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Hospital Outpatient Prospective Payment System: July 2025 Update

Related CR Release Date: June 23, 2025	**MLN Matters Number:** MM14091
Effective Date: July 1, 2025	**Related Change Request (CR) Number:** CR 14091
Implementation Date: July 7, 2025	**Related CR Transmittal Number:** R13258CP
Related CR Title: July 2025 Update of the Hospital Outpatient Prospective Payment System (OPPS)	

Affected Providers

- Hospitals
- Physicians
- Home health agencies
- Hospices
- Other providers billing Medicare Administrative Contractors (MACs) for outpatient hospital services

Action Needed

Make sure your billing staff knows about these updates effective July 1, 2025, including coding and billing changes for:

- New COVID-19, influenza, and respiratory syncytial virus vaccines
- COVID-19 monoclonal antibody therapy products, proprietary laboratory analyses (PLA) codes, and Hospital Outpatient Prospective Payment system (OPPS) device categories
- Status indicator changes
- Drugs, biologicals, and radiopharmaceuticals
- Skin substitutes

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Background

CR 14091 provides instructions on coding changes and policy updates that are effective July 1, 2025, for the Hospital OPPS.

Key Updates

New COVID-19, Influenza & Respiratory Syncytial Virus Vaccines

On April 1, 2025, the American Medical Association (AMA) released 5 new CPT codes (90382, 90612, 90613, 90635, and 91323) associated with COVID-19, influenza, and respiratory syncytial virus vaccines. On May 9, 2025, the AMA released another new CPT code (90631) associated with the influenza virus vaccine. These codes will be available once the vaccines receive FDA approval.

Effective July 1, 2025, CMS will assign these codes to status indicator E1 in the July 2025 Integrated Outpatient Code Editor (I/OCE).

See Table 1 and the July 2025 Hospital OPPS Addendum B for the long descriptors, status indicators, and payment rates (where applicable).

Note: For more information on status indicators and the latest definitions, refer to Addendum D1 of the CY 2025 Hospital OPPS and Ambulatory Surgical Center (ASC) final rule.

Deletion of COVID-19 Monoclonal Antibody Therapy Administration HCPCS Code

We're deleting 1 COVID-19 monoclonal antibody therapy administration HCPCS code (M0248) listed in Table 2 because FDA revoked its emergency use authorization effective December 13, 2024. We're deleting this code from the July 2025 I/OCE update effective December 31, 2024.

CPT PLA Coding Changes Effective July 1, 2025

The AMA CPT Editorial Panel established 23 new PLA codes (CPT codes 0552U–0574U) effective July 1, 2025. See Table 3 for the long descriptors and status indicators. Refer to Addendum B for the short descriptors and status indicators.

Hospital OPPS Device Pass-Through

Addition of a CPT Code to an Existing Device Code C1602

Section 1833(t)(6)(D)(ii) of the Social Security Act requires that we deduct an amount that reflects the device portion of the ambulatory payment classification (APC) amount from pass-through payments for devices. This deduction is the device offset or the portion of the APC amount that's 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.

Note: Effective July 1, 2025, we're adding CPT code 11012 for billing with HCPCS code C1602 (Orthopedic/device/drug matrix/absorbable bone void filler, antimicrobial-eluting (implantable)), in addition to the CPT codes we listed in the April 2024 Hospital OPPS update (CR 13568).

Addition of CPT Codes to an Existing Device Code C1739

In CR 13933, we noted that we preliminarily approved HCPCS code C1739 as part of the device pass-through quarterly review process with an effective date of January 1, 2025. We'll include and discuss the device application associated with this code in the CY 2026 Hospital OPPS and ASC proposed and final rules.

Note: Effective January 1, 2025, we're adding CPT codes 19081, 19083, and 19085 to be billed with C1739 (Tissue marker, probe detectable any method (implantable), with delivery system), in addition to the CPT codes listed in CR 13993.

See Table 4 for the entire list of current historical device category codes created since August 1, 2000, when we implemented the Hospital OPPS. This list can also be found in the Medicare Claims Processing Manual, Chapter 4, section 60.4.2.

