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January 2021 Update of the Ambulatory Surgical Center (ASC) Payment System

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Related Change Request (CR) Number: 12129
Related CR Release Date: January 8, 2021
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Related CR Transmittal Number: R10557CP
Implementation Date: January 4, 2021

Note: We revised this article to reflect the revised CR 12129, which CMS issued on January 8. The revisions to the CR did not change the substance of this article, In the article, we changed the CR release date, transmittal number (see above), and the web address of the CR. All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (A/B Medicare Administrative Contractors (A/B MACs)) for services to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article describes changes to and billing instructions for various payment policies implemented in the January 2021 Ambulatory Surgical Center (ASC) payment system update. CR 12129 also includes updates to HCPCS. Make sure that your billing staffs are aware of these changes.

BACKGROUND

CR 12129 includes Calendar Year (CY) 2021 payment rates for separately payable procedures/services, drugs and biologicals, including descriptors for newly created CPT and Level II HCPCS codes. CMS will issue a January 2021 ASC Fee Schedule (ASCFS) File, January 2021 ASC Payment Indicator (ASC PI) File, a January 2021 ASC Drug File, and a January 2021 ASC Code Pair file in conjunction with CR 12129.

Following are the key points of CR 12129:

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

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Act requires that 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 the OPPS. Three new device pass-through categories are established as of January 1, 2021. Table 1 of CR 12129 describes these categories for HCPCS codes C1825, C1052, and C1062.

a. Device Offset from Payment:

Section 1833(t)(6)(D)(ii) of the Act requires that we deduct 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 determined that there are device offset amounts associated with each of the new device pass-through categories effective January 1, 2021, that are included in Table 1. There are also device offset amount changes associated with existing device pass-through HCPCS C1839, C1748, and C1982.

We determined the device offset amounts for OPPS APC 5491 Level 1 Intraocular Procedures and OPPS APC 5492 Level 2 Intraocular Procedures that are associated with the costs of the device category described by HCPCS code C1839 (Iris prosthesis). The device in the category described by HCPCS code C1839 should always be billed by ASCs with one of the following CPT codes:

- CPT code 0616T – Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; without removal of crystalline lens or intraocular lens, without insertion of intraocular lens, which is assigned to OPPS APC 5491 for CY 2021
- CPT code 0617T – Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; with removal of crystalline lens and insertion of intraocular lens, which is assigned to OPPS APC 5492 for CY 2021
- CPT code 0618T – Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; with removal of crystalline lens and insertion of intraocular lens, which is assigned to OPPS APC 5492 for CY 2021

We determined the device offset amount for OPPS APC 5465 (Level 5 Neurostimulator and Related Procedures) that is associated with the cost of the device category described by HCPCS code C1825 (Generator, neurostimulator (implantable), non-rechargeable with carotid sinus baroreceptor stimulation lead(s)). The device in the category described by HCPCS code C1825 should be billed by ASCs with the following CPT code:

- CPT code 0266T (Implt/rpl crtd sns dev total), which is assigned to OPPS APC 5465 for CY 2021

We determined the device offset amounts for OPPS APC 5302 (Level 2 Upper Gastrointestinal (GI) Procedures) and OPPS APC 5312 (Level 2 Lower GI Procedures) that are associated with the cost of the device category described by HCPCS code C1052 (Hemostatic agent, gastrointestinal, topical). The device in the category described by HCPCS code C1052 should always be billed by ASCs with one of the following CPT codes:

- CPT code 43227 (Esophagoscopy control bleed), which is assigned to OPPS APC 5302 for CY 2021
- CPT code 43255 (Egd control bleeding any), which is assigned to OPPS APC 5302 for CY 2021
- CPT code 44366 (Small bowl endoscopy), which is assigned to OPPS APC 5302 for CY 2021
- CPT code 44378 (Small bowel endoscopy), which is assigned to OPPS APC 5302 for CY 2021
- CPT code 44391 (Colonoscopy for bleeding), which is assigned to OPPS APC 5312 for CY 2021
- CPT code 45334 (Sigmoidoscopy for bleeding), which is assigned to OPPS APC 5312 for CY 2021
- CPT code 45382 (Colonoscopy w/control bleed), which is assigned to OPPS APC 5312 for CY 2021

