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April 2019 Update of the Ambulatory Surgical Center (ASC) Payment System

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Related CR Transmittal Number: R4263CP
Implementation Date: April 1, 2019

PROVIDER TYPES AFFECTED

This MLN Matters Article is for physicians, providers, and suppliers billing Medicare Administrative Contractors (MACs) for services subject to the Ambulatory Surgical Center (ASC) payment system and provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR11232 describes changes to and billing instructions for various payment policies implemented in the April 2019 ASC payment system update. The CR also includes HCPCS updates. Please make sure your billing staffs are aware of these changes.

BACKGROUND

This article includes Calendar Year (CY) 2019 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 Centers for Medicare & Medicaid Services (CMS) is also including an April 2019 ASC Payment Indicator (ASC PI) file. CMS is not issuing April 2019 ASC Fee Schedule (ASCFS) and ASC Code Pair files in CR11232. The changes are as follows:

1. Drugs and Biologicals

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective April 1, 2019

For CY 2019, payment for non-pass-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. Also, in CY 2019, a single payment of ASP + 6 percent continues for Outpatient Prospective Payment System (OPPS)

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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 update on a quarterly basis as later-quarter ASP submissions become available. Updated payment rates effective April 1, 2019, are available in the April 2019 update of ASC Addendum BB at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html.

b. HCPCS Codes and Dosage Descriptors for Certain Drugs and Biologicals Effective April 1, 2019

For CY 2019, seven new HCPCS codes were created for reporting drugs and biologicals in the ASC payment system where there have not previously been specific codes available. Table 1 shows these new codes.

Table 1 – HCPCS Codes and Dosage Descriptors for Certain Drugs and Biologicals Effective April 1, 2019

HCPCS Code	Long Descriptor	Short Descriptor	ASC PI
C9040	Injection, fremanezumab-vfrm, 1mg	Injection, fremanezumab-vfrm	K2
C9041	Injection, coagulation factor Xa (recombinant), inactivated (andexxa), 10mg	Inj, coagulation faxtor Xa	K2
C9141	Injection, factor viii, (antihemophilic factor, recombinant), pegylated-aucl (jivi) 1 i.u.	Factor viii pegylated-aucl	K2
C9043	Injection, levoleucovorin, 1 mg	Injection, levoleucovorin	K2
C9044	Injection, cemiplimab-rwlc, 1 mg	Injection, cemiplimab-rwlc	K2
C9045	Injection, moxetumomab pasudotox-tdfk, 0.01 mg	Moxetumomab pasudotox-tdfk	K2
C9046	Cocaine hydrochloride nasal solution for topical administration, 1 mg	Cocaine hcl nasal solution	K2

c. HCPCS Code Change for Certain Drugs and Biologicals Effective April 1, 2019

One (1) code, HCPCS J3245, will be separately payable beginning April 1, 2019, and will have an ASC PI = K2 (Drugs and Biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate). This code was previously ASC PI = Y5 (Non-Surgical Procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made). Table 2 lists this code.

Table 2 – HCPCS Code Change for Certain drugs and Biologicals Effective April 1, 2019

HCPCS Code	Long Descriptor	Short Descriptor	Old ASC PI	ASC PI
J3245	Injection, tildrakizumab, 1 mg	Inj., tildrakizumab, 1 mg	Y5	K2

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 CMS 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 CMS website 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.

2. Reassignment of Skin Substitute Products from the Low-Cost Group to the High-Cost Group

Payments 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. CMS also implements this policy in the ASC payment system. The skin substitute products were divided into two groups for packaging purposes:

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

Table 3 lists the skin substitute product and its assignment as either a high-cost or a low-cost skin substitute product, when applicable.

Table 3 – Reassignment of Skin Substitute Products from the Low-Cost Group to the High-Cost Group Effective April 1, 2019

HCPCS Code	Short Descriptor	ASC PI	Low/High-Cost Skin Substitute
Q4183	Surgigraft, 1 sq cm	N1	High
Q4184	Cellesta, 1 sq cm	N1	High
Q4194	Novachor 1 sq cm	N1	High
Q4203	Derma-gide, 1 sq cm	N1	High

ASCs should not separately bill for packaged skin substitutes (ASC PI = N1). You should only use high-cost skin substitute products in combination with the performance of one of the skin application procedures described by the Current Procedural Terminology (CPT) codes 15271-15278. You should only use low-cost skin substitute products in combination with the performance of one 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 one of the skin application procedures described by CPT codes 15271-15278.

The skin substitute products in Table 3 are reassigned from the low-cost skin substitute group to the high-cost skin substitute group based on updated pricing information.

3. 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 that it is reasonable and necessary to treat the beneficiary's condition and whether to exclude it from payment.

ADDITIONAL INFORMATION

The official instruction, CR11232, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4263CP.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
March 22, 2019	Initial article released.

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