CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11937	**Date: March 31, 2023**
	Change Request 13136

Transmittal 11897 issued March 10, 2023, is being rescinded and replaced by Transmittal 11937, dated, March 31, 2023 to correct language under the Policy information in sections 4e, 5c, and 5g. All other information remains the same.

SUBJECT: April 2023 Update of the Hospital Outpatient Prospective Payment System (OPPS)

I. SUMMARY OF CHANGES: The purpose of this Recurring Update Notification (RUN) Change Request (CR) is to describe changes to and billing instructions for various payment policies implemented in the April 2023 Outpatient Prospective Payment System (OPPS) update. The April 2023 Integrated Outpatient Code Editor (I/OCE) will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this Change Request (CR). This RUN applies to Chapter 4, section 50.8 (Annual Updates to the OPPS Pricer for Calendar Year (CY) 2007 and Later).

EFFECTIVE DATE: April 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 3, 2023

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
R	4/Table of Contents
R	4/10.2.3/Comprehensive APCs
R	4/20.6/Use of Modifiers
R	4/20.6.1/Where to Report Modifiers on the Hospital Part B Claim
R	4/20.6.2/Modifier 50
R	4/20.6.3/Modifiers LT and RT
R	4/20.6.4/Modifiers 73 and 74
R	4/20.6.5/Modifiers 76 and 77
R	4/20.6.6/Modifiers for Radiology Services
R	4/20.6.7/Modifier CA
D	4/20.6.8/HCPCS Level II Modifiers
R	4/20.6.9/Modifier FB
R	4/20.6.10/Modifier FC
R	4/20.6.11/Modifier PO
R	4/20.6.12/Modifier PN
R	4/20.6.13/Modifier CT
R	4/20.6.14/Modifier FX
R	4/20.6.15/Modifier FY
R	4/20.6.16/Modifier JG
R	4/20.6.17/Modifier TB
R	4/20.6.18/Modifier ER
R	4/20.6.19/Modifier CG
R	4/60.4.2/Complete List of Device Pass-through Category Codes
R	4/170/Hospital and CMHC Reporting Requirements for Services Performed on the Same Day

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: 11937	Date: March 31, 2023	Change Request: 13136

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SUBJECT: April 2023 Update of the Hospital Outpatient Prospective Payment System (OPPS)

EFFECTIVE DATE: April 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 3, 2023

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification (RUN) provides instructions on coding changes and policy updates that are effective April 1, 2023 for the Hospital Outpatient Prospective Payment System (OPPS). The updates include coding and policy changes for new services, pass-through drug and devices, Covid-19 treatments, PLA codes and other items and services. The April 2023 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming April 2023 I/OCE CR.

B. Policy: 1. New Covid-19 CPT Vaccines and Administration Codes

American Medical Association (AMA) has been issuing unique Current Procedural Terminology (CPT) Category I codes which are developed based on collaboration with Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) for each coronavirus vaccine as well as administration codes unique to each such vaccine and dose. These codes are effective upon receiving Emergency Use Authorization (EUA) or approval from the Food and Drug Administration (FDA).

The Current Procedural Terminology (CPT) Editorial Panel has recently approved:

- A new CPT code (91316) describing the "Moderna COVID-19 Vaccine, Bivalent" for use as a booster for ages 6 months through 5 years.
- A new CPT code (0164A) describing the service to administer the "Moderna COVID-19 Vaccine, Bivalent" (91316).
- A new CPT code (91317) describing the "Pfizer-BioNTech COVID-19 Vaccine, Bivalent" for use as a third primary series dose for ages 6 months through 4 years.
- A new CPT code (0173A) describing the service to administer the "Pfizer-BioNtech COVID-19 Vaccine, Bivalent" (91317).

The Centers for Medicare & Medicaid Services (CMS) identifies an effective date of 12/08/2022 for both of the Moderna and Pfizer-BioNTech "COVID-19 Vaccine, Bivalent" administration CPT codes, 0164A and 0173A, respectively, which describe the service to administer the bivalent formulations of the vaccines. This effective date corresponds with Food and Drug Administration (FDA) Emergency Use Authorizations (EUA) and/or approvals for both the "Moderna COVID-19 Vaccine, Bivalent" and the "Pfizer-BioNTech COVID-19 Vaccine, Bivalent," described by CPT codes 91316 and 91317, effective 12/08/2022.

Effective December 8, 2022, CPT codes 91316 and 91317 are assigned to status indicator "L" (Not paid under OPPS. Paid at reasonable cost; not subject to deductible or coinsurance) in the April 2023 I/OCE update.

Effective December 8, 2022, CPT codes 0164A and 0173A are assigned to status indicator "S" (Procedure or Service, Not Discounted When Multiple, separate APC assignment) and APC 9398 (Covid-19 Vaccine Admin Dose 2 of 2, Single Dose Product or Additional Dose) in the April 2023 I/OCE update.

Beneficiary cost sharing shall not be applied to the new vaccine product codes or the new administration codes.

CMS will provide future direction to the contractors as EUAs and/or approvals become available.

Table 1, attachment A, lists the long descriptors for the codes. These codes, along with their short descriptors, status indicators, and payment rates (where applicable) are also listed in the April 2023 OPPS Addendum B that is posted on the CMS website. For information on the OPPS status indicators, refer to OPPS Addendum D1 of the CY 2023 Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center (ASC) final rule for the latest definitions.

2.OPPS Payment for COVID–19 Treatments after the Public Health Emergency (PHE)

After the PHE, payment for COVID-19 treatments will be packaged into the payment for a comprehensive APC (C-APC) when these services are billed on the same outpatient claim, subject to standard exclusions under the C-APC policy. Please see the updated CMS internet only manual language in the Medicare Claims Processing Manual, Pub.100-04, Chapter 4, Section 10.2.3 – Comprehensive APCs.

3. CPT Proprietary Laboratory Analyses (PLA) Coding Changes Effective April 1, 2023

The AMA CPT Editorial Panel established 23 new PLA codes, specifically, CPT codes 0364U through 0386U, effective April 1, 2023.

Table 2, attachment A, lists the long descriptors and status indicators for the codes. The codes have been added to the April 2023 I/OCE with an effective date of April 1, 2023. In addition, the codes, along with their short descriptors and status indicators, are listed in the April 2023 OPPS Addendum B that is posted on the CMS website. For more information on OPPS status indicators, refer to OPPS Addendum D1 of the Calendar Year 2023 OPPS/ASC final rule for the latest definitions.

4. a. New Device Pass-Through Category Effective January 1, 2023

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 (2), but not more than three (3) 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.

As discussed in section IV.A.2. (New Device Pass-Through Applications for CY 2023), of the CY 2023 OPPS/ASC final rule with comment period, for the January 2023 update, we approved three (3) new devices for pass-through status under the OPPS, specifically, HCPCS codes C1747, C1826, and C1827. For the full discussion on the criteria used to evaluate device pass-through applications, refer to the CY 2023 OPPS/ASC final rule with comment period, which was published in the **Federal Register** in November of CY 2022. Refer to Table 3A, attachment A, for the long descriptor, status indicator, APC, and offset amount for these three (3) HCPCS codes.

Furthermore, we are adding these three (3) new device category codes and their pass-through expiration dates to Table 4, attachment A. We note we are updating the device category long descriptor for device HCPCS code

C1831, which was effective October 1, 2021, from "Personalized, anterior and lateral interbody cage (implantable)" to "Interbody cage, anterior, lateral or posterior, personalized (implantable)" effective January 1, 2023. Refer to Table 4 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 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.

c. Transitional Pass-Through Payments for Designated Devices

Certain designated new devices are assigned to APCs and identified by 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 device(s) used in the procedure. The I/OCE will determine the proper payment amount for these APCs as well as the coinsurance and any applicable deductible. All related payment calculations will be returned on the same APC line and identified as a designated new device. We refer readers to Addendum P (Device-Intensive Procedures for CY 2023) of the CY 2023 OPPS/ASC final rule with comment period for the most current OPPS HCPCS Offset file. Addendum P is available via the Internet on the CMS website, specifically, at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.

Section 4141 of the Consolidated Appropriations Act of 2023 amended Section 1833(t)(6) of the Social Security Act to extend pass-through status for certain devices for a 1-year period beginning on January 1, 2023. The pass-through devices that received this extension are displayed in Table 3B, attachment A and noted in Table 4. Since the pass-through status for these devices were set to expire on December 31, 2022, the pass-through device costs were packaged into the cost of the associated procedures which determined the procedure's CY 2023 APC assignment. However, the changes to Section 1833(t)(6) as a result of Section 4141 also require that we do not remove the packaged cost of the extended pass-through device from the payment amount for a covered OPD service for which it is packaged. Therefore, we are maintaining the APC assignment for these procedures associated with these pass-through devices for CY 2023. Additionally, we are continuing the CY 2022 device offset amount, the device offset amount prior to packaging the pass-through device costs, for the procedures that are associated with the extended pass-through devices. The CY 2023 device offset amounts are displayed in Table 3B. The device offset amounts for the associated procedures performed with the extended pass-through devices are not reflected in Addendum P of the CY 2023 OPPS/ASC final rule with comment period.

d. Alternative Pathway for Devices That Have a Food and Drug Administration (FDA) Breakthrough Designation

For devices that have received FDA marketing authorization and a Breakthrough Device designation from the FDA, CMS provides an alternative pathway to qualify for device pass-through payment status, under which devices would not 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 that receive pass-through payment status effective on or after January 1, 2020. For information on the device criteria to qualify for pass-through status under the OPPS, refer to this CMS website, specifically at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.

e. Expiring Pass-through Status for One Device Category HCPCS Code Effective January 1, 2023

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 (2), but not more than three (3) years. The code is listed in Table 3C, attachment A. We note that the device category HCPCS code will remain active, however, its payment will be included in the primary service. As a reminder, for OPPS billing, because charges related to packaged services are used for outlier and future rate setting, hospitals are advised to report the device category HCPCS codes on the claim whenever they are provided in the HOPD setting. It is extremely important that hospitals report all HCPCS codes consistent with their descriptors, CPT and/or CMS instructions and correct coding principles, as well as all charges for all services they furnish, whether payment for the services is made separately or is packaged. 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, refer to Table 4, attachment A. We note this list can also be found in Chapter 4, Section 60.4.2 (Complete List of Device Pass-through Category Codes) of the Medicare Claims Processing Manual, Pub.100-04.

f. Device Pass-Through Category Removal

As discussed in the October 2022 OPPS and ASC Update CRs, we had conditionally approved a new device for pass-through status effective October 1, 2022. Specifically, we had established HCPCS code C1834 (Pressure sensor system, includes all components (e.g., introducer, sensor), intramuscular (implantable), excludes mobile (wireless) software application), effective October 1, 2022. However, after further review, we have determined that the conditional approval was in error, and consequently, we are deleting the code on March 31, 2023. We note that we have no claims data for C1834, so there should be no reprocessing of claims for HCPCS code C1834.

5. Drugs, Biologicals, and Radiopharmaceuticals

a. New CY 2023 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals Receiving Pass-Through Status Starting April 1, 2023

Twelve (12) new certain drugs, biologicals, and radiopharmaceuticals receiving pass-through status HCPCS codes will be established on April 1, 2023. These HCPCS codes are listed in Table 5, attachment A.

There are two (2) new certain drugs, biologicals, and radiopharmaceuticals receiving pass-through status HCPCS codes with a status indicator change for April 1, 2023. These codes are listed in Table 6, attachment A.

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

Eight (8) HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals in the outpatient setting that will have their pass-through status end on March 31, 2023. These codes are listed in Table 7, attachment A. Therefore, effective April 1, 2023, the status indicator for these codes is changing from “G” to either “K” or “N”. For more information on OPPS status indicators, refer to OPPS Addendum D1 of the Calendar Year 2023 OPPS/ASC final rule for the latest definition. These codes, along with their short descriptors and status indicators are also listed in the April 2023 Update of the OPPS Addendum B.

c. Newly Established HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals as of April 1, 2023

Twenty-one (21) new drug, biological, and radiopharmaceutical HCPCS codes will be established on April 1, 2023. These HCPCS codes are listed in Table 8, attachment A.

d. HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals Deleted on March 31, 2023

Two (2) drug, biological, and radiopharmaceutical HCPCS codes have been deleted on March 31, 2023. These HCPCS codes are listed in Table 9, attachment A.

e. HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals that will have a Changing Status Indicator and APC for April 1, 2023.

One (1) drug, biological, and radiopharmaceutical HCPCS code will have a changing status indicator and APC for April 1, 2023. See Table 10, attachment A.

f. Drugs and Biologicals that will have Manual Adjudication Status on April 1, 2023

HCPCS code J1411 (Injection, etranacogene dezaparvovec-drlb, per therapeutic dose) is receiving pass-through status starting April 1, 2023 as listed in Table 5, attachment A. Due to the magnitude of the required payment rate and technical operational limitations, MACs will manually pay claims following the ASP methodology, after consulting with CMS for pricing instructions. Due to the manual payment for HCPCS code J1411 by the MAC, a zero ($0.00) payment rate will be assigned to APC 9138, which will serve as an additional prompt for the MAC to manually price the code after receiving pricing instructions from CMS.

HCPCS code J3399 (Injection, Onasemnogene abeparvovec-xioi, per treatment, up to 5x10^15 vector genomes) is having its status indicator changed from "A" to "K" starting April 1, 2023 as listed in Table 10, attachment A. Due to the magnitude of the required payment rate and technical operational limitations, MACs will manually pay claims following the ASP methodology, after consulting with CMS for pricing instructions. Due to the manual payment for HCPCS code J3399 by the MAC, a zero ($0.00) payment rate will be assigned to APC 9141, which will serve as an additional prompt for the MAC to manually price the code after receiving pricing instructions from CMS.

