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Ambulatory Surgical Center Payment System: January 2024 Update

Related CR Release Date: January 2, 2024 Revised

Effective Date: January 1, 2024

Implementation Date: January 2, 2024

MLN Matters Number: MM13481

Related Change Request (CR) Number: [CR 13481]

Related CR Transmittal Number: R12429CP

Related CR Title: January 2024 Update of the Ambulatory Surgical Center (ASC) Payment System

What's changed: We changed the number of HCPCS codes in Tables 8 and 10 (pages 4-5) and updated the web address of the CR transmittal.

Affected Providers

This MLN Matters Article is for:

- ASCs
- Dentists
- Suppliers
- Other providers billing Medicare Administrative Contractors (MACs) for services they provide to Medicare patients

Action Needed

Make sure your billing staff knows about system updates for January, including new codes for:

- Covered devices for pass-through payments
- Biology-guided radiation therapy
- Facility services for covered dental rehabilitation procedures
- Surgical procedures
- Drugs and biologicals
- Skin substitutes

Background

The changes for the January 2024 ASC Payment system are:

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1. **Effective January 1, 2024:**

a. 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. Also, Section 1833(t)(6)(B)(ii)(IV) of the Act requires CMS to create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices. We apply this policy in the ASC payment system.

For the January 2024 update, we approved 5 new devices for pass-through status under the OPPS and are establishing the new device categories in the ASC payment system. HCPCS codes C1600, C1601, C1602, and C1603 are effective January 1, 2024. See Table 1 of CR 13481 for the HCPCS code, code descriptors, and ASC Payment Indicators (PI).

Note: HCPCS code C1604 (Grft, trnsmurl/trnsvens byps), which is newly approved for pass-through status under the OPPS effective January 1, 2024, isn't eligible to be payable in ASCs because there isn't a covered surgical procedure you can perform with C1604. We package C1604 (ASCPI=N1) in the ASC setting beginning January 1, 2024.

b. New Device Offset from Payment for Certain HCPCS Codes

Section 1833(t)(6)(D)(ii) of the Act requires that we deduct from OPPS pass-through payments for devices an amount that shows the device portion of the ambulatory payment classification (APC) payment amount. This deduction is the device offset, or the part of the APC amount that's associated with the cost of the pass-through device.

We've determined that offsets are associated with the costs of the new device categories described by the HCPCS codes. See Table 2 of CR 13481. Always bill each device in these categories in the ASC setting with 1 of the associated CPT codes in Table 2. The associated devices, procedures, and offset percentages are in the January 2024 ASC code pair file.

Note: Always bill device category HCPCS Codes C1600-C1603 with 1 of the paired CPT codes in Table 2.

c. Expiration of OPPS Pass-through Status for 8 Device Category HCPCS Codes

Section 1833(t)(6)(B) of the Act, under the OPPS, requires eligibility for transitional pass-through payments for at least 2 but not more than 3 years. The 3 codes, C1825, C1052, and C1062, expire January 1, 2024. See Table 3 of CR 13481. Also, we extended pass-through status for certain devices for a 1-year period starting January 1, 2023. The OPPS pass-through status of the devices with this extension expires December 31, 2023. These 5 codes, C1734, C1824, C1839, C1982, and C2596, are also in Table 3.

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These codes were separately payable in the ASC setting and we'll package them (ASC PI=N1) in the ASC setting starting January 1, 2024. We'll include payment for these codes in the primary service. ASCs shouldn't separately bill for packaged codes (ASC PI=N1) since they aren't reportable under the ASC payment system.

2. New HCPCS Code Describing Biology-Guided Radiation Therapy Service Effective January 1, 2024

There's 1 new separately payable HCPCS code, C9794, describing a biology-guided radiation therapy service in the ASC setting. See Table 4 of CR 13481 for code C9794, descriptors, and ASC PI.

3. Payment for HCPCS Code G0330 & CDT (Current Dental Terminology) Dental Codes Added to the ASC Payment System effective January 1, 2024

HCPCS code G0330 only describes facility services for covered dental rehabilitation procedures provided to a patient requiring monitored anesthesia (for example: general, intravenous sedation (monitored anesthesia care)) and use of an operating room. Use G0330 to bill the technical, facility-fee component of dental rehabilitation services only. See Table 5 of CR 13481 for code G0330, descriptors, and ASC PI.

Don't use G0330 to bill the professional services of dentists and other dental professionals.

The CY 2024 OPPS/ASC final rule added 104 dental procedures to the ASC Covered Procedures List (CPL), including those procedures that you bill with G0330. See Table 6 of CR 13481 for the dental codes effective January 1, 2024.

