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Hospital Outpatient Prospective Payment System: January 2024 Update

Related CR Release Date: December 21, 2023	MLN Matters Number: MM13488
Effective Date: January 1, 2024	Related Change Request (CR) Number: CR 13488
Implementation Date: January 2, 2024	Related CR Transmittal Numbers: R12421CP and R12421BP

Related CR Title: January 2024 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Affected Providers

- Physicians
- Dentists
- Nurse practitioners (NPs)
- Physician assistants (PAs)
- Clinical nurse specialists (CNSs)
- Hospitals
- Suppliers
- Other providers billing Medicare Administrative Contractors (MACs) for services they provide to Medicare patients

Action Needed

Make sure your billing staffs know about these payment system updates for January:

- COVID-19 vaccine and administration codes
- Covered devices for pass-through payments
- Inpatient-only list (IPO)
- Services
    - Covered dental rehabiltation procedures
    - Marriage and family therapist (MFT)
    - Mental health counselor (MHC)
- Drugs, biologicals, and radiopharmaceuticals
- Skin substitutes
- Pricer logic and wage index policies
- Revenue code reporting for cardiac computed tomography CPT Codes 75572, 75573, and 75574
- Coverage determinations

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Background

CR 13488 implements instructions on coding changes and policy updates effective January 1, 2024, for the OPPS. Updates include coding and policy changes for new services, pass-through drug and devices, COVID-19 treatments, proprietary laboratory analyses (PLA) codes, and other items and services.

The OPPS changes effective January 1, 2024, are:

1. Changes to COVID-19 CPT Vaccines and Administration Codes

The American Medical Association (AMA) has been issuing unique CPT Category I codes, which it develops based on collaboration with CMS and the CDC, for each COVID-19 vaccine as well as administration codes unique to each such vaccine and dose. These codes are effective upon getting an Emergency Use Authorization (EUA) or approval from the FDA.

Based on recent recommendations made by the FDA, the CPT Editorial Panel (the panel) approved new monovalent COVID-19 vaccine product CPT codes for Pfizer and Moderna vaccines and 1 new CPT code describing the service to administer vaccines. The panel approved:

- CPT codes 91318, 91319, and 91320 for new monovalent vaccine products from Pfizer
- CPT codes 91321 and 91322 for new monovalent vaccine products from Moderna
- CPT code 90480 for reporting the administration of any COVID-19 vaccine for any patient, pediatric or adult, replacing all previously approved specific vaccine administration codes

The new vaccine product and administration codes became effective September 11, 2023, upon FDA approval.

Starting September 11, 2023, CMS assigned CPT codes 91318, 91319, 91320, 91321, and 91322 to status indicator “L;” and CPT code 90480 to status indicator “S” and Ambulatory Payment Classification (APC) 9398.

We deleted all previously approved COVID-19 vaccine product and vaccine administration codes from the January 2024 integrated outpatient code editor (I/OCE) update effective November 1, 2023. The exception is CPT code 91304, which represents the Novavax COVID-19 vaccine product, which remains active.

The Novavax COVID-19 vaccine continues to be available for use, but we deleted the vaccine administration codes (CPT codes 0041A, 0042A, and 0044A) previously used for reporting its administration. Use CPT code 90480 to report administration of the Novavax vaccine. See:

- Table 1 of CR 13488 for the list of deleted COVID-19 vaccine products and administration codes
- Table 2 of CR 13488 for a list of the long descriptors for the active codes

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We list these codes, along with their short descriptors, status indicators, and payment rates, where applicable, in the January 2024 OPPS Addendum B. See OPPS Addendum D1 of the CY 2024 OPPS/Ambulatory Surgical Center (ASC) final rule for the latest definitions of the OPPS status indicators.

2. Updates to COVID-19 Ambulatory Payment Classifications (APCs)

Effective January 1, 2024, only 2 COVID-19 APCs listed below remain active based on the deletion of the COVID-19 vaccine administration codes listed in Table 1 of CR 13488.

