9363	Integra meshed bil wound mat	N1	High	High
Q4100	Skin substitute, nos	N1	Low	Low
Q4101	Apligraf	N1	High	High
Q4102	Oasis wound matrix	N1	Low	Low
Q4103	Oasis burn matrix	N1	High	High
Q4104	Integra bmwd	N1	High	High
Q4105	Integra drt or omnigraft	N1	High	High
Q4106	Dermagraft	N1	High	High
Q4107	Graftjacket	N1	High	High
Q4108	Integra matrix	N1	High	High*
Q4110	Primatrix	N1	High	High*
Q4111	Gammagraft	N1	Low	Low
Q4115	Alloskin	N1	Low	Low
Q4116	Alloderm	N1	High	High
Q4117	Hyalomatrix	N1	Low	Low
Q4121	Theraskin	N1	High	High*
Q4122	Dermacell, awm, porous sq cm	N1	High	High
Q4123	Alloskin	N1	High	High*
Q4124	Oasis tri-layer wound matrix	N1	Low	Low
Q4126	Memoderm/derma/tranz/integup	N1	High	High
Q4127	Talymed	N1	High	High
Q4128	Flexhd/allopatchhd/matrixhd	N1	High	High
Q4132	Grafix core, grafixpl core	N1	High	High
Q4133	Grafix stravix prime pl sqcm	N1	High	High
Q4134	Hmatrix	N1	Low	Low
Q4135	Mediskin	N1	Low	Low
Q4136	Ezderm	N1	Low	Low
Q4137	Amnioexcel biodexcel 1sq cm	N1	High	High
Q4138	Biodfence dryflex, 1cm	N1	High	High
Q4140	Biodfence 1cm	N1	High	High
Q4141	Alloskin ac, 1cm	N1	High	High*
Q4143	Repriza, 1cm	N1	High	High
Q4146	Tensix, 1cm	N1	High	High
Q4147	Architect ecm px fx 1 sq cm	N1	High	High
Q4148	Neox neox rt or clarix cord	N1	High	High
Q4150	Allowrap ds or dry 1 sq cm	N1	High	High
Q4151	Amnioband, guardian 1 sq cm	N1	High	High

CY 2019 HCPCS Code	CY 2020 Short Descriptor	ASC PI	CY 2019 High/Low Cost Assignment	CY 2020 High/Low Cost Assignment
Q4152	Dermapure 1 square cm	N1	High	High
Q4153	Dermavest, plurivest sq cm	N1	High	High
Q4154	Biovance 1 square cm	N1	High	High
Q4156	Neoxflo or clarixflo 1 mg	N1	High	High
Q4157	Revitalon 1 square cm	N1	High	High*
Q4158	Kerecis omega3, per sq cm	N1	High	High*
Q4159	Affinity1 square cm	N1	High	High
Q4160	Nushield 1 square cm	N1	High	High
Q4161	Bio-connekt per square cm	N1	High	High
Q4163	Woundex, bioskin, per sq cm	N1	High	High
Q4164	Helicoll, per square cm	N1	High	High*
Q4165	Keramatrix, kerasorb sq cm	N1	Low	Low
Q4166	Cytal, per square centimeter	N1	Low	Low
Q4167	Truskin, per sq centimeter	N1	Low	Low
Q4169	Artacent wound, per sq cm	N1	High	High
Q4170	Cygnus, per square cm	N1	Low	Low
Q4173	Palingen or palingen xplus	N1	High	High
Q4175	Miroderm	N1	High	High
Q4176	Neopatch, per sq centimeter	N1	High	High
Q4178	Floweramniopatch, per sq cm	N1	High	High
Q4179	Flowerderm, per sq cm	N1	High	High
Q4180	Revita, per sq cm	N1	High	High
Q4181	Amnio wound, per square cm	N1	High	High*
Q4182	Transcyte, per sq centimeter	N1	Low	Low
Q4183	Surgigraft, 1 sq cm	N1	High	High*
Q4184	Cellesta or duo per sq cm	N1	High	High*
Q4186	Epifix 1 sq cm	N1	High	High
Q4187	Epicord 1 sq cm	N1	High	High
Q4188	Amnioarmor 1 sq cm	N1	Low	Low
Q4190	Artacent ac 1 sq cm	N1	Low	Low
Q4191	Restorigin 1 sq cm	N1	Low	Low
Q4193	Coll-e-derm 1 sq cm	N1	Low	Low
Q4194	Novachor 1 sq cm	N1	High	High*
Q4195+	Puraply 1 sq cm	K2	High	High
Q4196+	Puraply am 1 sq cm	K2	High	High
Q4197	Puraply xt 1 sq cm	N1	High	High
Q4198	Genesis amnio membrane 1 sqcm	N1	Low	Low
Q4200	Skin te 1 sq cm	N1	Low	Low
Q4201	Matrion 1 sq cm	N1	Low	Low
Q4203	Derma-gide, 1 sq cm	N1	High	High*
Q4204	Xwrap 1 sq cm	N1	Low	Low

CY 2019 HCPCS Code	CY 2020 Short Descriptor	ASC PI	CY 2019 High/Low Cost Assignment	CY 2020 High/Low Cost Assignment
Q4205	Membrane graft or wrap sq cm	N1	Low	Low
Q4208	Novafix per sq cm	N1	Low	High
Q4209	Surgraft per sq cm	N1	Low	Low
Q4210	Axolotl graf dualgraf sq cm	N1	Low	Low
Q4211	Amnion bio or axobio sq cm	N1	Low	Low
Q4214	Cellesta cord per sq cm	N1	Low	Low
Q4216	Artacent cord per sq cm	N1	Low	Low
Q4217	Woundfix biowound plus xplus	N1	Low	Low
Q4218	Surgicord per sq cm	N1	Low	Low
Q4219	Surgigraft dual per sq cm	N1	Low	Low
Q4220	Bellacell hd, surederm sq cm	N1	Low	Low
Q4221	Amniowrap2 per sq cm	N1	Low	Low
Q4222	Progenamatrix, per sq cm	N1	Low	Low
Q4226	Myown harv prep proc sq cm	N1	Low	Low

* These products do not exceed either the proposed Mean Unit Cost (MUC) or Per Day Cost (PDC) threshold for CY 2020, but are assigned to the high-cost group because they were assigned to the high-cost group in CY 2019.
+ Pass-through payment status in CY 2020. Pass-through payment status expires September 30, 2020.

5. Coverage Determinations

The fact that a drug, device, procedure or service is assigned an 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 whether a drug, device, procedure or other service is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

ADDITIONAL INFORMATION

The official instruction, CR 11607, issued to your MAC regarding this change is available at https://www.cms.gov/files/document/r4485CP.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
December 31, 2019	Initial article released.