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

For CY 2023, payment for the majority of nonpass-through drugs, biologicals, and therapeutic radiopharmaceuticals is generally made at a single rate of ASP plus 6 percent (or ASP plus 6 or 8 percent of the reference product for biosimilars). In CY 2023, a single payment of ASP plus 6 percent for pass-through drugs, biologicals, and radiopharmaceuticals is generally 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 April 1, 2023, payment rates for many drugs and biologicals have changed from the values published in the CY 2023 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the fourth quarter of CY 2022. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the April 2023 Fiscal Intermediary Standard System (FISS) release. CMS is not publishing the updated payment rates in this Change Request implementing the April 2023 update of the OPPS. However, the updated payment rates effective April 1, 2023, can be found in the April 2023 update of the OPPS Addendum A and Addendum B on the CMS website at https:/www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS

h. 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/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html

Providers may resubmit claims that were affected by adjustments to a previous quarter's payment files.

6. Skin Substitutes

The payment for skin substitute products that do not qualify for pass-through status will be packaged into the payment for the associated skin substitute application procedure. For payment packaging purposes, the skin substitute products are divided into two groups: 1) high cost skin substitute products and 2) low cost skin substitute products. New skin substitute HCPCS codes are assigned into the low-cost skin substitute group unless CMS has pricing data that demonstrates that the cost of the product is above either the mean unit cost of $47 or the per day cost of $837 for CY 2023.

a. New Skin Substitute Products as of April 1, 2023

There are seven (7) new skin substitute HCPCS codes that will be active as of April 1, 2023. These codes are listed in Table 11, attachment A.

7. OPPS Payment Files (Addenda A and B) Format Change

Effective January 1, 2023, the Inflation Reduction Act of 2022 specifies that drug companies that raise their prices for certain Medicare Part B drugs faster than the rate of inflation must pay Medicare a rebate. Beneficiary coinsurance for certain Part B drugs (including biological products) with prices that increased at a rate faster than the rate of inflation will be adjusted so beneficiary coinsurance is based on the lower inflation-adjusted payment amount. This new inflation rebate applies to certain Medicare Part B single source drugs and biological products, including biosimilar biological products.

Starting April 1, 2023, when the Medicare Part B payment amount for a Part B rebatable drug for a calendar quarter is higher than the inflation-adjusted payment amount:

- Patient coinsurance will be based on 20% of the inflation-adjusted payment amount for the quarter and will be reflected as a percentage (that is less than 20%) of the Medicare Part B payment amount.
- The Medicare portion of the payment will be increased to the difference between the Medicare Part B payment amount and patient coinsurance, minus any Part B deductible and sequestration.
- Patients must be charged the correct amount of coinsurance, which may change quarterly.

Additional information pertaining to the IRA and its impact is included in the CY2023 OPPS/ASC final rule (CMS-1772-FC).

Due to this change, effective April 1, 2023, the OPPS Addenda A and B will include the following changes:

1. Addition of a new column for **"Adjusted Beneficiary Copayment"** to identify - any copayment adjustment due to either the inpatient deductible amount copayment cap, or the inflation-adjusted copayment of a Part B rebatable drug per Inflation Reduction Act (IRA) provisions.
2. Revision to the **"Note"** column which can now contain multiple messages including, but not limited to, inflation-adjusted copayment of a Part B rebatable drugs, the copayment for a code will be capped at the inpatient deductible of $1,600.00; or that the 8% of the reference product add-on applied for a biosimilar.

8. 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 OPPS 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.

II. 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	
13136.1	Medicare contractors shall adjust, as appropriate, claims brought to their attention with any retroactive changes that were received prior to implementation of the April 2023 OPPS I/OCE.	X		X						
13136.2	Medicare contractors shall manually insert the rate for J1411 in the HCPCS file after a claim is received. The claim will suspend a reason code 36467. When a contractor receives a claim with J1411, contact CMS at: OutpatientPPS@cms.hhs.gov for pricing instructions.	X								
13136.3	Medicare contractors shall manually insert the rate for J3399 in the HCPCS file after a claim is received. Medicare contractors shall remove the HCPCS file indicators to make contractor manually price J3399 on the claim. The claim will suspend a reason code 36467. When a contractor receives a claim with J3399, contact CMS at: OutpatientPPS@cms.hhs.gov for pricing instructions.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility		
		A/B MAC	DME	CED

		A	B	H H H	M A C	I
13136.4	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	X		X		

IV. 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

V. CONTACTS

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

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

VI. 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: 1

Attachment A − Tables for the Policy Section

Table 1. ─ Covid-19 Vaccine Product and Administration CPT Codes

CPT Code	Type	Labeler	Long Descriptor
91300	Vaccine/ Product Code	Pfizer-BioNTech	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted, for intramuscular use
0001A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; first dose
0002A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; second dose
0003A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, diluent reconstituted; third dose
0004A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, diluent reconstituted; booster dose

91301	Vaccine/ Product Code	Moderna	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage, for intramuscular use
0011A	Administration/ Immunization Code	Moderna	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; first dose
0012A	Administration/ Immunization Code	Moderna	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; second dose
0013A	Administration/ Immunization Code	Moderna	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5 mL dosage; third dose
91302	Vaccine/ Product Code	AstraZeneca/ University of Oxford	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, $5x10^{10}$ viral particles/0.5mL dosage, for intramuscular use
0021A	Administration/ Immunization Code	AstraZeneca/ University of Oxford	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free,

			$5x10^{10}$ viral particles/0.5mL dosage; first dose
0022A	Administration/ Immunization Code	AstraZeneca/ University of Oxford	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, $5x10^{10}$ viral particles/0.5mL dosage; second dose
91303	Vaccine/ Product Code	Janssen/Johnson&Johnson	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, $5x10^{10}$ viral particles/0.5mL dosage, for intramuscular use
0031A	Administration/ Immunization Code	Janssen/Johnson&Johnson	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, $5x10^{10}$ viral particles/0.5mL dosage; single dose
0034A	Administration/ Immunization Code	Janssen/Johnson&Johnson	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, $5x10^{10}$ viral particles/0.5mL dosage; booster dose
91304	Vaccine/ Product Code	Novavax	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein

			nanoparticle, saponin-based adjuvant, preservative free, 5 mcg/0.5mL dosage, for intramuscular use
0041A	Administration/ Immunization Code	Novavax	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, preservative free, 5 mcg/0.5mL dosage; first dose
0042A	Administration/ Immunization Code	Novavax	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, preservative free, 5 mcg/0.5mL dosage; second dose
0044A	Administration/ Immunization Code	Novavax	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, preservative free, 5 mcg/0.5mL dosage; booster dose
91305	Vaccine/ Product Code	Pfizer-BioNTech	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage,

			trissucrose formulation, for intramuscular use
0051A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation; first dose
0052A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation; second dose
0053A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation; third dose
0054A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation; booster dose
91306	Vaccine/ Product Code	Moderna	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein,

			preservative free, 50 mcg/0.25 mL dosage, for intramuscular use
0064A	Administration/ Immunization Code	Moderna	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 50 mcg/0.25 mL dosage, booster dose
91307	Vaccine/ Product Code	Pfizer-BioNTech	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use
0071A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; first dose
0072A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; second dose
0073A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV2) (coronavirus disease

			[COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; third dose
0074A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV- 2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; booster dose
91308	Vaccine/ Product Code	Pfizer-BioNTech	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 3 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use
0081A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 3 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; first dose
0082A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 3 mcg/0.2 mL dosage, diluent

			reconstituted, tris-sucrose formulation; second dose
0083A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 3 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; third dose
91309	Vaccine/ Product Code	Moderna	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.5 mL dosage, for intramuscular use
0091A	Administration/ Immunization Code	Moderna	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.5 mL dosage; first dose, when administered to individuals 6 through 11 years
0092A	Administration/ Immunization Code	Moderna	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.5 mL dosage; second dose, when administered to individuals 6 through 11 years

0093A	Administration/ Immunization Code	Moderna	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.5mL dosage; third dose, when administered to individuals 6 through 11 years
0094A	Administration/ Immunization Code	Moderna	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.5 mL dosage; booster dose, when administered to individuals 18 years and over
91310	Vaccine/ Product Code	Sanofi Pasteur	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, monovalent, preservative free, 5 mcg/0.5 mL dosage, adjuvant AS03 emulsion, for intramuscular use
0104A	Administration/ Immunization Code	Sanofi Pasteur	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, monovalent, preservative free, 5 mcg/0.5 mL dosage, adjuvant AS03 emulsion, booster dose
91311	Vaccine/ Product Code	Moderna	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein,

			preservative free, 25 mcg/0.25 mL dosage, for intramuscular use
0111A	Administration/ Immunization Code	Moderna	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 25 mcg/0.25 mL dosage; first dose
0112A	Administration/ Immunization Code	Moderna	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 25 mcg/0.25 mL dosage; second dose
0113A	Administration/ Immunization Code	Moderna	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 25 mcg/0.25 mL dosage; third dose
91312	Vaccine/ Product Code	Pfizer-BioNTech	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, bivalent spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use
0124A	Administration/	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease

	Immunization Code		[COVID-19]) vaccine, mRNA-LNP, bivalent spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation, booster dose
91313	Vaccine/ Product Code	Moderna	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, bivalent, preservative free, 50 mcg/0.5 mL dosage, for intramuscular use
0134A	Administration/ Immunization Code	Moderna	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, bivalent, preservative free, 50 mcg/0.5 mL dosage, booster dose
91314	Vaccine/ Product Code	Moderna	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, bivalent, preservative free, 25 mcg/0.25 mL dosage, for intramuscular use
0144A	Administration/ Immunization Code	Moderna	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRN-LNP, spike protein, bivalent, preservative free, 25 mcg/0.25 mL dosage, booster dose
91315	Vaccine/ Product Code	Pfizer-BioNTech	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, bivalent spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use

0154A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, bivalent spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, booster dose
91316	Vaccine/ Product Code	Moderna	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, bivalent, preservative free, 10 mcg/0.2 mL dosage, for intramuscular use
0164A	Administration/ Immunization Code	Moderna	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, bivalent, preservative free, 10 mcg/0.2 mL dosage, booster dose
91317	Vaccine/ Product Code	Pfizer-BioNTech	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, bivalent spike protein, preservative free, 3 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use
0173A	Administration/ Immunization Code	Pfizer-BioNTech	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, bivalent spike protein, preservative free, 3 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, third dose

Table 2. ─ PLA Coding Changes Effective April 1, 2023

CPT Code	Long Descriptor	OPPS SI
0364U	Oncology (hematolymphoid neoplasm), genomic sequence analysis using multiplex (PCR) and next-generation sequencing with algorithm, quantification of dominant clonal sequence(s), reported as presence or absence of minimal residual disease (MRD) with quantitation of disease burden, when appropriate	A
0365U	Oncology (bladder), analysis of 10 protein biomarkers (A1AT, ANG, APOE, CA9, IL8, MMP9, MMP10, PAI1, SDC1 and VEGFA) by immunoassays, urine, algorithm reported as a probability of bladder cancer	Q4
0366U	Oncology (bladder), analysis of 10 protein biomarkers (A1AT, ANG, APOE, CA9, IL8, MMP9, MMP10, PAI1, SDC1 and VEGFA) by immunoassays, urine, algorithm reported as a probability of recurrent bladder cancer	Q4
0367U	Oncology (bladder), analysis of 10 protein biomarkers (A1AT, ANG, APOE, CA9, IL8, MMP9, MMP10, PAI1, SDC1 and VEGFA) by immunoassays, urine, diagnostic algorithm reported as a risk score for probability of rapid recurrence of recurrent or persistent cancer following transurethral resection	Q4
0368U	Oncology (colorectal cancer), evaluation for mutations of APC, BRAF, CTNNB1, KRAS, NRAS, PIK3CA, SMAD4, and TP53, and methylation markers (MYO1G, KCNQ5, C9ORF50, FLI1, CLIP4, ZNF132 and TWIST1), multiplex quantitative polymerase chain reaction (qPCR), circulating cell-free DNA (cfDNA), plasma, report of risk score for advanced adenoma or colorectal cancer	E1
0369U	Infectious agent detection by nucleic acid (DNA and RNA), gastrointestinal pathogens, 31 bacterial, viral, and parasitic organisms and identification of 21 associated antibiotic-resistance genes, multiplex amplified probe technique	Q4

0370U	Infectious agent detection by nucleic acid (DNA and RNA), surgical wound pathogens, 34 microorganisms and identification of 21 associated antibioticresistance genes, multiplex amplified probe technique, wound swab	Q4
0371U	Infectious agent detection by nucleic acid (DNA or RNA), genitourinary pathogen, semiquantitative identification, DNA from 16 bacterial organisms and 1 fungal organism, multiplex amplified probe technique via quantitative polymerase chain reaction (qPCR), urine	Q4
0372U	Infectious disease (genitourinary pathogens), antibiotic-resistance gene detection, multiplex amplified probe technique, urine, reported as an antimicrobial stewardship risk score	Q4
0373U	Infectious agent detection by nucleic acid (DNA and RNA), respiratory tract infection, 17 bacteria, 8 fungus, 13 virus, and 16 antibiotic-resistance genes, multiplex amplified probe technique, upper or lower respiratory specimen	Q4
0374U	Infectious agent detection by nucleic acid (DNA or RNA), genitourinary pathogens, identification of 21 bacterial and fungal organisms and identification of 21 associated antibiotic-resistance genes, multiplex amplified probe technique, urine	Q4
0375U	Oncology (ovarian), biochemical assays of 7 proteins (follicle stimulating hormone, human epididymis protein 4, apolipoprotein A-1, transferrin, beta-2 macroglobulin, prealbumin [ie, transthyretin], and cancer antigen 125), algorithm reported as ovarian cancer risk score	A
0376U	Oncology (prostate cancer), image analysis of at least 128 histologic features and clinical factors, prognostic algorithm determining the risk of distant metastases, and prostate cancerspecific mortality, includes predictive algorithm to androgen deprivationtherapy response, if appropriate	Q4