We're revising the long descriptor for HCPCS code M0201 effective January 1, 2024. See Table 3 of CR 13488. M0201 is the only code assigned to APC 9399. We're revising the APC title for APC 9399 to match the descriptor of HCPCS code M0201 effective January 1, 2024. See Table 4 of CR 13488.

3. CPT PLA Coding Changes

The panel established 19 new PLA codes, specifically, CPT codes 0420U through 0438U, effective January 1, 2024. See Table 5 of CR 13488 for the long descriptors and status indicators for the codes.

4. OPPS Device Pass-Through

a. New Device Pass-Through Category

Section 1833(t)(6)(B) of the Social Security Act (the Act) requires that, under the 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 us to create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

We approved 5 new devices for pass-through status under the OPPS, specifically, HCPCS codes C1600, C1601, C1602, C1603, and C1604. See Table 6A of CR 13488 for the long descriptor, status indicator, APC, and offset amount for these 5 HCPCS codes. This table also shows other CPT codes you should bill with each of these new devices.

We're adding these 5 new device category codes and their pass-through expiration dates. See Table 7 of CR 13488 for the complete list of device category HCPCS codes and definitions used for present and previous transitional pass-through payment.

b. Device Offset from Payment for the Following HCPCS Codes

Section 1833(t)(6)(D)(ii) of the Act requires that we deduct from pass-through payments for devices an amount that reflects the device portion of the APC payment amount. This deduction is the device offset, or the portions of the APC amount that are 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.

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c. Transitional Pass-Through Payments and Offsets for Designated Devices

We assign certain new devices to APCs and identify them in the I/OCE as eligible for payment based on the reasonable cost of the new device reduced by the amount included in the APC for the procedure that reflects the packaged payment for devices used in the procedure. The I/OCE determines the proper payment amount for these APCs as well as the coinsurance and deductible. All related payment calculations are returned on the same APC line and identified as a designated new device. See Addendum P of the CY 2024 OPPS/ASC final rule with comment period for the most current OPPS HCPCS Offset file.

d. Alternative Pathway for Devices That Have an FDA Breakthrough Designation

For devices that have FDA marketing authorization and a Breakthrough Device designation from the FDA, we provide an alternative pathway to qualify for device pass-through payment status, under which devices wouldn't be evaluated in terms of the current substantial clinical improvement criterion for the purposes of determining device pass-through payment status.

The devices would still need to meet the other criteria for pass-through status. This applies to devices getting pass-through payment status effective on or after January 1, 2020. See the current information on the device criteria to qualify for pass-through status under the OPPS.

e. Expiring Pass-through Status for 8 Device Category HCPCS Codes

Categories of devices are eligible for transitional pass-through payments for at least 2, but not more than 3, years. Table 6B of CR 13488 lists the codes expiring on December 31, 2023.

Note: These device category HCPCS codes will remain active; however, their payment will be included in the primary service.

As a reminder for OPPS billing, because we use charges related to packaged services for outlier and future rate setting, hospitals should report the device category HCPCS codes on the claim whenever providing them in the hospital outpatient department (HOPD) setting.

See Table 7 of CR 13488 for the entire list of current and historical device category codes created since August 1, 2000, which is the implementation date of the hospital OPPS.

5. Changes to the IPO

The Medicare IPO list includes procedures typically provided only in the inpatient setting, and they aren't paid under the OPPS. For CY 2024, we're adding 10 procedures to the IPO list. See Table 8 of CR 13488 for the list of these procedures.

6. Comprehensive APC (C-APC) Exclusions Update

In CR 13488, we updated Section 10.2.3 of the Medicare Claims Processing Manual, Chapter 4 to remove a paragraph that excluded over the counter (OTC) COVID-19 tests and new COVID-19 treatments from C-APCs. After the COVID-19 public health emergency (PHE) ended on May 11, 2023, we packaged payment for these COVID-19 tests and treatments into the payment for

a C-APC when you bill these services on the same outpatient claim.