We determined the device offset amount for OPPS APC 5114 (Level 4 Musculoskeletal Procedures) that is associated with the cost of the device category described by HCPCS code C1062 (Intravertebral body fracture augmentation with implant (e.g., metal, polymer). The device in the category described by HCPCS code C1062 should always be billed with one of the following CPT codes:

- CPT code 22513 (Perq vertebral augmentation), which is assigned to OPPS APC 5114 for CY 2021
- CPT code 22514 (Perq vertebral augmentation), which is assigned to OPPS APC 5114 for CY 2021

On July 1, 2020, we determined that an offset would apply to HCPCS code C1748 (Endoscope, single-use, (i.e. disposable), Upper GI, imaging/illumination device (insertable)) because OPPS APC 5303 (Level 3 Upper GI Procedures) and OPPS APC 5331 (Complex GI Procedures) already contain costs associated with the device described by HCPCS code C1748. HCPCS code C1748 should always be billed with the CPT codes listed below. The device offset is a deduction from pass-through payments for HCPCS code C1748. After further review, we determined that the costs associated with HCPCS code C1748 are not already reflected in OPPS APCs 5303 or 5331. Therefore, CMS is not applying a device offset to HCPCS code C1748. This determination to not apply the device offset from payment will be retroactive to July 1, 2020. Your MAC will reprocess affected claims.

- CPT code 43260 (Ercp w/specimen collection), which is assigned to OPPS APC 5303 for CY 2021
- CPT code 43261 (Endo cholangiopancreatograph), which is assigned to OPPS APC 5303 for CY 2021
- CPT code 43262 (Endo cholangiopancreatograph), which is assigned to OPPS APC 5303 for CY 2021
- CPT code 43263 (Ercp sphincter pressure meas), which is assigned to OPPS APC 5303 for CY 2021
- CPT code 43264 (Ercp remove duct calculi), which is assigned to OPPS APC 5303 for CY 2021
- CPT code 43265 (Ercp lithotripsy calculi), which is assigned to OPPS APC 5331 for CY 2021
- CPT code 43274 (Ercp duct stent placement), which is assigned to OPPS APC 5331 for CY 2021
- CPT code 43275 (Ercp removed forgn body duct), which is assigned to OPPS APC 5303 for CY 2021
- CPT code 43276 (Ercp stent exchange w/dilate), which is assigned to OPPS APC 5331 for CY 2021
- CPT code 43277 (Ercp ea duct/ampulla dilate), which is assigned to OPPS APC 5303 for CY 2021
- CPT code 43278 (Ercp lesion ablate w/dilate), which is assigned to OPPS APC 5303 for CY 2021

We determined the device offset amount for APC 2025 (Cath, pressure, valve-occlu) that is associated with the cost of the device category described by HCPCS code C1982 (Cath, pressure, valve-occlu). The device in the category described by HCPCS code C1982 may be billed with the following CPT code:

- CPT code 37242 (Vasc embolize/occlude artery), which is assigned to APC 5193 for CY 2021

2. Device Pass-Through Payments

Per Transmittal 1325, which we issued on December 7, 2007, ASC pass-through device pricing is based on acquisition cost or invoice. Provider education regarding ASC pass-through device pricing, as well as billing guidance associated with MAC processing of pass-through device claims, will be posted to MAC websites.

3. New HCPCS Code Describing the Administration of Subretinal Therapies Requiring Vitrectomy

CMS is establishing a new HCPCS code C9770, to describe a vitrectomy, mechanical, pars plana approach, with subretinal injection of a pharmacologic or biologic agent. Table 2 of CR 12129 lists this HCPCS, short descriptor, long descriptor, and ASC PI.

4. New HCPCS Code Describing Nasal Endoscopy with Cryoablation of Nasal Tissue(s) and/or Nerve(s)

CMS is establishing HCPCS code C9771 to describe the technology associated with nasal endoscopy with cryoablation of nasal tissues and/or nerves. Table 3 of CR 12129 lists this HCPCS, short descriptor, long descriptor, and ASC PI.