0377U	Cardiovascular disease, quantification of advanced serum or plasma lipoprotein profile, by nuclear magnetic resonance (NMR) spectrometry with report of a lipoprotein profile (including 23 variables)	Q4
0378U	RFC1 (replication factor C subunit 1), repeat expansion variant analysis by traditional and repeat-primed PCR, blood, saliva, or buccal swab	A
0379U	Targeted genomic sequence analysis panel, solid organ neoplasm, DNA (523 genes) and RNA (55 genes) by nextgeneration sequencing, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability, and tumor mutational burden	A
0380U	Drug metabolism (adverse drug reactions and drug response), targeted sequence analysis, 20 gene variants and CYP2D6 deletion or duplication analysis with reported genotype and phenotype	A
0381U	Maple syrup urine disease monitoring by patient-collected blood card sample, quantitative measurement of alloisoleucine, leucine, isoleucine, and valine, liquid chromatography with tandem mass spectrometry (LCMS/MS)	Q4
0382U	Hyperphenylalaninemia monitoring by patient-collected blood card sample, quantitative measurement of phenylalanine and tyrosine, liquid chromatography with tandem mass spectrometry (LC-MS/MS)	Q4
0383U	Tyrosinemia type I monitoring by patient-collected blood card sample, quantitative measurement of tyrosine, phenylalanine, methionine, succinylacetone, nitisinone, liquid chromatography with tandem mass spectrometry (LC-MS/MS)	Q4
0384U	Nephrology (chronic kidney disease), carboxymethyllysine, methylglyoxal hydroimidazolone, and carboxyethyl lysine by liquid chromatography with tandem mass spectrometry (LCMS/MS) and HbA1c and	Q4

	estimated glomerular filtration rate (GFR), with risk score reported for predictive progression to high-stage kidney disease	
0385U	Nephrology (chronic kidney disease), apolipoprotein A4 (ApoA4), CD5 antigen-like (CD5L), and insulin-like growth factor binding protein 3 (IGFBP3) by enzyme-linked immunoassay (ELISA), plasma, algorithm combining results with HDL, estimated glomerular filtration rate (GFR) and clinical data reported as a risk score for developing diabetic kidney disease	Q4
0386U	Gastroenterology (Barrett's esophagus), P16, RUNX3, HPP1, and FBN1 methylation analysis, prognostic and predictive algorithm reported as a risk score for progression to high-grade dysplasia or esophageal cancer	A

Table 3A. —Device Pass-Through Category HCPCS Codes and Associated Device Offset Amounts

HCPCS Code	Long Descriptor	SI	APC	Device Offset Amount(s)
C1831	Interbody cage, anterior, lateral or posterior, personalized (implantable)	H	2034	CPT code 22630 $0.00
C1826	Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system	H	2038	CPT code 63685 $24,024.04
C1827	Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller	H	2039	CPT code 64568 $24,094.50
C1747	Endoscope, single-use (i.e. disposable), urinary tract, imaging/illumination device (insertable)	H	2040	CPT code 52344 $507.69

(1) Device Offset for HCPCS Code C1831 (Interbody cage, anterior, lateral or posterior, personalized (implantable))

Device category HCPCS code C1831 should always be billed with the following CPT codes:

HCPCS Code	Long Descriptor	SI	APC	Device Offset Amount
22630	(Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar)	J1	5116	$0.00
22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (list separately in addition to code for primary procedure)	N	N/A	N/A
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; lumbar	J1	5116	$0.00
22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; each additional interspace and segment (list separately in addition to code for primary procedure)	N	N/A	N/A

(2) Device Offset for HCPCS Code C1826 (Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system)

New device category HCPCS code C1826 should always be billed with the following CPT codes:

HCPCS Code	Long Descriptor	SI	APC	Device Offset Amount
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	J1	5465	$24,024.04

(3) Device Offset for HCPCS Code C1827 (Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller)

New device category HCPCS code C1827 should always be billed with the following CPT codes:

HCPCS Code	Long Descriptor	SI	APC	Device Offset Amount
64568	Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	J1	5465	$24,094.50

(4) Device Offset for HCPCS Code C1747 (Endoscope, single-use (i.e. disposable), urinary tract, imaging/illumination device (insertable))

New device category HCPCS code C1747 should always be billed with the following CPT codes:

HCPCS Code	Long Descriptor	SI	APC	Device Offset Amount
50080	Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy, stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; simple (eg, stone[s] up to 2 cm in single location of kidney or renal pelvis, nonbranching stones)	J1	5376	$1,050.86
50081	Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy, stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; complex (eg, stone[s] > 2 cm, branching stones, stones in multiple locations, ureter stones, complicated anatomy)	J1	5376	$1,026.05
50575	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with endopyelotomy (includes cystoscopy, ureteroscopy, dilation of ureter and ureteral pelvic junction, incision of	J1	5375	$570.84

HCPCS Code	Long Descriptor	SI	APC	Device Offset Amount
	ureteral pelvic junction and insertion of endopyelotomy stent)			
50951	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;	J1	5374	$169.87
50953	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter	J1	5374	$442.95
50955	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy	J1	5375	$423.20
50957	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy	J1	5375	$416.14
50961	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus	J1	5375	$461.75
50970	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;	J1	5374	$312.82
50972	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter	J1	5374	$760.57
50974	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy	J1	5375	$1,069.75
50976	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of	J1	5375	$2,043.10

HCPCS Code	Long Descriptor	SI	APC	Device Offset Amount
	radiologic service; with fulguration and/or incision, with or without biopsy			
50980	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus	J1	5375	$405.33
52344	Cysto/uretero stricture tx	J1	5374	$507.69
52345	Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)	J1	5374	$511.54
52346	Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)	J1	5375	$602.82
52351	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic	J1	5374	$169.55
52352	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)	J1	5374	$320.51
52353	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)	J1	5375	$252.04
52354	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of ureteral or renal pelvic lesion	J1	5375	$428.37
52355	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor	J1	5375	$371.94
52356	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, gibbons or double-j type)	J1	5375	$474.45
C9761	Cystourethroscopy, with ureteroscopy and/or pyeloscopy, with lithotripsy, and ureteral catheterization for steerable vacuum aspiration of the kidney, collecting system, ureter, bladder, and urethra if applicable	J1	5376	$789.86

Table 3B. —Devices with Extended Pass-Through Status from Section 4141 of the Consolidation Appropriations Act of 2023 and the Associated CY 2023 Device Offset Amounts

HCPCS Code	Long Descriptor	SI	APC	Device Offset Amount(s)
C1734	Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue-to bone (implantable)	H	2026	CPT code 27870 $0.00 CPT code 28705 $0.00 CPT code 28715 $0.00 CPT code 28725 $0.00
C1824	Generator, cardiac contractility modulation (implantable)	H	2024	CPT code 0408T $12,314.74
C1839	Iris prosthesis	H	2028	CPT code 0616T $657.47 CPT code 0617T $1,239.87 CPT code 0618T $1,239.87
C1982	Catheter, pressure-generating, one-way valve, intermittently occlusive	H	2025	CPT code 37242 $4,089.03 CPT code 37243 $2,234.30
C2596	Probe, image-guided, robotic, waterjet ablation	H	2027	CPT code 0421T $0.00

Table 3C.— Expiring Pass-through Status for one (1) Device Category HCPCS Code Effective January 1, 2023

HCPCS Code	Long Descriptor	Device Pass-through Status Expiration Date
C1823	Generator, neurostimulator (implantable), nonrechargeable, with transvenous sensing and stimulation leads	12/31/2022

Table 4.— List of Device Category HCPCS Codes and Definitions Used for Present and Previous Pass-Through Payment ***

	HCPCS Codes	Category Long Descriptor	Date First Populated	Pass-Through Expiration Date***
1.	C1883*	Adaptor/extension, pacing lead or neurostimulator lead (implantable)	8/1/00	12/31/02
2.	C1765*	Adhesion barrier	10/01/00 – 3/31/01; 7/1/01	12/31/03
3.	C1713*	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)	8/1/00	12/31/02

4.	L8690	Auditory osseointegrated device, includes all internal and external components	1/1/07	12/31/08
5.	**C1832**	**Autograft suspension, including cell processing and application, and all system components**	**1/1/22**	**12/31/2024**
6.	C1715	Brachytherapy needle	8/1/00	12/31/02
7.	C1716#	Brachytherapy source, non-stranded, Gold-198, per source	10/1/00	12/31/02
8.	C1717#	Brachytherapy source, non-stranded, high dose rate Iridium-192, per source	1/1/01	12/31/02
9.	C1718#	Brachytherapy source, Iodine 125, per source	8/1/00	12/31/02
10.	C1719#	Brachytherapy source, non-stranded, non-high dose rate Iridium-192, per source	10/1/00	12/31/02
11.	C1720#	Brachytherapy source, Palladium 103, per source	8/1/00	12/31/02
12.	C2616#	Brachytherapy source, non-stranded, Yttrium-90, per source	1/1/01	12/31/02
13.	C2632	Brachytherapy solution, iodine – 125, per mCi	1/1/03	12/31/04
14.	C1721	Cardioverter-defibrillator, dual chamber (implantable)	8/1/00	12/31/02
15.	C1882*	Cardioverter-defibrillator, other than single or dual chamber (implantable)	8/1/00	12/31/02
16.	C1722	Cardioverter-defibrillator, single chamber (implantable)	8/1/00	12/31/02
17.	C1888*	Catheter, ablation, non-cardiac, endovascular (implantable)	7/1/02	12/31/04
18.	C1726*	Catheter, balloon dilatation, non-vascular	8/1/00	12/31/02
19.	C1727*	Catheter, balloon tissue dissector, non-vascular (insertable)	8/1/00	12/31/02
20.	C1728	Catheter, brachytherapy seed administration	1/1/01	12/31/02
21.	C1729*	Catheter, drainage	10/1/00	12/31/02
22.	C1730*	Catheter, electrophysiology, diagnostic, other than 3D mapping (19 or fewer electrodes)	8/1/00	12/31/02
23.	C1731*	Catheter, electrophysiology, diagnostic, other than 3D mapping (20 or more electrodes)	8/1/00	12/31/02
24.	C1732*	Catheter, electrophysiology, diagnostic/ablation, 3D or vector mapping	8/1/00	12/31/02
25.	C1733*	Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, other than cool-tip	8/1/00	12/31/02
26.	C2630*	Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, cool-tip	10/1/00	12/31/02
27.	C1886	Catheter, extravascular tissue ablation, any modality (insertable)	01/01/12	12/31/13
28.	C1887*	Catheter, guiding (may include infusion/perfusion capability)	8/1/00	12/31/02
29.	C1750	Catheter, hemodialysis/peritoneal, long-term	8/1/00	12/31/02

30.	C1752	Catheter, hemodialysis/peritoneal, short-term	8/1/00	12/31/02
31.	C1751	Catheter, infusion, inserted peripherally, centrally or midline (other than hemodialysis)	8/1/00	12/31/02
32.	C1759	Catheter, intracardiac echocardiography	8/1/00	12/31/02
33.	C1754	Catheter, intradiscal	10/1/00	12/31/02
34.	C1755	Catheter, intraspinal	8/1/00	12/31/02
35.	C1753	Catheter, intravascular ultrasound	8/1/00	12/31/02
36.	C2628	Catheter, occlusion	10/1/00	12/31/02
37.	C1756	Catheter, pacing, transesophageal	10/1/00	12/31/02
39.	C2627	Catheter, suprapubic/cystoscopic	10/1/00	12/31/02
40.	C1757	Catheter, thrombectomy/embolectomy	8/1/00	12/31/02
41.	C2623	Catheter, transluminal angioplasty, drug-coated, non-laser	4/1/15	12/31/17
42.	C1885*	Catheter, transluminal angioplasty, laser	10/1/00	12/31/02
43.	C1725*	Catheter, transluminal angioplasty, non-laser (may include guidance, infusion/perfusion capability)	8/1/00	12/31/02
44.	C1714	Catheter, transluminal atherectomy, directional	8/1/00	12/31/02
45.	C1724	Catheter, transluminal atherectomy, rotational	8/1/00	12/31/02
46.	**C1761**	**Catheter, transluminal intravascular lithotripsy, coronary**	**7/1/21**	**6/30/2024**
47.	C1760*	Closure device, vascular (implantable/insertable)	8/1/00	12/31/02
48.	L8614	Cochlear implant system	8/1/00	12/31/02
49.	C1762*	Connective tissue, human (includes fascia lata)	8/1/00	12/31/02
50.	C1763*	Connective tissue, non-human (includes synthetic)	10/1/00	12/31/02
51.	C1881	Dialysis access system (implantable)	8/1/00	12/31/02
52.	C1884*	Embolization protective system	1/01/03	12/31/04
53.	C1749	Endoscope, retrograde imaging/illumination colonoscope device (implantable)	10/01/10	12/31/12

