CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13079	**Date: March 28, 2025**
	Change Request 13934

Transmittal 13044 issued January 10, 2025, is being rescinded and replaced by Transmittal 13079, dated March 28, 2025, to add an additional sub-Business Requirement (BR) (13934.13.3) and note to BR 13934.13 for the MACs for their work related to the implementation of the new CBSAs has been added. All other information remains the same. All other information remains the same.

SUBJECT: January 2025 Update of the Ambulatory Surgical Center [ASC] Payment System

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide changes to and billing instructions for various payment policies implemented in the January 2025 ASC payment system update.

EFFECTIVE DATE: January 1, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 6, 2025

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Recurring Update Notification

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 13079	Date: March 28, 2025	Change Request: 13934

Transmittal 13044 issued January 10, 2025, is being rescinded and replaced by Transmittal 13079, dated March 28, 2025, to add an additional sub-Business Requirement (BR) (13934.13.3) and note to BR 13934.13 for the MACs for their work related to the implementation of the new CBSAs has been added. All other information remains the same. All other information remains the same.

SUBJECT: January 2025 Update of the Ambulatory Surgical Center [ASC] Payment System

EFFECTIVE DATE: January 1, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 6, 2025

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide changes to and billing instructions for various payment policies implemented in the January 2025 ASC payment system update.

II. GENERAL INFORMATION

A. Background: As appropriate, this notification also includes updates to the Healthcare Common Procedure Coding System (HCPCS). This Recurring Update Notification (RUN) applies to Chapter 14, Section 40 of Publication (Pub.) 100-04. The January 2025 Ambulatory Surgical Center Fee Schedule (ASCFS) File, a revised partial January 2024 ASCFS File, a January 2025 Ambulatory Surgical Center Payment Indicator (ASC PI) File, a revised October 2024 and revised January 2024 ASC Payment Indicator (PI) files, a January 2025 ASC Code Pair file, and a January 2025 Ambulatory Surgical Center Drug File will be issued with this transmittal. Cloud service updates will be implemented for new and restated ASC Drug pricing.

B. Policy: 1. New Device Category Effective January 1, 2025

Section 1833(t)(6)(B) of the Social Security Act requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least two, but not more than three years. In addition, section 1833(t)(6)(B)(ii)(IV) of the Act requires that we create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices. This policy is also implemented in the ASC payment system.

For the January 2025 update, we approved five new devices for pass-through status under the OPPS, and are establishing the new device categories in the ASC payment system. Specifically, HCPCS codes C1735, C1736, C1737, C1738, and C9610 are effective January 1, 2025. Table 1 includes the HCPCS code, code descriptors, and ASC PI (see Attachment A: Policy Section Tables).

In addition, we note that HCPCS code C1739 (Tissue marker, imaging and non-imaging device (implantable)) which is newly approved for pass-through status under the OPPS effective January 1, 2025, isn't eligible to be payable in ASCs because there isn't a covered surgical procedure you can perform with C1739. We package C1739 (ASCPI=N1) in the ASC setting beginning January 1, 2025.

These codes, as well as the descriptors and ASC payment indicators are included in Table 1 (see Attachment A: Policy Section Tables). The list of CPT codes that must be performed with these codes are included in the January 2025 ASC code pair file, which is accessible on the CMS website at: https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc-payment/asc-code-pairs .

a. Device Offset from Payment for the Following HCPCS Codes Effective January 1, 2025

Section 1833(t)(6)(D)(ii) of the Act requires that we deduct from OPPS pass-through payments for devices 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. This device offset policy is also implemented in ASCs. In ASCs, the device offset from payment represents a deduction from the ASC procedure payment for the applicable pass-through device.