Retroactive Status Indicator Change for CPT Codes 98980 & 98981

We're changing the status indicator for CPT codes 98980 and 98981 from B to A (not paid under the Hospital OPPS. Paid by MACs under a fee schedule or payment system other than the Hospital OPPS). This change is retroactive to January 1, 2025, in the July 2025 I/OCE update.

See Table 5 for the long descriptor and status indicator. Refer to Addendum B for the short descriptors and status indicators.

Updated Long Descriptor, Status Indicator & APC Assignment for HCPCS Code C8005

On April 1, 2025, we established HCPCS code C8005 to describe transbronchial ablation of lung tumors using pulsed electric field energy. Now, we're updating this code's long descriptor, status indicator, and APC assignment effective retroactively to April 1, 2025.

See Table 6 for the long descriptor, status indicator, and APC assignment. Refer to Addendum B for the short descriptor, status indicator, and payment rate.

New CPT Category III Codes Effective July 1, 2025

The AMA releases CPT Category III codes twice a year:

- In January for implementation starting the following July
- In July for implementation starting the following January

For the July 2025 update, we're implementing 40 new CPT Category III codes that we released in January 2025 for implementation on July 1, 2025. See Table 7 for the status indicators and APC assignments for CPT codes 0948T–0987T. We added these codes to the July 2025 I/OCE update with an effective date of July 1, 2025. Refer to Addendum B to find the codes, short descriptors, status indicators, and payment rates (where applicable).

Drugs, Biologicals & Radiopharmaceuticals

New CY 2025 HCPCS Codes & Dosage Descriptors for Certain Drugs, Biologicals & Radiopharmaceuticals Receiving Pass-Through Status Effective July 1, 2025

We created 7 new HCPCS codes for reporting drugs and biologicals in the hospital outpatient setting where specific codes weren't previously available starting on July 1, 2025. See Table 8 for the list of codes that will receive drug pass-through status starting July 1, 2025.

Existing HCPCS Codes for Certain Drugs, Biologicals & Radiopharmaceuticals Starting Pass-Through Status as of July 1, 2025

There are 3 existing HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals in the outpatient setting that will have their pass-through status start on July 1, 2025, with a status indicator of G. See Table 9 for the list of codes.

Existing HCPCS Codes for Certain Drugs, Biologicals & Radiopharmaceuticals with Pass-Through Status Ending on June 30, 2025

There are 9 HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals in the outpatient setting that will have their pass-through status end on June 30, 2025, with a new status indicator of K. See Table 10 for the list of codes. Refer to Addendum B for the short descriptors and status indicators.

Newly Established HCPCS Codes for Drugs, Biologicals & Radiopharmaceuticals as of July 1, 2025

We're establishing 34 new drug, biological, and radiopharmaceutical HCPCS codes on July 1, 2025. See Table 11 for the list of codes.

HCPCS Codes for Drugs, Biologicals & Radiopharmaceuticals Deleted as of June 30, 2025

We're deleting 8 drug, biological, and radiopharmaceutical HCPCS codes on June 30, 2025. See Table 12 for the list of codes.

HCPCS Codes for Drug, Biological & Radiopharmaceutical Changing Status Indicators as of July 1, 2025

Two drug, biological, and radiopharmaceutical HCPCS codes will change its payment status indicator to K on July 1, 2025. See Table 13 for these codes.

HCPCS Codes for Drug, Biological & Radiopharmaceutical, Vaccine Changing Payment Status Retroactively

We're changing payment status indicators to K for 3 drug, biological, and radiopharmaceutical codes retroactive to April 1, 2025. See Table 14 for the list of codes and their status indicators. We're making these changes in the July 2025 I/OCE update effective April 1, 2025.

We're changing payment status indicators for 2 drug, biological, and radiopharmaceutical codes retroactive to April 1, 2025. We inadvertently had 2 active HCPCS codes (C9173 and Q5148) for the same drug in the April 2025 update. Effective April 1, 2025 – June 30, 2025, the status indicator for C9173 will change to E1 and the status indicator for Q5148 will change to G. We're deleting C9173 in the July 2025 I/OCE update effective July 1, 2025. See Table 15 for the list of codes and their revised status indicators.

We're also changing the status indicator for CPT code 90593 to M effective February 14, 2025. See Table 16 for its revised status indicator.

