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# Hospital Outpatient Prospective Payment System: April 2024 Update

Related CR Release Date: March 21, 2024
MLN Matters Number: MM13568
Effective Date: April 1, 2024
Related Change Request (CR) Number: CR 13568
Implementation Date: April 1, 2024
Related CR Transmittal Number: R12552CP
Related CR Title: April 2024 Update of the Hospital Outpatient Prospective Payment System (OPPS)

## Affected Providers

- Physicians
- Hospitals
- Suppliers
- Other providers billing Medicare Administrative Contractors (MACs) for services they provide to Medicare patients

## Action Needed

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

- New CPT & HCPCS codes
- Covered devices for OPPS pass-through payments
- Edit for Level 6 intraocular procedures ambulatory payment classification (APC)
- iDose TR (travoprost intracameral implant) for the treatment of glaucoma
- Clarification on the OPPS status indicator for the cardiovascular remote interrogation device evaluation
- Payment for intensive cardiac rehabilitation services (ICR) in an off-campus, non-excepted provider-based department (PBD) of a hospital
- Drugs, biologicals, and radiopharmaceuticals
- Skin substitutes

## Background

CR 13568 gives instructions on coding changes and policy updates effective April 1, 2024, for the OPPS. The OPPS changes effective April 1, 2024, are:

**1. CPT Proprietary Laboratory Analyses (PLA) Coding Changes Effective April 1, 2024**

The AMA CPT Editorial Panel established 11 new PLA codes, specifically, CPT codes 0439U-



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0449U. Table 1 of CR 13568 lists the long descriptors and status indicators (SIs) for the codes. We've added the codes to the April 2024 Integrated Outpatient Code Editor (I/OCE) with an effective date of April 1, 2024.

**2. OPPS Device Pass-Through**

**a. Clarification for New Device Pass-Through Categories Effective January 1, 2024**

Section 1833(t)(6)(B) of the Social Security Act (the Act) requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least 2, but not more than 3, years. The Act requires us to create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

CMS approved 4 new devices, HCPCS codes C1600, C1601, C1602, and C1603, for pass-through status under the OPPS. See the CY 2024 OPPS/Ambulatory Surgical Center (ASC) final rule with comment period, which we published in the Federal Register on November 22, 2023, for the criteria we use to evaluate device pass-through applications.

Also, we preliminarily approved HCPCS code C1604 as part of the device pass-through quarterly review process with an effective date of January 1, 2024. The device application associated with C1604 will be in the CY 2025 OPPS/ASC proposed and final rules. See Table 2 of CR 13568 for the long descriptor, SI, APC, and offset amount for these 5 HCPCS codes.

We're adding these 5 new device category codes and their pass-through expiration dates. See Table 3 of CR 13568 for the complete list of device category HCPCS codes and definitions we use for present and previous transitional pass-through payment.

**b. Addition of CPT Codes to an Existing Device Code C1602**

Section 1833(t)(6)(D)(ii) of the Act requires us to 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 portions of the APC amount that's associated with the cost of the pass-through device. The device offset from payment represents a deduction from pass-through payments for the applicable pass-through device.

Effective January 1, 2024, we're adding CPT codes 25145, 26236, and 28124 to be billed with HCPCS Code C1602, to the list of CPT codes we showed in MLN Matters Article MM13488.

**c. Updates for Device Offset Amounts to an Existing Device Code C1600**

Effective January 1, 2024, we're pairing CPT codes 36902, 36903, 36095, and 36906 to be billed with HCPCS Code C1600, as listed in MM13488. We're updating the device offset amount for each of the CPT codes paired with C1600 to $0.00.

**3. Edit for Level 6 Intraocular Procedures APC**

Effective CY 2024, the I/OCE will return to providers claims that report a procedure code

assigned to APC 5496 (Level 6 Intraocular Procedures), but don't report the correct device code that you must implant during the procedure.

The device code must correctly show the type of device you implanted during the procedure. Table 4 of CR 13568 displays the procedures assigned to APC 5496 as well as the appropriate device code that must be present on the claim for that procedure. Hospitals may not use modifier CG to bypass this edit.

This edit doesn't apply if you report 1 of the following modifiers with the procedure code:

- 52 – Reduced Services
- 73 – Discontinued outpatient procedure prior to anesthesia administration
- 74 – Discontinued outpatient procedure after anesthesia administration

If we return the claim to the provider for failure to pass the edit, you'll need to modify the claim by correcting the:

- Device code, only if the device code to be reported accurately describes the device that was implanted
- Procedure code on the claim before resubmission

**4. New HCPCS Codes C9796 and C9797 Effective January 1, 2024**

We established new HCPCS code C9796 to describe the repair of an enterocutaneous fistula in the small intestine or colon with a plug (porcine small intestine submucosa). Table 5 of CR 13568 for the official long descriptor, status indicator, and APC assignment for C9796. This code, along with its short descriptor, SI, and payment rate, is also in the April 2024 OPPS Addendum B.