We have determined that offsets are associated with the costs of the new device categories described by the HCPCS codes in Table 2 (see Attachment A: Policy Section Tables). The device in these categories should

always be billed in the ASC setting with one of the associated CPT codes that are included in Table 2. The associated new devices, procedures, and offset percentages, as well as existing ASC code pairs, are included in the January 2025 ASC code pair file, which is accessible on the CMS website at:

https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc-payment/asc-code-pairs

Device category HCPCS Codes C1735-C1738 and C9610 should always be billed with one of the paired CPT codes that are included in Table 2.

b. Expiring Separate Payment Status for Two Device Category HCPCS Codes, Effective January 1, 2025

As specified in section 1833(t)(6)(B) of the Social Security Act, under the OPPS, categories of devices are eligible for transitional pass-through payments for at least two, but not more than three years. The two codes listed in Table 3 (see Attachment A: Policy Section Tables) are expiring beginning January 1, 2025, in the OPPS. These codes have been separately payable in the ASC setting and will be packaged (ASC PI=N1) in the ASC setting beginning January 1, 2025. The payment for these codes will be included in the primary service.

ASCs should not separately bill for packaged codes (ASC PI=N1) since they are not reportable under the ASC payment system.

2. Payment for CPT Codes 0660T and 0661T, iDose TR (travoprost intracameral implant) for the Treatment of Glaucoma, Retroactive to January 1, 2024

For the July 2021 Update, the CPT Editorial Panel established CPT codes 0660T and 0661T to describe the service associated with the implantation, removal, and reimplantation of the iDose TR, which is a prostaglandin analog used for the reduction of intraocular pressure (IOP) in patients with open-angle glaucoma (OAG) or ocular hypertension (OHT). On December 13, 2023, the iDose TR received FDA NDA approval. Based on the December 2023 FDA approval, these codes are separately payable under the OPPS effective retroactive to January 1, 2024. These codes are also payable in the ASC.

Table 4 lists the CPT codes, descriptors, and ASC payment indicators for CPT codes 0660T and 0661T (see Attachment A: Policy Section Tables).

3. New HCPCS Code Describing the Automated Preparation of a Skin Cell Suspension Autograft, Effective January 1, 2025

CMS is establishing a new HCPCS code, C8002, to describe the automated preparation of a skin cell suspension autograft.

Table 5 lists the HCPCS code, descriptors, and ASC payment indicator for HCPCS code C8002 (see Attachment A: Policy Section Tables).

4. New HCPCS Code Describing the Implantation Procedure of a Medial Knee Shock Absorber, Effective January 1, 2025

CMS is establishing a new HCPCS code, C8003, to describe the implantation procedure of a medial knee extraarticular shock absorber.

Table 5 lists the HCPCS code, descriptors, and ASC payment indicator for HCPCS code C8003 (see Attachment A: Policy Section Tables).

5. Newly Payable ASC Surgical Procedures Effective January 1, 2025

We added 32 new separately payable procedures to the ASC covered procedures and covered ancillary lists. See Table 5 for the CPT codes, descriptors, and ASC PIs.

Additionally, we added 33 separately payable procedures to the ASC covered procedures list that were previously non-payable or packaged (ASC PI=N1/S1). This includes 19 dental procedures we are adding to the ASC covered procedures list. See Table 6 for the CPT codes, descriptors, and ASC PIs.

The ASC payment rates for the codes in Tables 5 and 6 can be found in the January 2025 ASC Addenda AA and BB.

6. Drugs, Biologicals, and Radiopharmaceuticals

a. Newly Established HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals as of January 1, 2025

We are establishing 33 new drug, biological, and radiopharmaceutical HCPCS codes on January 1, 2025. There are also several old HCPCS codes that will be deleted December 31st, 2024. These HCPCS codes, as well as the descriptors and ASC PIs, are listed in Table 7 (see Attachment A: Policy Section Tables).

b. Unpackaging Certain Diagnostic Radiopharmaceuticals as of January 1, 2025

Twenty-two (22) diagnostic radiopharmaceuticals that previously been packaged (ASCPI=N1/S1) will be separately payable (ASCPI=K2) as of January 1, 2025. These HCPCS codes are also listed in Table 8, attachment A.

c. HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals Deleted or Discontinued as of December 31, 2024

Sixteen (16) drug, biological, and radiopharmaceutical HCPCS codes will be deleted on December 31, 2024. These HCPCS code are listed in table 9, attachment A.