HCPCS Codes for Drugs, Biologicals & Radiopharmaceuticals with Descriptor Changes as of July 1, 2025

We're making substantial descriptor changes to 3 drug, biological, and radiopharmaceutical HCPCS codes effective July 1, 2025. See Table 17 for the list of codes.

Payment for HCPCS Code Q2058 (AUCATZYL®)

Q2058 can describe AUCATZYL®, which has a total recommended dose of 410 x 10^6 CD19 chimeric antigen receptor-positive T cells for split dose administration. Treatment requires a split dose infusion, including the first infusion on day 1 then, in most cases, a second infusion on day 10 (+/–2 days). To facilitate billing for each infusion individually and to account for all possible infusions of split dose (based on FDA-approved labeling), use the description "10 up to 400 million cd19 car-positive viable t cells" billed for each of the 2 infusions in the treatment regimen.

For each infusion in a split dose regimen, the unit quantity on the claim line will be 1 (a total of 2 billing units for the complete regimen of 2 infusions). If there isn't a second infusion, don't submit a claim. Since the product isn't a single-dose container based on the FDA-approved label, the JW and JZ modifiers don't apply, and the modifiers aren't necessary for billing. No modifier is necessary for an administered infusion. If there's no second infusion, don't use the JW modifier to bill Medicare.

Drugs & Biologicals with Payments Based on Average Sales Price

For CY 2025, we pay for most non-pass-through drugs, biologicals, and therapeutic radiopharmaceuticals at a single rate of average sales price (ASP) +6% (or ASP +6 or 8% of the reference product for biosimilars). In CY 2025, we make a single payment of ASP +6% for pass-through drugs, biologicals, and radiopharmaceuticals for both the acquisition cost and pharmacy overhead costs of these pass-through items (or ASP +6 or 8% of the reference product for biosimilars). We update payments for drugs and biologicals based on ASPs quarterly 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 Hospital OPPS and ASC final rule with comment period due to new ASP calculations based on sales price submissions from the first quarter of CY 2025. When we need to adjust payment rates, we'll incorporate them into the July 2025 Fiscal Intermediary Standard System release. We aren't publishing the updated payment rates in this CR; however, you can find the updated payment rates effective July 1, 2025, in the July 2025 Hospital OPPS Addendums A and B.

Drugs & Biologicals Based on ASP Methodology with Restated Payment Rates

We'll retroactively correct payment rates for some drugs and biologicals paid based on ASP methodology. These corrections occur quarterly. Find the latest list of drugs and biologicals with corrected payment rates on the first date of each quarter.

You may resubmit claims affected by adjustments to a prior quarter's payment files.

Skin Substitutes

We package payment for skin substitute products that don't qualify for pass-through status into the payment for the associated skin substitute application procedure. We divide skin substitute products into 2 groups for payment purposes:

- High-cost skin substitute products
- Low-cost skin substitute products

We assign new skin substitute HCPCS codes into the low-cost skin substitute group unless we have pricing data demonstrating the product cost is above either the mean unit cost of $50 or the per-day cost of $833 for CY 2025.

New Skin Substitute Products as of July 1, 2025

Thirteen new skin substitute HCPCS codes will be active as of July 1, 2025. See Table 18 for the list of codes.

Skin Substitute Products Reassigned to the High-Cost Skin Substitute Group as of July 1, 2025

We're reassigning 1 skin substitute HCPCS code from the low-cost skin substitute group to the high-cost skin substitute group as of July 1, 2025. See Table 19 for this code.

Coverage Determinations

Remember, when we assign a HCPCS code and payment rate to a drug, device, procedure, or service under the Hospital OPPS, it doesn't imply Medicare coverage. It only indicates how we pay for the product, procedure, or service if covered. MACs decide whether a drug, device, procedure, or other service meets program requirements for coverage. For example, MACs decide that it's reasonable and necessary to treat the patient's condition and whether it's excluded from payment.

Note: Your MAC will adjust claims you bring to their attention with any retroactive changes received prior to implementing the July 2025 Hospital OPPS I/OCE.

More Information

We issued CR 14091 to your MAC as the official instruction for this change. For more information, find your MAC's website.

Document History

Date of Change	Description
June 30, 2025	Initial article released.