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April 2022 Update of the Ambulatory Surgical Center (ASC) Payment System

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Provider Types Affected

This MLN Matters Article is for ASCs, and suppliers billing Medicare Administrative Contractors (MACs) for services they provide to Medicare patients.

Provider Action Needed

Make sure your billing staff knows about these changes:

- Updates to Calendar Year (CY) 2022 payment rates for separately payable procedures, services, drugs, and biologicals
- Descriptors for newly created CPT and Level II HCPCS codes

Background

The changes for the April 2022 ASC Payment system are:

1. Device Offset from Payment for HCPCS Codes C1748

CMS deducts from Outpatient Prospective Payment System (OPPS) passthrough payments, from devices, an amount that shows the device portion of the Ambulatory Payment Classification (APC) payment amount. This deduction is the device offset, or the portion(s) of the APC amount that's associated with the cost of the pass-through device. The device offset represents a deduction from the ASC procedure payment for the applicable passthrough device.

In the January 2021 ASC quarterly update (Transmittal 10557, CR 12129, January 8, 2021), we listed the procedure codes reportable with device category:

- HCPCS code C1748 (Endoscope, single-use (i.e. disposable) Upper GI, imaging/illumination device (insertable))

We specified the device offset amounts for the procedure codes associated with HCPCS code C1748. CPT codes 43260-43265 and CPT codes 43274-43278 have an offset amount of $0.00.

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Effective April 1, 2022, we're updating the list of procedure codes associated with HCPCS code C1748. You may also bill the device described by device category HCPCS code C1748 with 1 of the following CPT codes: 0652T, 0653T, 0654T, 43197, or 43198.

The long descriptors for these CPT codes are below. These codes also have an offset amount of $0.00. Note: The codes are assigned to APC 5301 (Level 1 Upper GI Procedures) and APC 5302 (Level 2 Upper GI Procedures).

- CPT code 0652T - Esophagogastroduodenoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
- CPT code 0653T - Esophagogastroduodenoscopy, flexible, transnasal; with biopsy, single or multiple
- CPT code 0654T - Esophagogastroduodenoscopy, flexible, transnasal; with insertion of intraluminal tube or catheter
- CPT code 43197 - Esophagoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
- CPT code 43198 - Esophagoscopy, flexible, transnasal; with biopsy, single or multiple

2. New HCPCS Code Describing the In Space Subacromial Tissue Spacer System Procedure

We're establishing a new HCPCS code, C9781, to describe the implantation of a saline-filled balloon for the shoulder to treat irreparably torn rotator cuff tendons. Table 1 of CR 12679 lists the short descriptor, long descriptor, and ASC PI for HCPCS code C9781.

3. Existing CY 2022 HCPCS Code and Dosage Descriptor for Certain Drugs Receiving Pass-Through Status Starting April 1, 2022

One drug with existing HCPCS codes for which pricing information and claims data weren't previously available will receive drug pass-through status starting April 1, 2022. The HCPCS code, descriptors, and ASC PIs are in Table 2 of CR 12679.

a. Newly Established HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals Effective April 1, 2022

We've established 9 new drug, biological, and radiopharmaceutical HCPCS codes effective April 1, 2022. These HCPCS codes and their descriptors, as well as codes deleted as of March 31, 2022, are in Table 3 of CR 12679.

b. HCPCS Code M1145 Deleted Retroactive to February 28, 2022

We're deleting HCPCS code M1145 (Most Favored Nation (MFN)) model drug add-on amount, per dose, (do not bill with line items that have the jw modifier)) retroactive to February 28, 2022. See Table 4 of CR 12679.

c. Rabies Immune Globulin that Will Retroactively Change from Non-Payable Status to Payable Status Effective January 1, 2021

We're revising the ASC payment indicator from K5 to K2, retroactive to January 1, 2021. This vaccine and its descriptor is in Table 5 of CR 12679.

d. Hepatitis-B Vaccine that Is Retroactively Payable at Reasonable Cost-Effective January 11, 2022

CPT code 90759 is retroactively payable at reasonable cost (ASC PI= F4) effective January 11, 2022, in the ASC payment system. This vaccine HCPCS code, descriptors, ASC PI, and effective date are in Table 6 of CR 12679.

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

For CY 2022, payment for nonpass-through drugs and biologicals continues at a single rate of ASP + 6%. This provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug or biological. Also, in CY 2022, a single payment of ASP + 6% continues for the OPPS pass-through drugs and biologicals. This provides payment for both the acquisition cost and pharmacy overhead costs of these pass-through items.