We note that HCPCS code J9036 will replace both J9058 and J9059 for the reporting of these therapeutically equivalent bendamustine; J9058 and J9059 will be deleted on December 31, 2024.

One drug, biological and radiopharmaceutical HCPCS code (J9198) will be changing to a non-payable payment indicator on January 1, 2025, as that product has been discontinued by the manufacturer. Therefore, effective January 1, 2025, the payment indicator for this code is changing from ASCPI = "K2" to ASCPI= "Y5." The descriptor and updated PI for this HCPCS code are listed in table 9, attachment A.

d. HCPCS Codes for Drug, Biological, and Radiopharmaceutical Changing Payment Indicators Retroactive to October 1, 2024

Two (2) drug, biological and radiopharmaceutical HCPCS codes will be changing payment indicators retroactive to October 1, 2024. These HCPCS codes are listed in table 10, attachment A.

e. HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals with Descriptor Changes as of January 1, 2025

Four (4) drug, biological, and radiopharmaceutical HCPCS codes have had a substantial descriptor change as of January 1, 2025. These HCPCS codes are listed in table 11, attachment A.

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

For CY 2025, payment for the majority of non pass-through drugs, biologicals, and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent (or ASP plus 6 or 8 percent of the reference product for biosimilars. In CY 2025, a single payment of ASP plus 6 percent for pass-through drugs, biologicals, and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items (or ASP plus 6 or 8 percent of the reference product for biosimilars). Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available.

Effective January 1, 2025, payment rates for many drugs and biologicals have changed from the values published in the CY 2025 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from third quarter of CY 2024. Updated payment rates effective January 1, 2025, can be found in the January 2025 update of the ASC Addendum BB on the CMS website at:

https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-payment-rates-addenda

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

Some drugs and biologicals paid based on ASP methodology will have payment rates that are 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/payment/prospective-payment-systems/hospital-outpatient/restated-drug-biological-payment-rates

Suppliers who think they may have received an incorrect payment for drugs and biologicals impacted by these corrections may request contractor adjustment of the previously processed claims.

7. Skin Substitutes

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: 1) high-cost skin substitute products and 2) low-cost skin substitute products for packaging purposes. High-cost skin substitute products should only be utilized 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 utilized in combination with the performance of one of the skin application procedures described by HCPCS codes C5271-C5278. New skin substitute HCPCS codes are assigned into the low-cost skin substitute group unless CMS has OPPS pricing data that demonstrates that the cost of the product is above either the mean unit cost of $50 or the per day cost of $833 for CY 2025.

a. New Skin Substitute Products as of January 1, 2025

There are eight new skin substitute HCPCS codes that will be active as of January 1, 2025. The codes are packaged and are assigned to the low-cost skin substitute group. These new packaged codes are listed in Table 12, (see Attachment A: Policy Section Tables).

Note that ASCs should not separately bill for packaged skin substitutes since packaged codes (ASC PI=N1) are not reportable under the ASC payment system.

b. Skin Substitute assignments to High Cost and Low Costs Groups for CY 2025

There are four skin substitute HCPCS codes that will be reassigned from the low-cost skin substitute group to the high-cost skin substitute group as of January 1, 2025. The codes are listed in Table 13 (see Attachment A: Policy Section Tables).

8. HCPCS Codes, Payment Indicators, APC Assignments and Payment Limitations for Qualifying Non-Opioid Treatments for Pain Relief Starting January 1, 2025.