54.	**C1748**	**Endoscope, single-use (i.e. disposable), Upper GI, imaging/illumination device (insertable)**	**7/1/20**	**6/30/2023**
55.	C1764	Event recorder, cardiac (implantable)	8/1/00	12/31/02
57.	C1822	Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system	1/1/16	12/31/17
58.	C1767**	Generator, neurostimulator (implantable), non-rechargeable	8/1/00	12/31/02
59.	C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system	1/1/06	12/31/07
60.	**C1825**	**Generator, neurostimulator (implantable), non-rechargeable with carotid sinus baroreceptor stimulation lead(s)**	**1/1/21**	**12/31/2023**
61.	C1823	Generator, neurostimulator (implantable), nonrechargeable , with transvenous sensing and stimulation leads	1/1/19	12/31/2022

62.	C1768	Graft, vascular	1/1/01	12/31/02
63.	C1769	Guide wire	8/1/00	12/31/02
64.	**C1052**	**Hemostatic agent, gastrointestinal, topical**	**1/1/21**	**12/31/2023**
65.	C1770	Imaging coil, magnetic resonance (insertable)	1/1/01	12/31/02
66.	C2624	Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components	1/1/15	12/31/16
67.	C1891	Infusion pump, non-programmable, permanent (implantable)	8/1/00	12/31/02
68.	C2626*	Infusion pump, non-programmable, temporary (implantable)	1/1/01	12/31/02
69.	C1772	Infusion pump, programmable (implantable)	10/1/00	12/31/02
70.	C1818*	Integrated keratoprosthesis	7/1/03	12/31/05
71.	C1821	Interspinous process distraction device (implantable)	1/1/07	12/31/08
72.	**C1062**	**Intravertebral body fracture augmentation with implant (e.g., metal, polymer)**	**1/1/21**	**12/31/2023**
73.	C1893	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, other than peel-away	10/1/00	12/31/02
74.	C1892*	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, peel-away	1/1/01	12/31/02
75.	C1766	Introducer/sheath, guiding, intracardiac electrophysiological, steerable, other than peel-away	1/1/01	12/31/02
76.	C1894	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, non-laser	8/1/00	12/31/02
77.	C2629	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, laser	1/1/01	12/31/02
79.	C1776*	Joint device (implantable)	10/1/00	12/31/02

80.	C1895	Lead, cardioverter-defibrillator, endocardial dual coil (implantable)	8/1/00	12/31/02
81.	C1777	Lead, cardioverter-defibrillator, endocardial single coil (implantable)	8/1/00	12/31/02
82.	C1896	Lead, cardioverter-defibrillator, other than endocardial single or dual coil (implantable)	8/1/00	12/31/02
83.	C1900*	Lead, left ventricular coronary venous system	7/1/02	12/31/04
84.	C1778	Lead, neurostimulator (implantable)	8/1/00	12/31/02
85.	C1897	Lead, neurostimulator test kit (implantable)	8/1/00	12/31/02
86.	C1898	Lead, pacemaker, other than transvenous VDD single pass	8/1/00	12/31/02
87.	C1779*	Lead, pacemaker, transvenous VDD single pass	8/1/00	12/31/02
88.	C1899	Lead, pacemaker/cardioverter-defibrillator combination (implantable)	1/1/01	12/31/02
89.	C1780*	Lens, intraocular (new technology)	8/1/00	12/31/02
90.	C1840	Lens, intraocular (telescopic)	10/01/11	12/31/13
91.	C2613	Lung biopsy plug with delivery system	7/1/15	12/31/17
92.	C1878*	Material for vocal cord medialization, synthetic (implantable)	10/1/00	12/31/02
93.	C1781*	Mesh (implantable)	8/1/00	12/31/02
94.	**C1833**	**Monitor, cardiac, including intracardiac lead and all system components (implantable)**	**1/1/22**	**12/31/2024**
95.	C1782*	Morcellator	8/1/00	12/31/02
96.	C1784*	Ocular device, intraoperative, detached retina	1/1/01	12/31/02
97.	C1783	Ocular implant, aqueous drainage assist device	7/1/02	12/31/04
99.	C2619	Pacemaker, dual chamber, non rate-responsive (implantable)	8/1/00	12/31/02
100.	C1785	Pacemaker, dual chamber, rate-responsive (implantable)	8/1/00	12/31/02
101.	C2621*	Pacemaker, other than single or dual chamber (implantable)	1/1/01	12/31/02
102.	C2620	Pacemaker, single chamber, non rate-responsive (implantable)	8/1/00	12/31/02
103.	C1786	Pacemaker, single chamber, rate-responsive (implantable)	8/1/00	12/31/02
104.	C1787*	Patient programmer, neurostimulator	8/1/00	12/31/02
105.	**C1831**	**Interbody cage, anterior, lateral or posterior, personalized (implantable)**	**10/1/2021**	**9/30/2024**
106.	C1788	Port, indwelling (implantable)	8/1/00	12/31/02
107.	C1830	Powered bone marrow biopsy needle	10/01/11	12/31/13
108.	C2618	Probe, cryoablation	4/1/01	12/31/03
110.	C2614	Probe, percutaneous lumbar discectomy	1/1/03	12/31/04
111.	C1789	Prosthesis, breast (implantable)	10/1/00	12/31/02
112.	C1813	Prosthesis, penile, inflatable	8/1/00	12/31/02

113.	C2622	Prosthesis, penile, non-inflatable	10/1/01	12/31/02
114.	C1815	Prosthesis, urinary sphincter (implantable)	10/1/00	12/31/02
115.	C1816	Receiver and/or transmitter, neurostimulator (implantable)	8/1/00	12/31/02
116.	C1771*	Repair device, urinary, incontinence, with sling graft	10/1/00	12/31/02
117.	C2631*	Repair device, urinary, incontinence, without sling graft	8/1/00	12/31/02
118.	C1841	Retinal prosthesis, includes all internal and external components	10/1/13	12/31/15
119.	C1814*	Retinal tamponade device, silicone oil	4/1/03	12/31/05
120.	C1773*	Retrieval device, insertable	1/1/01	12/31/02
121.	C2615*	Sealant, pulmonary, liquid (implantable)	1/1/01	12/31/02
122.	C1817*	Septal defect implant system, intracardiac	8/1/00	12/31/02
123.	C1874*	Stent, coated/covered, with delivery system	8/1/00	12/31/02
124.	C1875*	Stent, coated/covered, without delivery system	8/1/00	12/31/02
125.	C1876*	Stent, non-coated/non-covered, with delivery system	8/1/00	12/31/02
126.	C1877	Stent, non-coated/non-covered, without delivery system	8/1/00	12/31/02
127.	C2625*	Stent, non-coronary, temporary, with delivery system	10/1/00	12/31/02
128.	C2617*	Stent, non-coronary, temporary, without delivery system	10/1/00	12/31/02
129.	C1819	Tissue localization excision device	1/1/04	12/31/05
130.	C1879*	Tissue marker (implantable)	8/1/00	12/31/02
131.	C1880	Vena cava filter	1/1/01	12/31/02
132	**C1826**	**Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system**	**1/1/2023**	**12/31/2025**
133	**C1827**	**Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller**	**1/1/2023**	**12/31/2025**
134	**C1747**	**Endoscope, single-use (i.e. disposable), urinary tract, imaging/illumination device (insertable)**	**1/1/2023**	**12/31/2025**
135	**C1824^**	**Generator, cardiac contractility modulation (implantable)**	**1/1/2020**	**12/31/2023**
136	**C1982^**	**Catheter, pressure-generating, one-way valve, intermittently occlusive**	**1/1/2020**	**12/31/2023**
137	**C1839^**	**Iris prosthesis**	**1/1/2020**	**12/31/2023**
138	**C1734^**	**Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue-to bone (implantable)**	**1/1/2020**	**12/31/2023**
139	**C2596^**	**Probe, image-guided, robotic, waterjet ablation**	**1/1/2020**	**12/31/2023**

BOLD codes are still actively receiving pass-through payment.

Italicized codes have received preliminary approval for pass-through payment.

*** Refer to the definition below for further information on this device category code.**

**** Effective 1/1/06 C1767 descriptor was changed for succeeding claims. See CR 4250, Jan. 3, 2006 for details.**

***** Although the pass-through payment status for device category codes has expired, these codes are still active and hospitals are still required to report the device category C-codes (except the brachytherapy source codes, which are separately paid under the OPPS) on claims when such devices are used in conjunction with procedures billed and paid under the OPPS.**

^Sec. 4141. Extension of Pass-Through Status Under the Medicare Program for Certain Devices Impacted by COVID-19 of the Consolidated Appropriations Act, 2023 has extended pass-through status for a 1-year period beginning on January 1, 2023.

Table 5. ─ Newly Established HCPCS Codes for Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals Receiving Pass-Through Status Starting April 1, 2023

New HCPCS Code	Old HCPCS Code	Long Descriptor	SI	APC
C9145	N/A	Injection, aprepitant, (aponvie), 1 mg	G	9107
C9146	N/A	Injection, mirvetuximab soravtansine-gynx, 1 mg	G	9109
C9147	N/A	Injection, tremelimumab-actl, 1 mg	G	9110
C9148	N/A	Injection, teclistamab-cqyv, 0.5 mg	G	9111
C9149	N/A	Injection, teplizumab-mzwv, 5 mcg	G	9112
J0218	N/A	Injection, olipudase alfa-rpcp, 1 mg	G	9113
J1411	N/A	Injection, etranacogene dezaparvovec-drlb, per therapeutic dose	G	9138
J1449	N/A	Injection, eflapegrastim-xnst, 0.1 mg	G	9114
J1747	N/A	Injection, spesolimab-sbzo, 1 mg	G	9115
J2403	N/A	Chloroprocaine hcl ophthalmic, 3% gel, 1 mg	G	9116
Q5128	N/A	Injection, ranibizumab-eqrn (cimerli), biosimilar, 0.1 mg	G	9117
Q5130	N/A	Injection, pegfilgrastim-pbbk (fylnetra), biosimilar, 0.5 mg	G	9118

Table 6. ─ Certain Drugs, Biologicals, and Radiopharmaceuticals Receiving Pass-Through Status with Status Indicator Change Starting April 1, 2023

Current HCPCS Code	Long Descriptor	Old SI	New SI	APC
C9144	Injection, bupivacaine (posimir), 1 mg	N	G	9106
J1954	Injection, leuprolide acetate for depot suspension (cipla), 7.5 mg	E2	G	9136

Table 7. ─ HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals with Pass-Through Status Ending Effective March 31, 2023

CY 2023 HCPCS Code	CY 2023 Long Descriptor	January 2022 SI	April 2023 SI	April 2023 APC
J0179	Injection, brolucizumab-dbll, 1 mg	G	K	9340
J0223	Injection, givosiran, 0.5 mg	G	K	9343
J0791	Injection, crizanlizumab-tmca, 5 mg	G	K	9359
J1201	Injection, cetirizine hydrochloride, 0.5 mg	G	K	9361
J7331	Hyaluronan or derivative, synojoynt, for intra-articular injection, 1 mg	G	K	9337
Q5114	Injection, trastuzumab-dkst, biosimilar, (ogivri), 10 mg	G	K	9341
Q5115	Injection, rituximab-abbs, biosimilar (truxima), 10 mg	G	K	9336
Q5120	Injection, pegfilgrastim-bmez, biosimilar, (ziextenzo) 0.5 mg	G	K	9345

Table 8. ─ Newly Established HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals as of April 1, 2023

New HCPCS Code	Old HCPCS Code	Long Descriptor	SI	APC
C9145	N/A	Injection, aprepitant, (aponvie), 1 mg	G	9107
C9146	N/A	Injection, mirvetuximab soravtansine-gynx, 1 mg	G	9109
C9147	N/A	Injection, tremelimumab-actl, 1 mg	G	9110
C9148	N/A	Injection, teclistamab-cqyv, 0.5 mg	G	9111
C9149	N/A	Injection, teplizumab-mzwv, 5 mcg	G	9112
J0208	N/A	Injection, sodium thiosulfate, 100 mg	K	9119
J0218	N/A	Injection, olipudase alfa-rpcp, 1 mg	G	9113
J0612	N/A	Injection, calcium gluconate (fresenius kabi), per 10 mg	N	N/A

New HCPCS Code	Old HCPCS Code	Long Descriptor	SI	APC
J0613	N/A	Injection, calcium gluconate (wg critical care), per 10 mg	N	N/A
J1411	N/A	Injection, etranacogene dezaparvovec-drlb, per therapeutic dose	G	9138
J1449	N/A	Injection, eflapegrastim-xnst, 0.1 mg	G	9114
J1747	N/A	Injection, spesolimab-sbzo, 1 mg	G	9115
J2403	N/A	Chloroprocaine hcl ophthalmic, 3% gel, 1 mg	G	9116
J9196	N/A	Injection, gemcitabine hydrochloride (accord), not therapeutically equivalent to j9201, 200 mg	N	N/A
J9294	N/A	Injection, pemetrexed (hospira) not therapeutically equivalent to j9305, 10 mg	K	9123
J9296	N/A	Injection, pemetrexed (accord) not therapeutically equivalent to j9305, 10 mg	K	9127
J9297	N/A	Injection, pemetrexed (sandoz), not therapeutically equivalent to j9305, 10 mg	K	9128
Q5127	N/A	Injection, pegfilgrastim-fpgk (stimufend), biosimilar, 0.5 mg	K	9129
Q5128	N/A	Injection, ranibizumab-eqrn (cimerli), biosimilar, 0.1 mg	G	9117
Q5129	N/A	Injection, bevacizumab-adcd (vegzelma), biosimilar, 10 mg	E2	N/A
Q5130	N/A	Injection, pegfilgrastim-pbbk (fylnetra), biosimilar, 0.5 mg	G	9118

Table 9. ─ HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals Deleted on March 31, 2023

CY 2023 HCPCS Code	Long Descriptor	CY 2022 SI	APC
J0610	Injection, calcium gluconate (fresenius kabi), per 10 ml	N	N/A
J0611	Injection, calcium gluconate (wg critical care), per 10 ml	N	N/A

Table 10. – HCPCS Code for Drug, Biological, and Radiopharmaceutical that will have a Changing Status Indicator and APC for April 1, 2023.