5. New HCPCS Codes Describing Peripheral Intravascular Lithotripsy (IVL) Procedures

For the January 2021 update, we are establishing 4 additional new HCPCS codes to describe the technology associated with the IVL procedure, which has integrated lithotripsy emitters and is designed to enhance percutaneous transluminal angioplasty by enabling delivery of the calcium disrupting capability of lithotripsy prior to full balloon dilatation at low pressures. The application of lithotripsy mechanical pulse waves alters the structure of an occlusive vascular deposit (stenosis) prior to low-pressure balloon dilation of the stenosis and facilitates the passage of blood and is used for the treatment of Peripheral Artery Disease (PAD). Specifically, we are establishing HCPCS codes C9772, C9773, C9774, and C9775 to describe the surgical procedures utilizing IVL. Table 4 of CR 12129 lists these HCPCS, short descriptors, long descriptors, and ASC PIs.

6. Removal of Selected National Coverage Determinations (NCDs) Effective January 1, 2021

As stated in the CY 2021 Physician Fee Schedule (PFS) final rule with comment period, effective January 1, 2021, CMS removed certain NCDs. Table 5 of CR 12129 lists the NCD name and manual citation.

As a result of this change, the coverage determinations for the procedures, services, and items associated with the NCDs listed above will be made by the local MAC. Also, we revised the ASC PIs for the codes listed in Table 6 of CR 12129 from ASC PI = “Y5” (Non-Surgical Procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made.) to the ASC PIs listed below.

7. Existing HCPCS Codes for Certain Drugs and Biologicals That Will Start to Receive Separate Payment

There is one existing HCPCS code for certain drugs and biologicals in the ASC setting that will start to receive separate payment beginning on January 1, 2021. We list this code (J9198) in Table 7 of CR 12129.

8. Newly Established HCPCS Codes for Drug and Biologicals Effective January 1, 2021

Fifteen (15) new HCPCS codes have been created for reporting drugs and biologicals in the ASC payment effective January 1, 2021. Table 8 of CR 12129 lists these HCPCS codes. The HCPCS codes listed in the “old HCPCS codes” column of Table 8, are deleted effective January 1, 2021.

9. Retroactive Correction for HCPCS J1097 Effective October 1, 2020

Effective October 2020, HCPCS J1097 (Phenylep ketorolac opth soln), brand name Omidria, became separately payable in the ASC payment system. A payment rate wasn't available to MACs as part of the October release in the ASC payment system. Consequently, ASCs that may have submitted claims for this drug, may not have been paid correctly.

Retroactively, HCPCS J1097 is separately payable for ASC claims with dates of service beginning October 1, 2020.

Suppliers who think they may have previously received an incorrect payment or incorrect disposition associated with this correction for J1097, for claims beginning October 1, 2020, may request their MAC adjust the previously processed claims.

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

For CY 2021, 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 2021, 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, 2021, are in the January 2021 update of ASC Addendum BB at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html.

a. 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 their MAC adjust the previously processed claims.

11. Skin Substitute Procedure Edits

Payment for skin substitute products that don't 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.

Skin substitute products are divided into two groups:

1) High-cost skin substitute products
2) Low-cost skin substitute products for packaging purposes

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: The final rule skin substitute table incorrectly assigned Q4222 (Progenamatrix, per sq cm) to the low-cost group when it should have been assigned to the high-cost group for January. This correction is currently reflected in all relevant January ASC payment files and tables.

Table 9 of CR 12129 lists the skin substitute products and their assignment as either a high-cost or a low-cost skin substitute product, when applicable.

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

12. Coverage Determinations

Assignment of an HCPCS code and payment rate under the ASC payment system to a drug, device, procedure, or service 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 is reasonable and necessary to treat the beneficiary's condition and whether it's excluded from payment.

ADDITIONAL INFORMATION

The official instruction, CR 12129, issued to your MAC regarding this change is available at https://www.cms.gov/files/document/R10557CP.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
February 22, 2021	We revised this article to reflect the revised CR 12129, which CMS issued on January 8. The revisions to the CR did not change the substance of this article, In the article, we changed the CR release date, transmittal number (see above), and the web address of the CR. All other information remains the same.
January 5, 2021	Initial article released.