We'll update payments for drugs and biologicals based on ASPs on a quarterly basis as later-quarter ASP submissions become available. Updated payment rates effective April 1, 2022, are in the April 2022 update of ASC Addendum BB.

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

We may correct retroactively the payment rates of some drugs and biologicals based on the ASP methodology. These retroactive corrections usually happen on a quarterly basis. The list of drugs and biologicals with corrected payment rates is available on the first date of the quarter at Restated Drug and Biological Payment Rates.

Suppliers who think they got an incorrect payment for drugs and biologicals affected by these corrections may request their MAC adjust previously processed claims.

g. Billing and Payment for New Drugs, Biologicals, or Radiopharmaceuticals Approved by the FDA but Before Assignment of a Product-Specific HCPCS Code

As in the OPPS, ASCs are allowed to use the unclassified drug/biological HCPCS code C9399 (Unclassified drugs or biological) to bill for new drugs, biologicals, and therapeutic radiopharmaceuticals approved by the FDA on or after January 1, 2004, for which OPPS pass-through status hasn't been approved and a C-code and APC payment haven't been assigned. Drugs, biologicals, and therapeutic radiopharmaceuticals you bill with HCPCS code C9399 are MAC priced.

Diagnostic radiopharmaceuticals and contrast agents are policy packaged under both the OPPS

and ASC payment system unless they've been granted pass-through status. Therefore, new diagnostic radiopharmaceuticals and contrast agents are an exception to the above policy and shouldn't be billed with C9399 prior to the approval of pass-through status. These are packaged instead in the ASC setting with payment already included in the surgical procedure performed and aren't billed.

4. Skin Substitutes

We package payment for skin substitute products that don't qualify for hospital OPPS pass-through status into the OPPS payment for the associated skin substitute application procedure. This policy also applies in the ASC payment system. The skin substitute products are divided into 2 groups for packaging purposes:

- High-cost skin substitute products
- Low-cost skin substitute products

You should only use high-cost skin substitute products in combination with the performance of 1 of the skin application procedures described by CPT codes 15271-15278.

Only use low-cost skin substitute products in combination with the performance of 1 of the skin application procedures described by HCPCS codes C5271-C5278.

You should bill all OPPS pass-through skin substitute products (ASC PI=K2) in combination with 1 of the skin application procedures described by CPT code 15271-15278.

a. New Skin Substitute Products Low-Cost Group/High-Cost Group Assignment Effective April 1, 2022

There are 9 skin substitute HCPCS codes that are newly added to the ASC payment system as of April 1, 2022. These codes are in Table 7 of CR 12679. Don't separately bill for packaged skin substitutes (ASC PI=N1) since packaged codes aren't reportable under the ASC payment system.

b. Skin Substitute Products Reassigned to the High-Cost Skin Substitute Group as of April 1, 2022

There is 1 skin substitute HCPCS code that is reassigned from the low-cost skin substitute group to the high-cost skin substitute group as of April 1, 2022. The code (Q4199) is in Table 8 of CR 12679.

5. ASC Device Pass-Through Code Payments Reminder

As a reminder, ASC pass-through devices are covered ancillary services, which are paid separately, and are MAC priced based on acquisition cost or invoice. Payable ASC pass-through device codes carry an ASC PI= J7 (OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced). More

information is in Chapter 14 of the Medicare Claims Processing Manual.

6. ASC Offset for Payment for Pass-through Devices

As a reminder, MACs reduce the approved payment amount for specifically identified procedures with an offset amount greater than 0 when provided in conjunction with a specific pass-through device. We identify these code pairs as part of the quarterly update to the ASC payment system transmittals. The device offset amount is the device portion in Addendum FF of the quarterly addenda file. To determine the payment rate for the approved surgical procedure that is billed with an OPPS pass-through device, subtract the device portion from the ASC payment rate.

There's no related calculation or offset performed on the device. The ASC code pair file procedure percent reductions impact only the core based statistical area procedure payment rate. More information is in Chapter 14 of the Medicare Claims Processing Manual.

Updates to both the ASC code pairs and the ASC addenda are available on the CMS website.

7. Coverage Determinations

The fact that we assign a HCPCS code and a payment rate to a drug, device, procedure, or service under the ASC payment system doesn't 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's reasonable and necessary to treat the patient's condition and whether it's excluded from payment.

More Information

We issued CR 12679 to your MAC as the official instruction for this change.

For more information, find your MAC's website.

Document History

Date of Change	Description
March 24, 2022	Initial article released.