CY 2023 HCPCS Code	Long Descriptor	Previous Status Indicator	New Status Indicator	Previous APC	New APC
J3399	Injection, Onasemnogene abeparvovec-xioi, per treatment, up to 5x10^15 vector genomes	A	K	N/A	9141

Table 11. – New Skin Substitute Products as of April 1, 2023

CY 2023 HCPCS Code	Short Descriptor	CY 2023 SI	Low/High Cost Skin Substitute
Q4265	Neostim tl, per square centimeter	N	Low
Q4266	Neostim membrane, per square centimeter	N	Low
Q4267	Neostim dl, per square centimeter	N	Low
Q4268	Surgraft ft, per square centimeter	N	Low
Q4269	Surgraft xt, per square centimeter	N	Low
Q4270	Complete sl, per square centimeter	N	Low
Q4271	Complete ft, per square centimeter	N	Low

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

(Rev.11937; Issued: 03-31-23)

Transmittals for Chapter 4

20.6.2 - Modifier 50

20.6.3 - Modifiers LT and RT

20.6.4 - Modifiers 73 and 74

20.6.5 - Modifiers 76 and 77

20.6.7 - Modifier CA

20.6.9 - Modifier FB

20.6.10 - Modifier FC

20.6.11 - Modifier PO

20.6.12 - Modifier PN

20.6.13 - Modifier CT

20.6.14 - Modifier FX

20.6.15 - Modifier FY

20.6.16 - Modifier JG

20.6.17- Modifier TB

20.6.18- Modifier ER

20.6.19 - Modifier CG

10.2.3 - Comprehensive APCs

(Rev. 11937; Issued: 03-31-23; Effective: 04-01-23; Implementation: 04-03-23)

Comprehensive APCs provide a single payment for a primary service, and payment for all adjunctive services reported on the same claim is packaged into payment for the primary service. With few exceptions, all other services reported on a hospital outpatient claim in combination with the primary service are considered to be related to the delivery of the primary service and packaged into the single payment for the primary service.

HCPCS codes assigned to comprehensive APCs are designated with status indicator J1, See Addendum B at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS for the list of HCPCS codes designated with status indicator J1.

Claims reporting at least one J1 procedure code will package the following items and services that are not typically packaged under the OPPS:

- major OPPS procedure codes (status indicators P, S, T, V)
- lower ranked comprehensive procedure codes (status indicator J1)
- non-pass-through drugs and biologicals (status indicator K)
- blood products (status indicator R)
- DME (status indicator Y)
- therapy services (HCPCS codes with status indicator A reported on therapy revenue centers)

The following services are excluded from comprehensive APC packaging:

- ambulance services
- brachytherapy sources (status indicator U)
- diagnostic and mammography screenings
- physical therapy, speech-language pathology and occupational therapy services reported on a separate facility claim for recurring services
- pass-through drugs, biologicals, and devices (status indicators G or H)
- preventive services defined in 42 CFR 410.2
- self-administered drugs (SADs) - drugs that are usually self-administered and do not function as supplies in the provision of the comprehensive service
- services assigned to OPPS status indicator F (including certain CRNA services, Hepatitis B vaccines and corneal tissue acquisition)
- services assigned to OPPS status indicator L (including influenza, pneumococcal pneumonia, and COVID-19 vaccines)
- certain Part B inpatient services – Ancillary Part B inpatient services payable under Part B when the primary J1 service for the claim is not a payable Medicare Part B inpatient service (for example, exhausted Medicare Part A benefits, beneficiaries with Part B only)
- services assigned to a New Technology APC
- Any drug or biological described by HCPCS code C9399 (Unclassified drugs or biologicals)
- For the remainder of the PHE for COVID-19,
    - Over-the-counter (OTC) COVID-19 tests
    - New COVID-19 treatments that meet the following criteria:
        1) The treatment must be a drug or biological product (which could include a blood product) authorized to treat COVID-19, as indicated in section "I. Criteria for Issuance of Authorization" of the letter of authorization for the drug or biological product, or the drug or biological product must be approved by the FDA for treating COVID-19
        2) The emergency use authorization (EUA) for the drug or biological product (which could include a blood product) must authorize the use of the product in the outpatient setting or not limit its use to the inpatient setting, or the product must be approved by the FDA to treat COVID-19 disease and not limit its use to the inpatient setting.
    - *After the PHE, which ends on May 11, 2023, payment for these COVID-19 treatments will be packaged into the payment for a C-APC when these services are billed on the same outpatient claim.*

20.6 - Use of Modifiers

(Rev. 11937; Issued: 03-31-23; Effective: 04-01-23; Implementation: 04-03-23)

Modifiers are two-digit identifiers that are reported with CPT and HCPCS Level II codes to provide additional information about how an item, procedure, or service is provided, and improve the accuracy of coding. These two-digit modifiers can be alphabetic, numeric, or a combination of both. The use of modifiers is not limited to certain code sets. Specifically, CPT modifiers may be used with HCPCS Level II codes when appropriate. Similarly, HCPCS Level II modifiers may be used with CPT codes to appropriately describe how an item, procedure, or service is provided. Providers may use any applicable modifier where appropriate. For Medicare purposes, modifiers are used either as pricing or informational/tracking indicators.

The Integrated Outpatient Code Editor (I/OCE) accepts all valid CPT and HCPCS *Level II* modifiers on OPPS claims. *As of April 1, 2023, there are approximately 410 active and valid modifiers.* Definitions for *all valid* modifiers may be found in the *latest* CPT and HCPCS *Level II code references. The complete descriptions for all CPT modifiers can be found in the latest CPT code book. Alternatively, the complete descriptions for the HCPCS Level II modifiers can be found in the latest HCPCS Level II code book, as well as in the latest HCPCS Level II code file that is available on the CMS HCPCS website, specifically, at https://www.cms.gov/medicare/coding/hcpcsreleasecodesets/hcpcs-quarterly-update. Additional guidance on the use of modifiers can also be found on the Medicare Administrative Contractors' (MAC) websites. Note that, under the OPPS, the use of modifiers applies to services/procedures performed on the same calendar day.*

The following subsections provide information on the use of certain modifiers under the hospital OPPS. For information on additional modifiers not described below, refer to your MAC website(s) for guidance.

20.6.1 - Where to Report Modifiers on the Hospital Part B Claim

(Rev. 11937; Issued: 03-31-23; Effective: 04-01-23; Implementation: 04-03-23)

Modifiers are reported on the hardcopy Form CMS-1450 with the HCPCS code. See Chapter 25 of this manual for related instructions. *For electronic submissions, see*
the ASC X12 837 Institutional Claim implementation guide for instructions *related to* HCPCS modifiers when using the ASC X12 837 institutional claim format. *Note there is space for four modifiers on the hardcopy and electronic forms*.

HOPDs are reminded that the most specific modifier should be used first. That is, when modifiers E1 through E4, FA through F9, LC, LD, RC, and TA through T9 apply, they should be used before modifiers LT, RT, or 59.

20.6.2 - Modifier 50

(Rev. 11937; Issued: 03-31-23; Effective: 04-01-23; Implementation: 04-03-23)

50: Bilateral Procedure

Modifier 50 is used to report bilateral procedures that are performed *on both sides of the body* at the same operative session. Do not *report* modifiers RT and LT when modifier 50 applies. Do not submit two line items to report a bilateral procedure using modifier 50. *Report one line with modifier 50 using one unit of service.*

Modifier 50 applies to any bilateral procedure performed on both sides at the same operative session. The bilateral modifier 50 is restricted to operative sessions only.
Modifier 50 may not be used:

To report surgical procedures identified by their terminology as “bilateral,” or
To report surgical procedures identified by their terminology as “unilateral or bilateral”.

The unit entry to use when modifier 50 is reported is one *unit*.

20.6.3 - Modifiers LT and RT
(Rev. 11937; Issued: 03-31-23; Effective: 04-01-23; Implementation: 04-03-23)

LT: Left side (used to identify procedures performed on the left side of the body)
RT: Right side (used to identify procedures performed on the right side of the body)

Modifiers LT *and* RT apply to codes that identify procedures that can be performed on paired organs, e.g., ears, eyes, nostrils, kidneys, lungs, and ovaries.

These modifiers should be used whenever a procedure is performed on only one side. Hospitals *should report* the appropriate RT or LT modifier to identify which of the paired organs was operated upon. *Do not report modifiers RT and LT when modifier 50 applies.*

20.6.4 - Modifiers *73 and 74*
(Rev. 11937; Issued: 03-31-23; Effective: 04-01-23; Implementation: 04-03-23)

73: Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure prior to the administration of anesthesia
74: Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure after administration of anesthesia

A. General

Modifiers *73 and 74* provide a way for hospitals to report and be paid for expenses incurred in preparing a patient for a procedure and scheduling a room for performing the procedure where the service is subsequently discontinued. This instruction *applies* to both hospital *outpatient* departments *(HOPDs)* and to ambulatory surgical centers *(ASCs)*.

Modifier 73 is used by the facility to indicate that a procedure requiring anesthesia was terminated due to extenuating circumstances or to circumstances that threatened the well-being of the patient after the patient had been prepared for the procedure (including procedural pre-medication when provided), and been taken to the room where the procedure was to be performed, but prior to administration of anesthesia. For purposes of billing for services furnished in the hospital outpatient department, anesthesia is defined to include local, regional block(s), moderate sedation/analgesia (“conscious sedation”), deep sedation/analgesia, or general anesthesia. This modifier code was created so that the costs incurred by the hospital to prepare the patient for the procedure and the resources expended in the procedure room and recovery room (if needed) could be recognized for payment even though the procedure was discontinued.

Modifier 74 is used by the facility to indicate that a procedure requiring anesthesia was terminated after the induction of anesthesia or after the procedure was started (e.g., incision made, intubation started, scope inserted) due to extenuating circumstances or circumstances that threatened the well-being of the patient.

This modifier may also be used to indicate that a planned surgical or diagnostic procedure was discontinued, partially reduced or cancelled at the physician's discretion after the administration of anesthesia. For purposes of billing for services furnished in the hospital outpatient department, anesthesia is defined to include local, regional block(s), moderate sedation/analgesia (“conscious sedation”), deep sedation/analgesia, and general anesthesia. This modifier code was created so that the costs incurred by the hospital to initiate the procedure (preparation of the patient, procedure room, recovery room) could be recognized for payment even though the procedure was discontinued prior to completion.

Coinciding with the addition of the modifiers 73 and 74, modifiers 52 and 53 were revised. Modifier 52 is

used to indicate partial reduction, cancellation, or discontinuation of services for which anesthesia is not planned. The modifier provides a means for reporting reduced services without disturbing the identification of the basic service. Modifier 53 is used to indicate discontinuation of physician services and is not approved for use for outpatient hospital services.

Note that the elective cancellation of a procedure should not be reported.

Modifiers 73 and 74 are only used to indicate discontinued procedures for which anesthesia is planned or provided.

B. Effect on Payment

Procedures that are discontinued after the patient has been prepared for the procedure and taken to the procedure room but before anesthesia is provided will be paid at 50 percent of the full OPPS payment amount. Modifier 73 is used for these procedures. As of January 1, 2016, for device-intensive procedures that append modifier 73, we will reduce the APC payment amount for the discontinued device-intensive procedure by 100 percent of the device offset amount prior to applying the additional payment adjustments that apply when the procedure is discontinued as modified *in the CY 2016 OPPS/ASC final rule that was* published in the November 13, 2015 "Federal Register" (80 FR 70424-*70426*). Beginning January 1, 2017, device-intensive procedures are defined as those procedures requiring the insertion of an implantable device that also have a HCPCS-level device offset greater than 40 percent. From January 1, 2016, through December 31, 2016, device-intensive procedures were defined as those procedures that involve implantable devices that are assigned to a device-intensive APC (defined as those APCs with a device offset greater than 40 percent). Beginning January 1, 2019, device-intensive procedures are defined as procedures that involve the surgical implantation or insertion of an implantable device that is assigned a CPT or HCPCS code (including single-use devices) and has a device offset amount that exceeds 30 percent of the procedure's mean cost.

Procedures that are discontinued, partially reduced, or cancelled after the procedure has been initiated and/or the patient has received anesthesia will be paid at the full OPPS payment amount. Modifier 74 is used for these procedures.

Procedures for which anesthesia is not planned that are discontinued, partially reduced, or cancelled after the patient is prepared and taken to the room where the procedure is to be performed will be paid at 50 percent of the full OPPS payment amount. Modifier 52 is used for these procedures.

20.6.5 - Modifiers ***76 and 77***
(Rev. 11937; Issued: 03-31-23; Effective: 04-01-23; Implementation: 04-03-23)

76: Repeat procedure or service by same physician or other qualified health care professional
77: Repeat procedure by another physician or other qualified health care professional

Two repeat procedure modifiers are applicable for hospital use:

- Modifier 76 is used to indicate that the same physician *or qualified health care professional* repeated a procedure or service.