7. New HCPCS Code Describing 3D Predictive Model Generation for Pre-Planning of a Cardiac Procedure

We're establishing a new HCPCS code, C9793, to describe 3D predictive model generation for pre-planning of a cardiac procedure. See Table 9 of CR 13488 for the long descriptor, status indicator, and APC assignment for C9793.

8. New HCPCS Codes Describing Biology-Guided Radiation Therapy Service

We've established 2 new HCPCS codes, C9794 and C9795, to describe a biology-guided radiation therapy service. Table 10 of CR 13488 lists the official long descriptors, status indicators, and APC assignments for HCPCS codes C9794 and C9795.

9. Clarification on Billing of HCPCS code G0330 for Payment under the OPPS

We created HCPCS code G0330 to describe facility services for dental rehabilitation procedures you provide to patients who require monitored anesthesia (general, intravenous sedation (monitored anesthesia care)) and use of an operating room. HCPCS code G0330 doesn't describe the professional services of dentists and other dental professionals. G0330 only describes facility services that HOPDs and ASCs provide that we pay under the OPPS or ASC payment systems.

Use G0330 only to describe facility fees for rehabilitation services that meet Medicare payment and coverage requirements. See Table 11 of CR 13488 for the long descriptor, status indicator, and APC assignment for G0330.

Many CDT and CPT codes that describe dental services are already assigned to APCs and we believe the billing of G0330 will be limited. HOPDs should:

- Bill more specific CPT and/or CDT codes instead of G0330 whenever possible
- Bill G0330 only when no other more specific code is available to describe the service
- Bill G0330 once per claim, in limited circumstances, when it's appropriate

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.

10. Technical Changes to Hospital Billing for MFT Services and MHC Services

We're amending regulations at 42 CFR 419.22 to add MFT services and the MHC services to the list of hospital services excluded from payment under the OPPS, at new sections (w) and (x), respectively. We're also amending regulations at 42 CFR 410.27(g) to revise the definition

of “nonphysician practitioner” to include MFTs and MHCs.

11. Changes to Partial Hospitalization Program (PHP) and Establishment of Intensive Outpatient Program (IOP) Payment Policies

Section 4124 of Division FF of the Consolidated Appropriations Act (CAA) 2023 established Medicare coverage for IOP services provided by a hospital to its outpatients, or by a community mental health center (CMHC), a Federally Qualified Health Center (FQHC) or a rural health clinic (RHC), as a distinct and organized intensive ambulatory treatment service offering less than 24-hour daily care in a location other than an individual’s home or inpatient or residential setting, effective January 1, 2024.

For the IOP, the CY 2024 OPPS final rule includes the:

- Scope of benefits
- Physician certification requirements
- Coding and billing
- Payment rates

The CY 2024 OPPS final rule includes updates to the PHP payment rates, coding and billing requirements, and related payment policies.

12. Drugs, Biologicals, and Radiopharmaceuticals

a. New CY 2024 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals Receiving Pass-Through Status

We created 15 new HCPCS codes for reporting drugs and biologicals in the HOPD setting, where there haven’t previously been specific codes available. These drugs and biologicals will receive drug pass-through status starting January 1, 2024. See Table 12 of CR 13488.

b. Existing HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals Starting Pass-Through Status as of January 1, 2024

There are 4 existing HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals in the outpatient setting that will have their pass-through status start on January 1, 2024. See Table 13 of CR 13488 for a list of these codes and their status indicators.

c. Existing HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals with Pass-Through Status Ending on December 31, 2023

There are 11 HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals in the outpatient setting that will have their pass-through status end on December 31, 2023. See Table 14 of CR 13488 for a list of these codes and their status indicators.

d. Newly Established HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals

We’re establishing 66 new drug, biological, and radiopharmaceutical HCPCS codes on January

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1, 2024. See Table 15 of CR 13488 for a list of these codes, their status indicators, and APCs.

e. HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals Deleted as of December 31, 2023

We're deleting 1 drug, biological, and radiopharmaceutical HCPCS code December 31, 2023. See Table 16 of CR 13488.

f. New HCPCS Codes and Change to the Existing HCPCS Code for HIV Pre-Exposure Prophylaxis (PrEP) Effective January 2, 2024

There are 9 new HCPCS codes for HIV PrEP effective January 2, 2024. See Table 17 of CR 13488 for a list of these codes and their status indicators.