Section 4135 of the Consolidated Appropriations Act (CAA), 2023 established the eligibility criteria for temporary additional payments for certain non-opioid treatments for pain relief, and was finalized in the CY 2025 OPPS/ASC final rule with comment period. CMS has fully evaluated applicable non-opioid treatments against the statutory eligibility criteria and determined that the products in Table 14, attachment A, meet the statutory definition of a Non-opioid Treatment for Pain Relief and should be paid according to the finalized policy beginning January 2025. Section 1833(t)(16)(G)(iii) of the Act states that the separate payment amount specified in clause (ii), shall not exceed the estimated average of 18 percent of the OPD fee schedule amount for the OPD service (or group of services) with which the non-opioid treatment for pain relief is furnished, as determined by the Secretary. The finalized payment limitation amount for each product can be found in Table 15, attachment A, and will be updated annually.

The ASC payment indicator “L6” (“New Technology Intraocular Lens (NTIOL); special payment” has been redefined as “Special payment; New Technology Intraocular Lens (NTIOL) or qualifying non-opioid devices”) and accounts for non-opioid devices paid for under the ASC payment system, pursuant to section 4135 of the CAA, 2023.

9. CY 2025 ASC Wage Index

As discussed and finalized in the FY 2025 IPPS/LTCH PPS final rule with comment period (89 FR 69252 through 69266), we finalized our proposal to use the new Core Based Statistical Area delineations issued by the Office of Management and Budget (OMB) in OMB Bulletin 23-01, dated July 21, 2023, for the IPPS hospital wage index beginning in CY 2025. As discussed in the CY 2025 OPPS/ASC final rule with comment period (89 FR 94362), we finalized our proposal to use the new CBSA delineations for the ASC payment system because

the ASC wage indexes for the calendar years are the pre-floor and pre-reclassified IPPS hospital wage indexes for the fiscal year. Attachment B provides a comprehensive list of all county-to-CBSA delineations for CY 2025.

Additionally, for CY 2025 and subsequent years, we finalized our policy to limit year-to-year wage index decreases for each facility to 5 percent of the previous year's wage index value. Therefore, as we adopt the new CBSA delineations for the ASC payment system, facilities in certain counties (or county equivalents) may be subject to the 5 percent limit and the counties of a CBSA may have different CY 2025 ASC wage indexes. Attachment B provides the final CY 2025 ASC wage index for each county (or county equivalent) that is inclusive of the 5 percent limit.