We added 2 new ASC PIs:

1. D1 (Ancillary dental service/item; no separate payment made) separates packaged dental HCPCS D-codes from packaged medical codes we assign to ASC PI=N1 (Packaged service/item; no separate payment made). D-codes with an ASC PI=D1 assignment indicate ancillary dental services. We expect ASCs to bill these packaged D1 codes with HCPCS G0330.
   - We added 78 ancillary dental services to the list of covered ancillary services, and each ancillary service has a packaged payment indicator of D1.
   - The complete list of dental services assigned to ASC PI=D1 is in ASC Addendum BB.
2. D2 (Non-office-based dental procedure added in CY 2024 or later) is for separately payable HCPCS D-code surgical procedures.
   - We added 26 dental procedures as separately payable dental surgical procedures on the ASC CPL with ASC PI=D2.
   - The complete list of dental services assigned to ASC PI=D2 is in ASC Addendum AA.

Notes for G0330:

- We assigned G0330 to ASC PI=D2.

- You can bill G0330 only:
  - Once in an encounter
  - With 1 or more ancillary dental services with ASC PI=D1 when these dental services are inextricably linked to the clinical success of an otherwise covered medical service and are related and essential to that primary medical service
- You may perform the dental services before or along with covered medical service
- You don't have to perform the dental service during the same encounter as the covered medical services

ASC billing of HCPCS code G0330 without 1 or more ASC PI=D1 codes will result in the denial of the G-code.

Remember, these dental services must be so integral to other medically necessary services that they're inextricably linked to the clinical success of that medical service. These dental services aren't in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth within the meaning of Section 1862(a)(12) of the Act. Rather, these dental services are inextricably linked to the clinical success of an otherwise covered medical service, and are payable under Medicare Parts A and B. See MLN Matters Article MM13452.

4. New ASC Surgical Procedures Effective January 1, 2024

We added 41 new separately payable procedures to the ASC covered procedure list. See Table 7 of CR 13481 for the CPT codes, descriptors, and ASC PIs. The ASC payment rates for these codes are in the January 2024 ASC Addenda AA and BB.

5. Drugs, Biologicals, & Radiopharmaceuticals

a. Newly Established HCPCS Codes for Drugs & Biologicals as of January 1, 2024

We're establishing 27 new drug and biological HCPCS codes on January 1, 2024. See Table 8 of CR 13481 for these HCPCS codes as well as the descriptors and ASC PIs. We'll delete the former codes included in the "old HCPCS code" column of Table 8 on December 31, 2023.

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

For CY 2024, we continue paying for nonpass-through drugs and biologicals at a single rate of ASP + 6% (or ASP + 6 or 8% of the reference product for biosimilars). This payment includes both the acquisition cost and pharmacy overhead costs associated with the drug or biological.

We'll update payments for drugs and biologicals based on ASPs on a quarterly basis as later quarter ASP submissions become available. Effective January 1, 2024, payment rates for many drugs and biologicals have changed from the values published in the CY 2024 OPPS/ASC final rule with comment period as a result of more recent ASP data. Updated payment rates effective January 1, 2024, are in the January 2024 update of ASC Addendum BB.

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

We may retroactively correct payment rates for some drugs and biologicals with payment rates based on ASP methods. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payment rates will be available on the first date of the quarter at Restated Drug and Biological Payment Rates.

If you think you may have gotten an incorrect payment for drugs and biologicals impacted by these corrections, you may ask your MAC to adjust the previously processed claims.

5. Skin Substitutes

We package the 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 to the ASC payment system. Skin substitute products are packaged into 2 groups:

1. High-cost skin substitute products – Only use these when you perform 1 of the skin application procedures described by CPT codes 15271-15278.
2. Low-cost skin substitute products –Only use these when you performed 1 of the skin application procedures described by HCPCS codes C5271-C5278.

We assign new skin substitute HCPCS codes into the low-cost skin substitute group unless we have OPPS pricing data showing the cost of the product is above either of these:

- The mean unit cost of $47
- The per day cost of $807 for CY 2024

a. New Skin Substitute Products as of January 1, 2024

There are 19 new skin substitute HCPCS codes effective January 1, 2024. We packaged and assigned these codes to the low-cost skin substitute group. See Table 9 of CR 13481 for these new packaged codes.

Note: ASCs shouldn't separately bill for packaged skin substitutes since you can't report packaged codes (ASC PI=N1) under the ASC payment system.

b. Skin Substitute Products Reassigned to the High-Cost Skin Substitute Group as of January 1, 2024

Effective January 1, 2024, we reassigned 2 HCPCS codes, Q4278 and A2025, from the low-cost skin substitute group to the high-cost skin substitute group. See Table 10 of CR 13481.

6. Coverage Determinations

The fact that we assign a drug, device, procedure, or service a HCPCS code and a payment rate under the ASC payment system doesn't imply coverage by the Medicare Program. It only

shows how we pay for the product, procedure, or service if Medicare covers it. MACs decide if a drug, device, procedure, or other service meets all program coverage requirements. For example, MACs decide that it's reasonable and necessary to treat the patient's condition and if it's excluded from payment.

More Information

We issued CR 13481 to your MAC as the official instruction for this change.

For more information, find your MAC's website.

Document History

Date of Change	Description
January 3, 2024	We changed the number of HCPCS codes in Tables 8 and 10 (pages 4-5) and updated the web address of the CR transmittal.
December 21, 2023	Initial article released.

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