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

For CY 2024, payment for most non-pass-through drugs, biologicals, and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6% — or ASP plus 6% or 8% of the reference product for biosimilars.

In CY 2024, a single payment of ASP plus 6% 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% 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, 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 because of the new ASP calculations based on sales price submissions from second quarter of CY 2023. The updated payment rates effective January 1, 2024, are in the January 2024 update of the OPPS Addendum A and Addendum B.

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

We correct the payment rates of some drugs and biologicals paid based on ASP methodology retroactively. These retroactive corrections typically occur quarterly. The list of drugs and biologicals with corrected payment rates will be available on the first date of the quarter. You may resubmit claims that were affected by corrections to a previous quarter's payment files.

13. Skin Substitutes

Payment for skin substitute products that don't qualify for pass-through status will be packaged into the payment for the associated skin substitute application procedure. For payment packaging purposes, skin substitute products are divided into 2 groups:

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

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We assign new skin substitute HCPCS codes into the low-cost skin substitute group unless we've 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

Tables 19-21 have more information on skin substitute products.

14. Payment Adjustment for Certain Cancer Hospitals

For certain cancer hospitals that get interim monthly payments associated with the cancer hospital adjustment, Section 16002(b) of the 21st Century Cures Act requires that, for CY 2018 and later CYs, the target payment-to-cost ratio (PCR) we use in calculating the interim monthly payments and at final cost report settlement be reduced by 0.01. For CY 2024, the target PCR, after including the reduction Section 16002(b) requires, is 0.88.

15. Method to Control for Unnecessary Increases in Utilization of Outpatient Services/G0463 with Modifier PO

In CY 2019, we finalized a policy to apply an amount equal to the site-specific Physician Fee Schedule (PFS) payment rate for nonexcepted items and services provided by a nonexcepted off-campus provider-based department (PBD). This applies to the clinic visit service HCPCS code G0463, when provided at an off-campus PBD (departments that bill the modifier PO on claim lines). We completed the phase-in of the policy in CY 2020.

The PFS-equivalent amount paid to nonexcepted off-campus PBDs is approximately 60% less than the OPPS rate for CY 2024. The 60% payment reduction will apply in CY 2024. This means we'll pay these departments 40% of the OPPS rate for the clinic visit service in CY 2024.

Note: In the CY 2024 OPPS/ASC final rule, we finalized the continued exemption of rural sole community hospitals from the payment reduction associated with this policy.

16. Changes to OPPS Pricer Logic

a. Rural Sole Community Hospitals (SCHs) and Essential Access Community Hospitals (EACHs) continue to get a 7.1% payment increase for most services in CY 2024. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and items paid under the pass-through payment policy per Section 1833(t)(13)(B) of the Act.

b. New OPPS payment rates and copayment amounts will be effective January 1, 2024. We limit all copayment amounts to a maximum of 40% of the APC payment rate. Copayment amounts for each service can't be more than the CY 2024 inpatient deductible of $1,632. For most OPPS services, copayments are set at 20% of the APC payment rate.

c. For hospital outlier payments under OPPS, there's no change in the multiple threshold of 1.75 for 2024.

d. The fixed-dollar threshold for OPPS outlier payments decreases in CY 2024 relative to CY 2023. The estimated cost of a service must be greater than the APC payment amount plus $7,750 to qualify for outlier payments.

e. For outliers for CMHCs using bill type 76x, there's no change in the multiple threshold of 3.4 for 2024.

f. The OPPS Pricer will apply a reduced update ratio of 0.9806 to the payment and copayment for hospitals that fail to meet their hospital outpatient quality data reporting requirements or that fail to meet our validation edits. We use the reduced payment amount to calculate outlier payments.

g. Effective January 1, 2024, we're adopting the FY 2024 Inpatient Prospective Payment System (IPPS) post-reclassification wage index values with application of the CY 2024 out-commuting adjustment.

h. Effective January 1, 2024, rural SCHs won't get payment reductions for HCPCS code G0463 when billed with modifier PO based on our final CY 2024 policy to continue to exempt rural SCHs from the method to control for unnecessary increases in volume policy.