We established new HCPCS code C9797 to describe a vascular embolization or occlusion procedure with use of a pressure-generating catheter, for example, 1-way valve, intermittently occluding. As noted in the long descriptor for C9797 that appears in Table 5 of CR 1356, this code includes all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention.

When reporting C9797, hospital outpatient departments (HOPDs) should also report HCPCS code C1982 (Catheter, pressure-generating, one-way valve, intermittently occlusive).

**Note:** C9797 describes the procedure, while C1982 describes the device you use during the procedure. Don't bill C1982 with either CPT Code 37242 or 37243.

**5. Clarification on the OPPS Status Indicator for the Cardiovascular Remote Interrogation Device Evaluation HCPCS Codes G2066, 93297, and 93298**

HCPCS codes 93297, 93298, and G2066 describe services associated with a cardiovascular remote interrogation device evaluation. CPT codes 93297 and 93298 were effective January 1, 2009, and since then have been assigned to OPPS status indicator 'M' to show that the codes describe physician and professional-only services. HCPCS code G2066 was effective January

1, 2020, and deleted December 31, 2023. Under the OPPS, G2066 was assigned to status indicator Q1 and APC 5741 (Level 1 Electronic Analysis of Devices).

For CY 2024, under the Physician Fee Schedule (PFS), we assigned 93297 and 93298 to direct practice inputs, and designated with global, technical, and professional indicators.

In the 2024 PFS final rule, 93297 and 93298 were billed under G2066. Since G2066, which was the code previously reported for 93297 and 93298, was deleted and 93297 and 93298 were designated as having a technical component under the PFS, we've assigned these codes to separately payable status under the OPPS for CY 2024.

Effective January 1, 2024, we assigned 93297 and 93298 to status indicator (SI) Q1 and APC 5741, which is the same APC that we assigned to G2066. Table 6 of CR 13568 lists the long descriptors and OPPS SIs for G2066, 93297, and 93298.

**6. iDose TR (travoprost intracameral implant) for the Treatment of Glaucoma**

For the July 1, 2021 update, the CPT Editorial Panel established CPT codes 0660T and 0661T to describe the service associated with the implantation, removal, and reimplantation of the iDose TR, which is a prostaglandin analog used for the reduction of intraocular pressure (IOP) in patients with open-angle glaucoma (OAG) or ocular hypertension (OHT).

On December 13, 2023, the iDose TR got FDA new drug application (NDA) approval. Since July 1, 2021, we assigned CPT codes 0660T and 0661T an SI of E1 (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to show the codes aren't payable under the OPPS because the drug associated with these codes hadn't received FDA approval. Based on the recent FDA approval, these codes are now separately payable under the OPPS.

Specifically, we reassigned CPT codes 0660T and 0661T from SI of E1 to J1 (Hospital Part B Services Paid Through a Comprehensive APC; Paid under OPPS) and APC 5492 (Level 2 Intraocular Procedures) effective April 1, 2024. Table 7 of CR 13568 lists the long descriptors and OPPS SI for CPT codes 0660T and 0661T.

**7. APC Assignment Change for HCPCS Code C9790 (Histotripsy (non-thermal ablation via acoustic energy delivery) of malignant renal tissue, including image guidance) Retroactive to January 1, 2024**

The APC Assignment for HCPCS code C9790 will change from APC 1575 (New Technology - Level 38 ($10,001-$15,000)) with a payment rate of $12,500.50 to APC 1576 (New Technology - Level 39 ($15,001-$20,000)) with a payment rate of $17,500.50 retroactive to January 1, 2024. Table 8 of CR 13568 lists the official descriptor, SI, and APC assignment for C9790.

**8. New HCPCS Code G0138 Assigned to New Technology APC 1508 Effective April 1, 2024**

HCPCS code G0138 (Intravenous infusion of cipaglucosidase alfa-atga, including provider/supplier acquisition and clinical supervision of oral administration of miglustat in preparation of receipt of cipaglucosidase alfa-atga) describes the service of administration of

cipaglucosidase alfa-atga (Pombiliti), which includes the intravenous administration of cipaglucosidase alfa-atga, the provider or supplier's acquisition cost of miglustat, clinical supervision, and oral administration of miglustat.

Effective April 1, 2024, we're assigning G0138 to New Technology APC 1508 (New Technology - Level 8 ($601 - $700)) with an SI of S (Paid under OPPS; separate APC payment). Table 9 of CR 13568 lists the official descriptor, SI, and APC assignment for G0138.