- Modifier 77 is used to indicate that another physician *or qualified health care professional* repeated a procedure or service.

Since OPPS claims generally span only one calendar day, modifier 76 and 77 should be used to report procedures or services that are performed in a separate operative session on the same day or separate encounter on the same day.

If there is a question regarding whom the ordering physician*/provider* was and whether or not the same physician/*provider* ordered the second procedure, the code selected is based on whether or not the physician*/provider* performing the procedure is the same. The procedure must be the same procedure. It is listed once and then listed again with the appropriate modifier.

20.6.6 - Modifiers for Radiology Services
(Rev. 11937; Issued: 03-31-23; Effective: 04-01-23; Implementation: 04-03-23)

52: Reduced services
59: Distinct procedural service
76: Repeat procedure or service by same physician or other qualified health care professional
77: Repeat procedure by another physician or other qualified health care professional
Level II modifiers: use as applicable

Modifiers 52, 59, 76, and 77, and the Level II modifiers apply to radiology services.

When a radiology procedure is reduced, the correct reporting is to code to the extent of the procedure performed. If no HCPCS code exists for the service that has been completed, report the intended HCPCS code with modifier 52 appended.

20.6.7 - Modifier *CA*
(Rev. 11937; Issued: 03-31-23; Effective: 04-01-23; Implementation: 04-03-23)

CA: Procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission

In the CY 2003 OPPS final rule (67 FR 66799), we discussed the creation of the new HCPCS modifier CA to address situations where a procedure on the OPPS inpatient-only list must be performed to resuscitate or stabilize a patient (whose status is that of an outpatient) with an emergent, life-threatening condition, and the patient dies before being admitted as an inpatient. HCPCS modifier CA is defined as a procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission. In section VI of Transmittal A–02–129, issued on January 3, 2003, we instructed hospitals on the use of this modifier. Transmittal A-02-129 is available on the cms.gov website. For a complete description of the history of the policy and the development of the payment methodology for these services, refer to the CY 2004 OPPS final rule (68 FR 63467 through 63468), CY 2005 OPPS Final Rule (69 FR 65841), CY 2007 OPPS final rule (71 FR 68157 through 68158), and CY 2012 OPPS/ASC final rule (76 FR 74153 through 74154).

(Rev. 11937; Issued: 03-31-23; Effective: 04-01-23; Implementation: 04-03-23)

20.6.9 - Modifier FB
(Rev. 11937; Issued: 03-31-23; Effective: 04-01-23; Implementation: 04-03-23)

FB: Item provided without cost to provider, supplier, or practitioner, or full credit received for replaced device (examples, but not limited to, covered under warranty, replaced due to defect, free samples)

From 2007 through 2013, HOPDs were required to report modifier FB when appropriate. As discussed in the CY 2007 OPPS final rule (71 FR 68076 through 68077), effective for services furnished on or after January 1, 2007, Medicare reduced the amount of payment for certain APCs when the hospital reported that it received a listed device without cost or where the hospital received a full credit for the cost of a replaced listed device. The reduction applied only when specific devices were replaced. To indicate that the hospital received the device without cost, modifier FB must have been reported.

In addition, OPPS hospitals *were required to report* modifier FB on the same line as the *surgical or* procedure code (not the *HCPCS Level II* device code) for a service that *required* a device for which neither the hospital, nor the beneficiary, was liable to the manufacturer. *Similarly, hospitals were required to* report modifier FB on the same line as the *surgical or* procedure code *(not the device code)* for a service that required a device when the manufacturer gave credit for a device that was replaced with a more costly device. *Refer to section 61.3 of this manual for instructions regarding charges for items billed with the FB modifier.*

As of January 1, 2014, modifier FB is no longer required on OPPS claims, and has been replaced with value code FD (credit received from the manufacturer for a replaced medical device) as discussed in the CY 2014 OPPS/ASC final rule (78 FR 75006 through 75007), as well as in section 61.3.6 of this manual. Specifically, effective January 1, 2014, HOPDs are no longer required to report modifier FB, and instead, must report value code FD to indicate the amount of the credit in the amount portion for value code FD when the hospital receives a credit for a replaced device that is 50 percent or greater than the cost of the device. For more information on value code FD, refer to MLN Factsheet MLN909368 dated May 2022, which is available on the cms.gov website, specifically, at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/cardiacdevicecredits-ICN909368.pdf

Although no longer required for OPPS claims, modifier FB is still required on ASC claims.

20.6.10 - Modifier FC
(Rev. 11937; Issued: 03-31-23; Effective: 04-01-23; Implementation: 04-03-23)

FC: Partial credit received for replaced device

A. General

From 2008 through 2013, HOPDs were required to report modifier FC when appropriate. As discussed in the CY 2008 OPPS/ASC final rule (72 FR 66744 through 66749), effective for services furnished on or after January 1, 2008, OPPS hospitals *were required to* report modifier FC for cases in which the hospital received a partial credit of 50 percent or more of the cost of a new replacement device under warranty, recall, or field action. The hospital must have appended modifier FC to the *surgical or* procedure code (not the device code) that reported the services provided to replace the device. *Refer to section 61.3 of this manual for instructions regarding charges for items billed with the FC modifier.*

As of January 1, 2014, modifier FC is no longer required on OPPS claims, and has been replaced with value code FD (credit received from the manufacturer for a replaced medical device) as discussed in the CY 2014 OPPS/ASC final rule (78 FR 75006 through 75007), as well as in section 61.3.6 of this manual. Specifically, effective January 1, 2014, HOPDs are no longer required to report modifier FC, and instead, must report value code FD to indicate the amount of the credit in the amount portion for value code FD when the hospital receives a credit for a replaced device that is 50 percent or greater than the cost of the device. For more information on value code FD, refer to MLN Factsheet MLN909368 dated May 2022, which is available on the cms.gov website, specifically, at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/cardiacdevicecredits-ICN909368.pdf

Although no longer required for OPPS claims, modifier FC is still required on ASC claims.

20.6.11 - Modifier PO
(Rev. 11937; Issued: 03-31-23; Effective: 04-01-23; Implementation: 04-03-23)

PO: Excepted service provided at an off-campus, outpatient, provider-based department of a hospital

As described in the CY 2015 OPPS/ASC final rule (79 FR 66910 through 66914), CMS established HCPCS modifier PO to describe excepted service provided at an off-campus, outpatient, provider-based department of a hospital. This modifier *should* be reported with every HCPCS code for all outpatient hospital items and services furnished in an excepted off-campus provider-based department of a hospital. See 42 CFR 413.65(a)(2) for a definition of "campus".

This modifier should not be reported for remote locations of a hospital (defined at 42 CFR 413.65(a)(2)), satellite facilities of a hospital (defined at 42 CFR 412.22(h)), or for services furnished in an emergency department.

Note that reporting of this modifier *was* voluntary for CY 2015, *but is* required beginning January 1, 2016.

We note that, beginning in CY 2019, we *finalized* a policy to pay for clinic visits (G0463) billed at excepted off-campus provider-based departments (departments that bill modifier "PO" on their claim lines) at the PFS-equivalent amount. We *phased-in* this policy in over a two-year period. Specifically, half of the total 60-percent payment reduction, a 30-percent reduction, *was applied* in CY 2019. *Consequently*, these departments *were* paid 70 percent of the OPPS rate (100 percent of the OPPS rate minus the 30-percent payment reduction that applies in CY 2019) for the clinic visit. *In CY 2020, the two-year phase-in was completed. The PFS-equivalent rate for CY 2020 and subsequent years is 40 percent of the proposed OPPS payment (that is, 60 percent less than the proposed OPPS rate).*

Off-campus provider-based departments should not report both the PO and PN modifiers on the same claim line. However, if services reported on a claim reflect items and services furnished from both an excepted and a nonexcepted off-campus PBD of the hospital, the PO modifier should be used on the excepted claim lines and the PN modifier should be used on the nonexcepted claim lines.

Neither the PO nor the PN modifier is to be reported by the following hospital departments:

- *A dedicated emergency department as defined in existing regulations at 42 CFR 489.24(b);*
- *A PBD that is "on the campus," or within 250 yards, of the hospital or a remote location of the hospital as defined under 42 CFR 413.65.*

20.6.12 - Modifier PN
(Rev. 11937; Issued: 03-31-23; Effective: 04-01-23; Implementation: 04-03-23)

PN: Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital

A. General

In accordance with Section 1833(t)(21) of the Act, as added by section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74), CMS established modifier PN to identify and pay nonexcepted items and services billed on an institutional claim. Effective January 1, 2017, non-excepted off-campus provider-based departments of a hospital are required to report this modifier on each claim line for non-excepted items and services. The use of modifier PN will trigger a payment rate under the Medicare Physician Fee Schedule (PFS). This modifier must be reported with each nonexcepted item and service including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services. Nonexcepted items and services are described in the regulations at 42 CFR 419.48.

Off-campus provider-based departments should not report both the PO and PN modifiers on the same claim line. However, if services reported on a claim reflect items and services furnished from both an excepted and a nonexcepted off-campus PBD of the hospital, the PO modifier should be used on the excepted claim lines and the PN modifier should be used on the nonexcepted claim lines.

Neither the PO nor the PN modifier is to be reported by the following hospital departments:

- *A dedicated emergency department as defined in existing regulations at 42 CFR 489.24(b);*
- *A PBD that is "on the campus," or within 250 yards, of the hospital or a remote location of the hospital as defined under 42 CFR 413.65.*

B. Effect on Payment

Payment for nonexcepted items and services furnished at nonexcepted off-campus provider-based departments reported with modifier PN will result in a payment rate under the PFS effective January 1, 2017. The PN modifier is required to be reported on each claim line with each nonexcepted item and service including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services.

20.6.13 - Modifier CT
(Rev. 11937; Issued: 03-31-23; Effective: 04-01-23; Implementation: 04-03-23)

CT: Computed tomography services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) XR-29-2013 Standard

A. General

In accordance with section 1834(p) of the Act, CMS established modifier CT (Computed tomography services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) XR-29-2013 standard) effective January 1, 2016, to identify computed tomography (CT) scans that are furnished on equipment that does not meet the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013, titled "Standard Attributes on CT Equipment Related to Dose Optimization and Management."

Modifier CT is required to be reported on claims for computed tomography (CT) scans described by applicable HCPCS codes that are furnished on non-NEMA Standard XR-29-2013-compliant equipment. The applicable CT services are identified by HCPCS codes 70450 through 70498; 71250 through 71275; 72125 through 72133; 72191 through 72194; 73200 through 73206; 73700 through 73706; 74150 through 74178; 74261 through 74263; and 75571 through 75574 (and any succeeding codes).

HOPDs are reminded that this modifier should not be reported with codes that describe CT scans not listed above.

B. Effect on Payment

Effective January 1, 2016, the use of this modifier resulted in a payment reduction of 5 percent for the applicable computed tomography (CT) services when the service was paid separately. However, for CY 2017 and subsequent years, the use of this modifier results in a payment reduction of 15 percent for the applicable computed tomography (CT) services when the service is paid separately. The payment reduction is also applied to the APC payment for the HCPCS codes listed above that are subject to the multiple imaging composite policy.

20.6.14 - Modifier FX
(Rev. 11937; Issued: 03-31-23; Effective: 04-01-23; Implementation: 04-03-23)

FX: X-ray taken using film

A. General

Consistent with the requirements set forth in section 1833(t)(16)(F)(i), and in accordance with provisions allowed under section 1833(t)(16)(F)(iv) of the Act, CMS established modifier FX to identify imaging services that are x-rays taken using film. As stated in the CY 2017 OPPS/ASC final rule (81 FR 79729 through 79730), hospitals are required to use this modifier to report imaging services that are X-rays taken using film effective January 1, 2017.

B. Effect on Payment

Payment for x-ray services taken using film reported with modifier FX will be reduced by 20 percent effective January 1, 2017. We note that when payment for an x-ray service taken using film is packaged into the payment for another item or service under the OPPS, no separate payment for the x-ray service taken using film is made. Accordingly, the payment reduction in this instance would be 0 percent (that is, 20 percent of $0). All imaging services that are x-rays are listed in the OPPS Addendum B, which is available via the Internet on the CMS Web site.

20.6.15 - Modifier FY
(Rev. 11937; Issued: 03-31-23; Effective: 04-01-23; Implementation: 04-03-23)

FY: X-ray taken using computed radiography technology/cassette-based imaging

A. General

Consistent with the requirements set forth in section 1833(t)(16)(F)(ii) and in accordance with provisions allowed under section 1833(t)(16)(F)(iv) of the Act, CMS established modifier FY to identify an imaging service that is an X-ray taken using computed radiography technology. Effective January 1, 2018, hospitals are required to use this modifier to report imaging services that are X-rays taken using computed radiography technology.

B. Effect on Payment

Payment for x-ray services taken using computed radiography technology will be reduced by 7 percent from January 1, 2018, through December 31, 2022, and thereafter to 10 percent beginning January 1, 2023. We note that when payment for an x-ray service taken using computed radiography technology is packaged into the payment for another item or service under the OPPS, no separate payment for the x-ray service taken using computed radiography technology is made. Accordingly, the payment reduction in this instance would be 0 percent (that is, 20 percent of $0). All imaging services that are x-rays are listed in the OPPS Addendum B, which is available via the Internet on the CMS Web site.