17. Update the Outpatient Provider Specific File (OPSF)

MACs continue to maintain the accuracy of the provider records in their OPSF as changes occur in data element values.

a. Updating the OPSF for the Supplemental Wage Index and Supplemental Wage Index Flag Fields

In CY 2024, the Supplemental Wage Index and Supplemental Wage Index Flag fields will be used to implement the cap on wage index decrease policy.

b. Updating the OPSF for Expiration of Transitional Outpatient Payments (TOPs)

Section 1833(t)(7)(D)(ii) of the Act holds cancer and children's hospitals harmless and they continue to get hold harmless TOPs permanently. For CY 2024, cancer hospitals will continue to get an additional payment adjustment.

c. Updating the OPSF for the Hospital Outpatient Quality Reporting (HOQR) Program Requirements

Effective for OPPS services provided on or after January 1, 2009, Subsection (d) hospitals that fail to submit timely hospital outpatient quality data will get payment under the OPPS that reflects a 2% reduction from the annual OPPS update. This reduction doesn't apply to hospitals that aren't required to submit quality data or hospitals that aren't paid under the OPPS.

d. Updating the OPSF for Cost to Charge Ratios (CCRs)

MACs must maintain the accuracy of the data and update the OPSF as changes occur in data element values, including changes to provider CCRs and, when applicable, device department

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CCRs. The OPPS hospital upper limit CCRs and statewide CCRs are in the Annual Policy Files.

e. Updating the County Code Field

For the CY 2024 OPPS, the OPPS Pricer will continue to assign the outmigration adjustment using the County Code field in the OPSF.

f. Updating the Wage Index Location Core-Based Statistical Areas (CBSA) Field

Hospitals with wage index reclassifications for wage adjustment purposes under the IPPS would also have those wage index reclassifications applied under the OPPS on a CY basis.

18. Wage Index Policies in the CY 2024 OPPS Final Rule

In the FY 2024 IPPS and CY 2024 OPPS final rules, we finalized the following changes to the wage index:

- Increased the wage index values for hospitals with a wage index value below the 25th percentile wage index value of 0.8667 across all hospitals
- Applied a 5% cap for CY 2024 on any wage index values that decreased relative to CY 2023

19. Revenue Code Reporting for Cardiac Computed Tomography CPT Codes 75572, 75573, and 75574

We recently identified an outdated return-to-provider (RTP) HCPCS-to-revenue code edit that limited certain claims submissions to specific revenue codes for CPT codes 75572, 75573, and 75574. We had RTP-ed these claims to the providers for resubmission. We removed this outdated edit, so, when appropriate, you may bill these codes with any appropriate revenue code.

20. Coverage Determinations

The fact that we assign a drug, device, procedure, or service a HCPCS code and a payment rate under the OPPS 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 determine if a drug, device, procedure, or other service meets all Program coverage requirements. For example, MACs determine that it's reasonable and necessary to treat the patient's condition and if it's excluded from payment.

Note: The required level of supervision for pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation isn't changing and remains the direct level of supervision as defined at 42 CFR 410.27(a)(1)(iv)(B)(1).

Contractors will adjust, as appropriate, claims brought to their attention with any retroactive changes that were received before implementation of the January 2024 OPPS PRICER.

Relevant updated manual text is attached to this CR.

More Information

We issued CR 13488 in 2 transmittals to your MAC as the official instruction for these changes. One transmittal updates relevant portions of the Medicare Benefit Policy Manual, and the other updates relevant portions of the Medicare Claims Processing Manual.

For more information, find your MAC's website.

Document History

Date of Change	Description
January 10, 2024	Initial article released.

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