**9. Payment for Intensive Cardiac Rehabilitation Services (ICR) Provided by an Off-Campus, Non-Excepted Provider Based Department (PBD) of a Hospital**

Effective January 1, 2017, non-excepted off-campus PBDs of a hospital had to report modifier PN on each claim line for non-excepted items and services. The use of modifier PN triggers a payment rate under the PFS that's approximately 40% of the OPPS rate.

The CY 2024 OPPS/ASC final rule excluded ICR services from the 40% PFS Relativity Adjuster policy at the code level by modifying the claims processing of HCPCS codes G0422 (Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session) and G0423 (Intensive cardiac rehabilitation; with or without continuous ECG monitoring without exercise, per session). Under this change, we pay 100% of the OPPS rate for ICR irrespective of the presence of the PN modifier on the claim.

Claims for G0422 and G0423 submitted with the PN modifier from January to April 2024 were paid at the 40% rate. Upon the April I/OCE release, we'll pay an additional amount retroactively applied to these claims so they're paid at 100% of the OPPS rate.

**10. Drugs, Biologicals, and Radiopharmaceuticals**

**a. New CY 2024 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals Receiving Pass-Through Status Effective April 1, 2024**

We created 5 new HCPCS codes for reporting drugs and biologicals in the hospital outpatient setting, where there haven't previously been specific codes available. These drugs and biologicals will get drug pass-through status starting April 1, 2024. See Table 10 of CR 13568.

**b. Existing HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals with Pass-Through Status Ending on March 31, 2024**

There are 3 HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals in the outpatient setting that'll have their pass-through status end on March 31, 2024. Table 11 of CR 13568 lists these codes and their SIs. Effective April 1, 2024, the SI for these codes is changing from G to K.

**c. Newly Established HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals as of April 1, 2024**

We're establishing 39 new drug, biological, and radiopharmaceutical HCPCS codes on April 1, 2024. Table 12 of CR 13568 for a list of these codes, their SIs, and APCs.

**d. HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals Deleted as of March 31, 2024**

We're deleting 11 drug, biological, and radiopharmaceutical HCPCS codes on March 31, 2024. Table 13 of CR 13568 shows these codes.

**e. HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals Changing to a Non-Payable Status on April 1, 2024**

One drug, biological, and radiopharmaceutical HCPCS code will be changing to a non-payable status on April 1, 2024. This HCPCS code is in Table 14 of CR 13568.

**f. HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals with Descriptor Changes as of April 1, 2024**

There are 7 drug, biological, and radiopharmaceutical HCPCS codes that have a descriptor change as of April 1, 2024. Table 15 of CR 13568 lists these codes.

**g. Vaccine that Will Retroactively Change from Non-Payable Status to Payable Status Effective November 9, 2023, in the April 2024 I/OCE Update**

The SI for CPT code 90589 (Chikungunya virus vaccine, live attenuated, for intramuscular use), effective November 9, 2023, will change retroactively from status indicator E1 to status indicator M in the April 2024 I/OCE Update. Table 16 of CR 13568 shows this code.

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

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

In CY 2024, we make a single payment of ASP plus 6% for pass-through drugs, biologicals, and radiopharmaceuticals to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items, or ASP + 6% or 8% of the reference product for biosimilars. We update payments for drugs and biologicals based on ASPs on a quarterly basis as later-quarter ASP submissions become available.

Effective April 1, 2024, payment rates for many drugs and biologicals have changed from the values published in the CY 2024 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from third quarter of CY 2023. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the April 2024 Fiscal Intermediary Standard System (FISS) release. We aren't publishing the updated payment rates in the April 2024 update of the OPPS. The updated payment rates effective April 1, 2024, are in the April 2024 update of the OPPS Addendum A and Addendum B.

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

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

### 11. Skin Substitutes

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

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

We assign new skin substitute HCPCS codes into the low-cost skin substitute group unless we've OPPS pricing data showing the cost of the product is above either the mean unit cost of $47 or the per-day cost for CY 2024 of $807.

### a. New Skin Substitute Products as of April 1, 2024

Table 17 of CR 13568 lists 5 new skin substitute HCPCS codes active as of April 1, 2024.

### b. Skin Substitute Product Codes Deleted Effective March 31, 2024

Table 18 of CR 13568 lists 1 skin substitute product code deleted as of March 31, 2024.

### 12. Coverage Determinations

The fact that we assign a drug, device, procedure, or service an HCPCS code and a payment rate under the OPPS doesn't imply coverage by the Medicare Program. It only shows how we pay for the product, procedure, or service if Medicare covers it. MACs decide if a drug, device, procedure, or other service meets all Program coverage requirements. For example, MACs decide that it's reasonable and necessary to treat the patient's condition and if it's excluded from payment.

## More Information

We issued CR 13568 to your MAC as the official instruction for this change.

For more information, find your MAC's website.

## Document History

| Date of Change | Description |
|---|---|
| March 25, 2024 | Initial article released. |