20.6.16 - Modifier JG
(Rev. 11937; Issued: 03-31-23; Effective: 04-01-23; Implementation: 04-03-23)

JG: Drug or biological acquired with 340b drug pricing program discount, reported for informational purposes

A. General

On January 1, 2018, CMS established HCPCS Level II modifier JG to identify and pay 340B-acquired drugs and biologicals. Specifically, beginning January 1, 2018, hospitals paid under the OPPS that are not excepted from the 340B drug payment adjustment, and beginning January 1, 2019, nonexcepted off-campus PBDs of a hospital (that is not otherwise excepted from the 340B drug payment adjustment) paid under the PFS are required to report modifier JG on the same claim line as the drug or biological HCPCS code to identify if a drug or biological was acquired under the 340B Program. The phrase "acquired under the 340B Program" is inclusive of all drugs and biologicals acquired under the 340B Program or PVP, regardless of the level of discount applied to the drug.

Effective January 1, 2023, the JG modifier is required to be used by hospitals (except for rural sole community hospitals, children's hospitals, and PPS-exempt cancer hospitals) to identify 340B drugs for informational purposes only, with no effect on payment.

B. Effect on Payment

Starting in CY 2018, payment for certain drugs and biologicals (reported with status indicator "K") acquired through the 340B Program that are furnished by providers paid under the OPPS, and beginning January 1, 2019, payment for certain drugs and biologicals furnished by nonexcepted off-campus PBDs of a hospital paid under the PFS (departments that bill modifier PN on their claim lines), were required to report modifier JG on the same claim line as the drug or biological HCPCS code to identify if a drug or biological was acquired under the 340B Program, which triggered a payment adjustment such that the 340B-acquired drug is paid at the drug's average sales price minus 22.5 percent (or equivalent payment rate derived from the ASP methodology). Starting September 28th, 2022, CMS revised the OPPS drug files that will apply the default rate (generally ASP plus 6 percent) to 340B-acquired drugs for the rest of that calendar year. Effective January 1, 2023, the presence of modifier JG on a claim to indicate a drug is acquired under the 340B program will not trigger a payment reduction and will be used only for informational purposes. Claims for 340B drugs and biologicals identified with a JG modifier will be paid at the same statutory default rate as non-340B drugs and biologicals.

A document explaining the use of this modifier is available via the Internet on the CMS Web site at https://www.cms.gov/files/document/part-b-inflation-rebate-guidance340b-modifierfinal.pdf.

20.6.17 - Modifier TB
(Rev. 11937; Issued: 03-31-23; Effective: 04-01-23; Implementation: 04-03-23)

TB: Drug or biological acquired with 340b drug pricing program discount, reported for informational purposes for select entities

A. General

On January 1, 2018, CMS established HCPCS Level II modifier TB to facilitate the collection and tracking of 340B claims data for OPPS providers that are excepted from the 340B payment adjustment in CY 2018. Beginning January 1, 2019, modifier TB shall be reported by both select hospitals paid under the OPPS and by nonexcepted off-campus PBDs of a hospital paid under the PFS if a drug or biological was acquired under the 340B Program. The phrase "acquired under the 340B Program" is inclusive of all drugs and biologicals acquired under the 340B Program or PVP, regardless of the level of discount applied to the drug.

Effective January 1, 2023, the TB modifier will be used by rural sole community hospitals, children's hospitals, and PPS-exempt cancer hospitals to identify 340B drugs for informational purposes. Additionally, all pass-through drugs (reported with the status indicator "G") purchased through the 340B drug discount program will report with the modifier TB by all OPPS providers.

B. Effect on Payment

From CY 2018 through CY 2022, rural SCHs, children's hospitals, and PPS-exempt cancer hospitals providers that were exempt from the 340B drug payment adjustment reported the informational modifier TB to identify OPPS separately payable drugs (reported with status indicator "K") purchased through the 340B discount program. The use of modifier TB did not trigger a payment adjustment, and these providers received and will continue to receive ASP plus 6 percent (or equivalent payment rate derived from the ASP methodology) for separately payable drugs furnished by these select providers. Furthermore, between CY 2019 and CY 2022, nonexcepted off-campus PBDs paid under the PFS (departments that bill the modifier PN on their claim lines) that furnished 340B-acquired drugs and biologicals and were exempt from the 340B payment adjustment (because their hospital is a rural SCH or children's hospital) were required to bill under the PFS using the institutional claim form and report the informational modifier TB for 340B-acquired drugs and biologicals, which did not trigger a payment adjustment, and these providers received ASP+6 percent for separately payable drugs furnished in CY 2019, even if such drugs were acquired under the 340B Program.

For CY 2023, the presence of modifier TB on a claim to indicate a drug is acquired under the 340B program will continue to not trigger a payment reduction and be used only for informational purposes. Claims for 340B drugs and biologicals identified with a TB modifier will be paid at the same statutory default rate as non-340B drugs and biologicals. Additionally, the requirement of the TB modifier to identify drugs acquired through the 340B Program complies with certain requirements of the Inflation Reduction Act because these modifiers are an established mechanism that have been in use by hospitals paid under the OPPS. The Inflation Reduction Act establishes a Part B inflation rebate by manufacturers for certain single source drugs and biologicals with prices increasing faster than the rate of inflation. However, it also specifically excludes units of drugs for which the manufacturer provides a discount under the 340B program from the units of drugs for which a manufacturer otherwise may have a Part B inflation rebate liability.

A document explaining the use of this modifier is available via the Internet on the CMS Web site at https://www.cms.gov/files/document/part-b-inflation-rebate-guidance340b-modifierfinal.pdf.

20.6.18 - Modifier ER
(Rev. 11937; Issued: 03-31-23; Effective: 04-01-23; Implementation: 04-03-23)

ER: Items and services furnished by a provider-based, off-campus emergency department

Effective January 1, 2019, hospitals were required to report HCPCS modifier ER on every claim line that contains a CPT/HCPCS code for an outpatient hospital service furnished in an off-campus provider-based emergency department. This modifier is required to be reported in provider-based off-campus emergency departments that meet the definition of a "dedicated emergency department" as defined in 42 Code of Federal Regulations (CFR) 489.24 under the Emergency Medical Treatment and Labor Act (EMTALA) regulations. Per 42 CFR 489.24, a "dedicated emergency department" means any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:

(1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;

(2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or

(3) During the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

This modifier would be reported on the UB–04 form (CMS Form 1450) for hospital outpatient services. Reporting of this modifier is not required for Critical access hospitals (CAHs). While this modifier is required, it does not have an effect on payment.

20.6.19 - Modifier CG

(Rev. 11937; Issued: 03-31-23; Effective: 04-01-23; Implementation: 04-03-23)

CG: Policy criteria applied

Effective January 1, 2019, modifier CG can be reported with certain device-intensive procedures to reflect situations in which a device was not used during the device-intensive procedure. *Refer to section 61.2.1 of this manual for further information on modifier CG.*

This modifier would be reported on the UB–04 form (CMS Form 1450) for hospital outpatient device-intensive procedures. Reporting of this modifier is not required for Critical access hospitals (CAHs). While this modifier is required, it does not have an effect on payment.

60.4.2 - Complete List of Device Pass-through Category Codes

(Rev. 11937; Issued: 03-31-23; Effective: 04-01-23; Implementation: 04-03-23)

List of Device Category Codes for Present or Previous Pass-Through Payment and Related Definitions

The table below shows the complete list of the device category HCPCS codes used presently or previously for pass-through payment, along with their expiration dates, and definitions. This list does not include all device codes reportable under the OPPS; there are additional HCPCS codes for devices that were not eligible for pass-through payment. See section 61, Chapter 4 of the IOM, pub. 100-4, currently available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf, for detailed information onrequirements for reporting device codes and satisfying device edits in the OPPS.

Section 402(a) of the Benefits Improvement and Protection Act of 2000 (BIPA), which was enacted on December 21, 2000, required the creation of categories for pass-through devices under the hospital OPPS. As a result of BIPA, new category codes were created for pass-throughdevices that became effective April 1, 2001.

As indicated in section 1833(t)(6) of the Social Security Act, payments for pass-through devices are limited to at least two years but no more than three years. Starting on January 1, 2017, we changed our policy to allow for quarterly expiration of pass-through payment status for devices, beginning with pass-through devices approved in CY 2017 and subsequent calendar years, to afford a pass-through payment period that is as close to a full 3 years as possible for all pass-through payment devices. Note that payment for pass-through devices is based on the charge on the individua l bill, converted to cost by application of a hospital-specific cost-to-charge ratio, and subject (in some instances) to a reduction that offsets the cost of similar devices already included in the APC payment rate for the associated procedure.

When the category codes became effective April 1, 2001, many of the item-specific C-codes that were cross-walked in Transmittal A-01-41 and Transmittal A-01-97 to the new category codes were approved for pass-through status before April 1, 2001. In determining the expiration dates for those initial pass-through device category codes listed below, we determined when specific devices that are described by the categories were paid as pass-through devices through their item-specific C-codes prior to the creation of the categories, pursuant to the statute, section 1833(t)(6)(iii)(I). These dates are listed in the column below titled "Date First Populated." Thus, many of the category codes that were made effective April 1, 2001, expired on December 31, 2002. Despite the expiration of pass-through payment status for device category codes, hospitals are still required to report the device category C-codes on claims when such devices are used in conjunction with procedures billed and paid under the OPPS.

In the CY 2015 final rule, we finalized a policy and implemented claims processing edits that require any of the device codes used in the previous device-to-procedure edits to be present on the claim whenever a procedure code assigned to any of the APCs listed in TableH1 (the formerly device dependent APCs) is reported on the claim (79 FR 66795).

List of Device Category HCPCS Codes and Definitions Used for Present and Previous Pass-Through Payment ***

	HCPCS Codes	Category Long Descriptor	Date First Populated	Pass-Through Expiration Date***
1.	C1883*	Adaptor/extension, pacing lead or neurostimulator lead (implantable)	8/1/00	12/31/02
2.	C1765*	Adhesion barrier	10/01/00 – 3/31/01; 7/1/01	12/31/03
3.	C1713*	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)	8/1/00	12/31/02
4.	L8690	Auditory osseointegrated device, includes all internal and external components	1/1/07	12/31/08
5.	**C1832**	**Autograft suspension, including cell processing and application, and all system components**	**1/1/22**	***12/31/2024***
6.	C1715	Brachytherapy needle	8/1/00	12/31/02
7.	C1716#	Brachytherapy source, non-stranded, Gold-198, per source	10/1/00	12/31/02
8.	C1717#	Brachytherapy source, non-stranded, high dose rate Iridium-192, per source	1/1/01	12/31/02
9.	C1718#	Brachytherapy source, Iodine 125, per source	8/1/00	12/31/02

10.	C1719#	Brachytherapy source, non-stranded, non-high dose rate Iridium-192, per source	10/1/00	12/31/02
11.	C1720#	Brachytherapy source, Palladium 103, per source	8/1/00	12/31/02
12.	C2616#	Brachytherapy source, non-stranded, Yttrium-90, per source	1/1/01	12/31/02
13.	C2632	Brachytherapy solution, iodine – 125, per mCi	1/1/03	12/31/04
14.	C1721	Cardioverter-defibrillator, dual chamber (implantable)	8/1/00	12/31/02
15.	C1882*	Cardioverter-defibrillator, other than single or dual chamber (implantable)	8/1/00	12/31/02
16.	C1722	Cardioverter-defibrillator, single chamber (implantable)	8/1/00	12/31/02
17.	C1888*	Catheter, ablation, non-cardiac, endovascular (implantable)	7/1/02	12/31/04
18.	C1726*	Catheter, balloon dilatation, non-vascular	8/1/00	12/31/02
19.	C1727*	Catheter, balloon tissue dissector, non-vascular (insertable)	8/1/00	12/31/02
20.	C1728	Catheter, brachytherapy seed administration	1/1/01	12/31/02
21.	C1729*	Catheter, drainage	10/1/00	12/31/02
22.	C1730*	Catheter, electrophysiology, diagnostic, other than 3D mapping (19 or fewer electrodes)	8/1/00	12/31/02
23.	C1731*	Catheter, electrophysiology, diagnostic, other than 3D mapping (20 or more electrodes)	8/1/00	12/31/02
24.	C1732*	Catheter, electrophysiology, diagnostic/ablation, 3D or vector mapping	8/1/00	12/31/02
25.	C1733*	Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, other than cool-tip	8/1/00	12/31/02
26.	C2630*	Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, cool-tip	10/1/00	12/31/02
27.	C1886	Catheter, extravascular tissue ablation, any modality (insertable)	01/01/12	12/31/13
28.	C1887*	Catheter, guiding (may include infusion/perfusion capability)	8/1/00	12/31/02
29.	C1750	Catheter, hemodialysis/peritoneal, long-term	8/1/00	12/31/02
30.	C1752	Catheter, hemodialysis/peritoneal, short-term	8/1/00	12/31/02
31.	C1751	Catheter, infusion, inserted peripherally, centrally or midline (other than hemodialysis)	8/1/00	12/31/02
32.	C1759	Catheter, intracardiac echocardiography	8/1/00	12/31/02
33.	C1754	Catheter, intradiscal	10/1/00	12/31/02
34.	C1755	Catheter, intraspinal	8/1/00	12/31/02
35.	C1753	Catheter, intravascular ultrasound	8/1/00	12/31/02
36.	C2628	Catheter, occlusion	10/1/00	12/31/02
37.	C1756	Catheter, pacing, transesophageal	10/1/00	12/31/02