10. Coverage Determinations

As a reminder, the fact that a drug, device, procedure, or service is assigned a 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. Medicare Administrative Contractors (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 is excluded from payment.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13934.1	Medicare contractors shall use the cloud service or MCS to process ASC Fee Schedule (FS) claims, based on CMS direction. NOTE: As a reminder, Contractors get the January 2025 ASC FS pricing, as well as restated quarterly ASC FS payment rates, as applicable, from the cloud. Mainframe ASC FS files are no longer issued. Date of retrieval will be provided in a separate email communication from CMS		X							
13934.2	Medicare contractors shall use the cloud service to process ASC drug claims. NOTE: As a reminder, Contractors get the January 2025 ASC Drug pricing, as well as restated quarterly ASC drug payment rates, as		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	applicable, from the cloud. Mainframe ASC Drug files are no longer issued. NOTE: Date of retrieval will be provided in a separate email communication from CMS									
13934.2.1	Medicare contractors shall use the cloud fee schedule, as appropriate, to adjust claims brought to their attention that: 1) Have dates of service January 1, 2024 – December 31, 2024 and; 2) Were originally processed prior to the installation of the revised cloud fee schedule.		X							
13934.3	Medicare contractors shall ensure that the updated cloud service payment rate is applied to effected claims.		X							
13934.4	Medicare contractors shall download and install the January 2025 ASC Payment Indicator (PI) file. FILENAME: MU00.@BF12390.ASC.CY25.PI.JANA.V1206 NOTE: Date of retrieval will be provided in a separate email communication from CMS.		X							
13934.5	Medicare contractors shall download and install the January 2025 ASC Code Pair file. FILENAME:		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	MU00.@BF12390.ASC.CY25.CP.JANA.V1206 NOTE: Date of retrieval will be provided in a separate email communication from CMS.									
13934.6	Contractors and Common Working File (CWF) shall add Type of Service (TOS) F, for HCPCS included in tables 1, 5, 8, 12 and 15 and attachment A as appropriate effective for dates of service January 1, 2025 and later.		X						X	CVM
13934.7	Contractors and CWF shall add Type of Service (TOS) F, as appropriate, for HCPCS included in attachment A table 4 effective for services January 1, 2024 and later payable in the ASC setting.		X						X	CVM
13934.8	Medicare contractors shall make January 2025 ASCFS fee data for their ASC payment localities available on their web sites.		X							
13934.9	Medicare contractors and CWF shall end date CY 2024 HCPCS/CPT codes listed in Attachment A, table 9 as appropriate, in their systems, effective December 31, 2024.		X						X	CVM
13934.10	CMS shall provide PECOS (CGI) with the list of 2021/2025 CBSA Codes.									CMS
13934.10.1	CGI shall provide a list to the MACs of all impacted ASC supplier records that need to be updated/converted to PECOS with the following data elements: (1) Contractor ID, (2) Medicare ID- current and end- dated (CGI is working under the assumption that all Medicare IDs									PECOS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	that are associated to a CBSA Code conversion are current/active and end-dated.), (3) County Code (as stored in PECOS on the MCS Screen), (4) 2021 CBSA, and; (5) 2025 CBSA									
13934.10.1.1	CGI/PECOS shall provide an additional list to MACs of the ASC providers that could not be successfully converted to the 2025 CBSA values.									PECOS
13934.11	PECOS shall update the tool-tip reference document available in PECOS to remove the complete 2021 CBSA Code set and add the complete 2025 CBSA Code set based on the data.									PECOS
13934.12	PECOS/CGI shall gather the list of all impacted supplier records AND make the necessary CBSA updates based off Attachment B.									PECOS
13934.12.1	PECOS/CGI shall convert the impacted CBSA records in PECOS.									PECOS
13934.13	If applicable upon making any manual CBSA update related to this change request, contractors should default to any required PECOS sections to their best ability to avoid development to the provider until their normal revalidation period. This should include marking an AO as the Managing Employee, marking the MRCA as the correspondence, bypassing a site visit requirement, or similar action (e.g., 'Right Now' ticket to bypass the errors).		X							PECOS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	NOTE: PECOS will expedite any RightNow tickets submitted for any errors.									
13934.13.1	MACs shall update the CBSA assignment in PECOS as needed, if applicable for their jurisdictional ASCs, including for any non-automated 2025 CBSA conversion that may be required.		X							
13934.13.2	MACs shall perform manual updates in PECOS as needed for providers not listed on the CBSA master file in BR 13934.11.1.		X							
13934.13.3	PECOS shall extract the converted records with the revised CBSA codes and the 'Original' tab to the shared system.									PECOS
13934.14	RRB shall convert the 2024 CBSA Codes that have changed to the appropriate 2025 CBSA Codes for all impacted records as appropriate in the Provider Enrollment System (PES), based on the list of 2024/2025 CBSA Codes received. • RRB shall end-date the 2024 CBSA Codes that have been converted to a 2025 CBSA Code and apply the end date of December 31, 2024 to the 2024 CBSA Code • RRB shall apply the Effective Date of January 1, 2025 to the new 2025 CBSA Codes on each ASC record that has been converted NOTE: Reference Attachment B for CBSA crosswalk									RRB-SMAC

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the

newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part B

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information:N/A

VI. CONTACTS

Pre-Implementation Contact(s): Marina Kushnirova, marina.kushnirova@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 2