38.	C2627	Catheter, suprapubic/cystoscopic	10/1/00	12/31/02
39.	C1757	Catheter, thrombectomy/embolectomy	8/1/00	12/31/02
40.	C2623	Catheter, transluminal angioplasty, drug-coated, non-laser	4/1/15	12/31/17
41.	C1885*	Catheter, transluminal angioplasty, laser	10/1/00	12/31/02
42.	C1725*	Catheter, transluminal angioplasty, non-laser (may include guidance, infusion/perfusion capability)	8/1/00	12/31/02
43.	C1714	Catheter, transluminal atherectomy, directional	8/1/00	12/31/02
44.	C1724	Catheter, transluminal atherectomy, rotational	8/1/00	12/31/02
45.	**C1761**	**Catheter, transluminal intravascular lithotripsy, coronary**	**7/1/21**	***6/30/2024***
46.	C1760*	Closure device, vascular (implantable/insertable)	8/1/00	12/31/02
47.	L8614	Cochlear implant system	8/1/00	12/31/02
48.	C1762*	Connective tissue, human (includes fascia lata)	8/1/00	12/31/02
49.	C1763*	Connective tissue, non-human (includes synthetic)	10/1/00	12/31/02
50.	C1881	Dialysis access system (implantable)	8/1/00	12/31/02
51.	C1884*	Embolization protective system	1/01/03	12/31/04
52.	C1749	Endoscope, retrograde imaging/illumination colonoscope device (implantable)	10/01/10	12/31/12
53.	**C1748**	**Endoscope, single-use (i.e. disposable), Upper GI, imaging/illumination device (insertable)**	**7/1/20**	***6/30/2023***
54.	C1764	Event recorder, cardiac (implantable)	8/1/00	12/31/02
55.	C1822	Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system	1/1/16	12/31/17
56.	C1767**	Generator, neurostimulator (implantable), non-rechargeable	8/1/00	12/31/02
57.	C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system	1/1/06	12/31/07
58.	**C1825**	**Generator, neurostimulator (implantable), non-rechargeable with carotid sinus baroreceptor stimulation lead(s)**	**1/1/21**	***12/31/2023***
59.	C1823	Generator, neurostimulator (implantable), nonrechargeable, with transvenous sensing and stimulation leads	1/1/19	*12/31/2022*
60.	C1768	Graft, vascular	1/1/01	12/31/02
61.	C1769	Guide wire	8/1/00	12/31/02
62.	**C1052**	**Hemostatic agent, gastrointestinal, topical**	**1/1/21**	***12/31/2023***
63.	C1770	Imaging coil, magnetic resonance (insertable)	1/1/01	12/31/02
64.	C2624	Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components	1/1/15	12/31/16

65.	C1891	Infusion pump, non-programmable, permanent (implantable)	8/1/00	12/31/02
66.	C2626*	Infusion pump, non-programmable, temporary (implantable)	1/1/01	12/31/02
67.	C1772	Infusion pump, programmable (implantable)	10/1/00	12/31/02
68.	C1818*	Integrated keratoprosthesis	7/1/03	12/31/05
69.	C1821	Interspinous process distraction device (implantable)	1/1/07	12/31/08
70.	**C1062**	**Intravertebral body fracture augmentation with implant (e.g., metal, polymer)**	**1/1/21**	***12/31/2023***
71.	C1893	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, other than peel-away	10/1/00	12/31/02
72.	C1892*	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, peel-away	1/1/01	12/31/02
73.	C1766	Introducer/sheath, guiding, intracardiac electrophysiological, steerable, other than peel-away	1/1/01	12/31/02
74.	C1894	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, non-laser	8/1/00	12/31/02
75.	C2629	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, laser	1/1/01	12/31/02
76.	C1776*	Joint device (implantable)	10/1/00	12/31/02
77.	C1895	Lead, cardioverter-defibrillator, endocardial dual coil (implantable)	8/1/00	12/31/02
78.	C1777	Lead, cardioverter-defibrillator, endocardial single coil (implantable)	8/1/00	12/31/02
79.	C1896	Lead, cardioverter-defibrillator, other than endocardial single or dual coil (implantable)	8/1/00	12/31/02
80.	C1900*	Lead, left ventricular coronary venous system	7/1/02	12/31/04
81.	C1778	Lead, neurostimulator (implantable)	8/1/00	12/31/02
82.	C1897	Lead, neurostimulator test kit (implantable)	8/1/00	12/31/02
83.	C1898	Lead, pacemaker, other than transvenous VDD single pass	8/1/00	12/31/02
84.	C1779*	Lead, pacemaker, transvenous VDD single pass	8/1/00	12/31/02
85.	C1899	Lead, pacemaker/cardioverter-defibrillator combination (implantable)	1/1/01	12/31/02
86.	C1780*	Lens, intraocular (new technology)	8/1/00	12/31/02
87.	C1840	Lens, intraocular (telescopic)	10/01/11	12/31/13
88.	C2613	Lung biopsy plug with delivery system	7/1/15	12/31/17
89.	C1878*	Material for vocal cord medialization, synthetic (implantable)	10/1/00	12/31/02
90.	C1781*	Mesh (implantable)	8/1/00	12/31/02
91.	**C1833**	**Monitor, cardiac, including intracardiac lead and all system components (implantable)**	**1/1/22**	***12/31/2024***
92.	C1782*	Morcellator	8/1/00	12/31/02
93.	C1784*	Ocular device, intraoperative, detached retina	1/1/01	12/31/02

94.	C1783	Ocular implant, aqueous drainage assist device	7/1/02	12/31/04
95.	C2619	Pacemaker, dual chamber, non rate-responsive (implantable)	8/1/00	12/31/02
96.	C1785	Pacemaker, dual chamber, rate-responsive (implantable)	8/1/00	12/31/02
97.	C2621*	Pacemaker, other than single or dual chamber (implantable)	1/1/01	12/31/02
98.	C2620	Pacemaker, single chamber, non rate-responsive (implantable)	8/1/00	12/31/02
99.	C1786	Pacemaker, single chamber, rate-responsive (implantable)	8/1/00	12/31/02
100.	C1787*	Patient programmer, neurostimulator	8/1/00	12/31/02
101.	**C1831**	**Interbody cage, anterior, lateral or posterior, personalized (implantable)**	**10/1/21**	***9/30/2024***
102.	C1788	Port, indwelling (implantable)	8/1/00	12/31/02
103.	C1830	Powered bone marrow biopsy needle	10/01/11	12/31/13
104.	C2618	Probe, cryoablation	4/1/01	12/31/03
105.	C2614	Probe, percutaneous lumbar discectomy	1/1/03	12/31/04
106.	C1789	Prosthesis, breast (implantable)	10/1/00	12/31/02
107.	C1813	Prosthesis, penile, inflatable	8/1/00	12/31/02
108.	C2622	Prosthesis, penile, non-inflatable	10/1/01	12/31/02
109.	C1815	Prosthesis, urinary sphincter (implantable)	10/1/00	12/31/02
110.	C1816	Receiver and/or transmitter, neurostimulator (implantable)	8/1/00	12/31/02
111.	C1771*	Repair device, urinary, incontinence, with sling graft	10/1/00	12/31/02
112.	C2631*	Repair device, urinary, incontinence, without sling graft	8/1/00	12/31/02
113.	C1841	Retinal prosthesis, includes all internal and external Components	10/1/13	12/31/15
114.	C1814*	Retinal tamponade device, silicone oil	4/1/03	12/31/05
115.	C1773*	Retrieval device, insertable	1/1/01	12/31/02
116.	C2615*	Sealant, pulmonary, liquid (implantable)	1/1/01	12/31/02
117.	C1817*	Septal defect implant system, intracardiac	8/1/00	12/31/02
118.	C1874*	Stent, coated/covered, with delivery system	8/1/00	12/31/02
119.	C1875*	Stent, coated/covered, without delivery system	8/1/00	12/31/02
120.	C1876*	Stent, non-coated/non-covered, with delivery system	8/1/00	12/31/02
121.	C1877	Stent, non-coated/non-covered, without delivery system	8/1/00	12/31/02

122.	C2625*	Stent, non-coronary, temporary, with delivery system	10/1/00	12/31/02
123.	C2617*	Stent, non-coronary, temporary, without delivery system	10/1/00	12/31/02
124.	C1819	Tissue localization excision device	1/1/04	12/31/05
125.	C1879*	Tissue marker (implantable)	8/1/00	12/31/02
126.	C1880	Vena cava filter	1/1/01	12/31/02
127.	***C1826***	***Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system***	***1/1/2023***	***12/31/2025***
128.	***C1827***	***Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller***	***1/1/2023***	***12/31/2025***
129.	***C1747***	***Endoscope, single-use (i.e. disposable), urinary tract, imaging/illumination device (insertable)***	***1/1/2023***	***12/31/2025***
130.	***C1824^***	***Generator, cardiac contractility modulation (implantable)***	***1/1/2020***	***12/31/2023***
131.	***C1982^***	***Catheter, pressure-generating, one-way valve, intermittently occlusive***	***1/1/2020***	***12/31/2023***
132.	***C1839^***	***Iris prosthesis***	***1/1/2020***	***12/31/2023***
133.	***C1734^***	***Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue-to bone (implantable)***	***1/1/2020***	***12/31/2023***
134.	***C2596^***	***Probe, image-guided, robotic, waterjet ablation***	***1/1/2020***	***12/31/2023***

BOLD codes are still actively receiving pass-through payment.

Italicized codes have received preliminary approval for pass-through payment.

*** Refer to the definition below for further information on this device category code.**

**** Effective 1/1/06 C1767 descriptor was changed for succeeding claims. See CR 4250, Jan. 3, 2006 for details.**

***** Although the pass-through payment status for device category codes has expired, these codesare still active and hospitals are still required to report the device category C-codes (except the brachytherapy source codes, which are separately paid under the OPPS) on claims when such devices are used in conjunction with procedures billed and paid under the OPPS.**

 # The brachytherapy descriptors were changed to the ones shown above, effective 7/1/07. These 6 brachytherapy source codes were paid as pass-through devices from 2000 through 2002, as noted. Beginning in 2004, all brachytherapy sources have been paid separately as non-pass-through items from the procedure with which they are billed, and additional brachytherapy source HCPCS codes have been added for payment. To see the most current comprehensive list of brachytherapy source codes, see the latest OPPS/ASC final rule.

^Sec. 4141. Extension of Pass-Through Status Under the Medicare Program for Certain Devices Impacted by COVID-19 of the Consolidated Appropriations Act, 2023 has extended pass-through status for a 1-year period beginning on January 1, 2023.

170 - Hospital and CMHC Reporting Requirements for Services Performed on the Same Day

(Rev. 11937; Issued: 03-31-23; Effective: 04-01-23; Implementation: 04-03-23)

When reporting a HCPCS code for a separately payable, non-repetitive hospital OPPS service, report charges for all services and supplies associated with that service that were furnished on the same date (services subject to the 3-day payment window are an exception to this OPPS policy).

When a hospital provides electroconvulsive therapy (ECT) on the same day as partial hospitalization services, both the ECT and partial hospitalization services should be reported on the same hospital claim. In this instance, the claim should contain condition code 41. As noted above, report charges for all services and supplies associated with the ECT service that were furnished on the same date(s) on the same claim.

When a hospital provides non-partial hospitalization mental health services to a partial hospitalization patient, all partial hospitalization services and non-partial hospitalization mental health services should be reported on the same hospital claim with condition code 41.

NOTE: For a list of revenue codes that are considered repetitive services, see Chapter 1, §50.2.2.

EXAMPLE 1

If a patient receives a laboratory service on May 1st and has an emergency room (ER) visit on the same day, one bill may be submitted since the laboratory service is paid under the clinical diagnostic laboratory fee schedule and not subject to OPPS. In this situation, the laboratory service was not related to the ER visit or done in conjunction with the ER visit.

EXAMPLE 2

If the patient receives physical therapy on July 7th, 29th, and 30th, and receives services in the ER on July 28th, the provider shall submit separate claims since the isolated individual service (ER visit) did not occur on the same day as the repetitive service (physical therapy).

EXAMPLE 3

If a patient has an ER visit (OPPS service) on May 15th and also receives a physical therapy visit (repetitive, non-OPPS service) on the same day (as well as other physical therapy visits provided May 1st through May 31st) the services shall be billed on separate claims. The provider would bill the ER service on one claim and the therapy services on the monthly repetitive claim. Please note, as stated above, the procedures for billing repetitive services remains in effect under OPPS. Therefore, in this example, it would not be appropriate to submit one therapy claim for services provided May 1st through May 15th, a second claim for the ER visit provided on May 15th, and a third claim for therapy visits provided on May 16th through May 31st. Providers

shall not split repetitive services in mid-month when another outpatient service occurs.

EXAMPLE 4

If a patient receives chemotherapy, or radiation therapy, clinical laboratory services, a CT scan and an outpatient consultation on the same date of service, the hospital may report all services on the same claim or may submit multiple claims. Chemotherapy, while commonly administered in multiple encounters across a span of time, is not a repetitive service as defined in Chapter 1, Section 50.2.2. The clinical laboratory services may be reported either on the single consolidated claim or on a separate claim that reports the services furnished on the same date as the laboratory services.

EXAMPLE 5

If a partial hospitalization patient receives remote non-partial hospitalization mental health services, the hospital should report all partial hospitalization services and non-partial hospitalization remote mental health services on the same claim. For each date of service with at least 3 partial hospitalization services (see section 260.1 of this chapter), all partial hospitalization services will be packaged under the hospital-based partial hospitalization APC 5863. When APC 5863 is assigned, all remote non-partial hospitalization mental health services on the same date of service will be packaged under APC 8010 with no additional payment. For any dates of service with less than 3 partial hospitalization services, each remote non-partial hospitalization mental health service will be paid at the corresponding APC payment rate or packaged under the daily mental health composite APC 8010.