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Hospital Outpatient Prospective Payment System: April 2025 Update

Related CR Release Date: March 20, 2025	**MLN Matters Number:** MM13993
Effective Date: April 1, 2025	**Related Change Request (CR) Number:** CR 13993
Implementation Date: April 7, 2025	**Related CR Transmittal Number:** R13135CP
Related CR Title: April 2025 Update of the Hospital Outpatient Prospective Payment System (OPPS)	

Affected Providers

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

Action Needed

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

- Certain laboratory tests, COVID-19 monoclonal antibody therapy products, and Hospital Outpatient Prospective Payment System (OPPS) device categories
- Ambulatory payment classifications (APCs)
- Surgical and imaging procedures
- Drugs, biologicals, and radiopharmaceuticals
- Skin substitute products

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Background

CR 13993 implements changes to and billing instructions for various payment policies in the April 2025 Hospital OPPS update. These coding changes and policy updates are effective April 1, 2025.

CPT PLA Coding Changes Effective April 1, 2025

The American Medical Association (AMA) CPT Editorial Panel established 21 new PLA codes (CPT codes 0531U–0551U) effective April 1, 2025. See Table 1 and April 2025 Hospital OPPS Addendum B for the long descriptors and status indicators.

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

Status Indicator Changes for PLA Code 0464U Retroactive to October 3, 2024

We're changing the status indicator for PLA code 0464U from "E1" to "A" in the April 2025 Integrated Outpatient Code Editor (I/OCE) update, retroactive to October 3, 2024. See Table 2 for the long descriptor and status indicator assignment. Refer to Addendum B for the short descriptor and status indicator.

Status Indicator Change for CPT Code 83718 Effective April 1, 2025

We're changing the status indicator for CPT code 83718 from "Q4" to "A" in the April 2025 I/OCE update effective April 1, 2025. See Table 3 for the long descriptor and status indicator assignment. Refer to Addendum B for the short descriptor and status indicator.

New HCPCS Code Describing a New Screening DNA & Ribonucleic Acid Test for Hepatitis C Virus Effective June 27, 2024

We're creating new HCPCS code G0567 to describe a new screening DNA and ribonucleic acid test for hepatitis C virus. See Table 4 for the long descriptor and status indicator assignment. Refer to Addendum B for the short descriptor and status indicator.

Deleting Certain COVID-19 Monoclonal Antibody Therapy Products & Their Administration HCPCS Codes

We're deleting 19 COVID-19 monoclonal antibody therapy products and their administration HCPCS codes because FDA revoked their emergency use authorizations. Table 5 lists the effective dates of these deletions. We're deleting these HCPCS codes from the April 2025 I/OCE update effective December 31, 2023:

- M0245
- M0246
- Q0245

We're deleting HCPCS codes M0220–Q0247 from the April 2025 I/OCE effective December 31, 2024.

Hospital OPPS Device Pass-Through

Updates for Long Descriptor to an Existing Device Pass-Through Category C1739

Section 1833(t)(6)(B) of the Social Security Act requires categories of devices to be eligible for transitional pass-through payments for at least 2, but not more than 3 years under the Hospital OPPS. In addition, section 1833(t)(6)(B)(ii)(IV) of the Social Security 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.

We preliminarily approved HCPCS code C1739 as part of the device pass-through quarterly review process effective January 1, 2025 (see CR 13933). We'll include the device application associated with C1739 with discussion in the CY 2026 Hospital OPPS and ASC proposed and final rules.

We're updating the long descriptor for C1739 to, "Tissue marker, probe detectable any method (implantable), with delivery system" effective January 1, 2025. See Table 6A for the long descriptor, status indicator, APC, and offset amount.

Table 7 lists the current and historical device category codes created since we implemented the Hospital OPPS on August 1, 2000. This list is also available in the Medicare Claims Processing Manual, Chapter 4, section 60.4.2.

New HCPCS Code Describing Software that Reports the Volume of Cardiac Chambers & Left Ventricular Wall Mass Effective April 1, 2025

We're establishing new HCPCS code G0183 to describe a software that uses data from previously obtained computed tomography (CT) scans to report the volume of cardiac chambers and left ventricular wall mass. See Table 8 for the long descriptor, status indicator, and APC assignment. Refer to Addendum B for the short descriptor, status indicator, and payment rate.

APC Assignment Change for HCPCS Code C8001 Describing the 3D Anatomical Segmentation Imaging Software Service

In the January 2025 update, we established HCPCS code C8001 to describe the 3D anatomical segmentation imaging intended as software for preoperative surgical planning and the intraoperative display of multi-dimensional digital images. In the April 2025 update, we're revising the APC assignment for this code from APC 5521 (Level 1 Imaging without Contrast) to APC 5721 (Level 1 Diagnostic Tests and Related Services).

See Table 9 for the long descriptor, status indicator, and APC assignment. Refer to Addendum B to find the short descriptor, status indicator, and payment rate.

New HCPCS Code for Simulation Angiogram for Radioembolization of Tumors Effective April 1, 2025

We're establishing HCPCS code C8004 to describe the simulation angiogram service using a pressure-generating catheter (1-way valve, intermittently occluding) for subsequent therapeutic radioembolization of tumors. See Table 10 for the long descriptor, status indicator, and APC assignment. Refer to Addendum B to find the short descriptor, status indicator, and payment rate.

New HCPCS Code Describing Transbronchial Ablation of Lung Tumors Using Pulsed Electric Field Energy Effective April 1, 2025

We're establishing HCPCS code C8005 to describe transbronchial ablation of lung tumors using Pulsed Electric Field energy. See Table 11 for the long descriptor, status indicator, and APC assignment. Refer to Addendum B to find the short descriptor, status indicator, and payment rate.

New HCPCS Code Describing 3D Image Generation Used in Surgical Planning & Navigation for Placing Implants and Devices

We're establishing HCPCS code G0566 to describe the 3D image generation used in surgical planning and navigation for placing implants and devices in the spine and pelvis. See Table 12 for the long descriptor, status indicator, and APC assignment. Refer to Addendum B to find the short descriptor, status indicator, and payment rate.

APC & Status Indicator Assignments for CPT Codes 0446T & 0448T, Implantable Interstitial Glucose Sensor System for Diabetic Patients Effective April 1, 2025

For the CY 2025 Hospital OPPS and ASC final rule, we created codes G0564 and G0565 to specifically describe the 365-day implantable glucose monitoring system. CPT codes 0446T and 0448T described previous versions of the system (90- and 180-day sensors) even though the descriptors didn't contain sensor life (90 or 180 days). For the April 2025 update, we're deleting G0564 and G0565 and revising the APC assignments for 0446T and 0448T (which describe the implantable glucose monitoring system) to be consistent with the APC assignments for the G-codes we're deleting.

See Table 13 for the long descriptors, status indicators, and APC assignments. Refer to Addendum B to find the short descriptors, status indicators, and payment rates.

Revision of the Long & Short Descriptors for HCPCS Code C9793 Effective April 1, 2025

We're revising the short and long descriptors for HCPCS code C9793, which describes 3D predictive model generation for pre-planning of a cardiac procedure using data from CT angiography to include data from magnetic resonance imaging. See Table 14 for the revised long descriptor, revised short descriptor, status indicator, and APC assignment. Refer to Addendum B to find the short descriptor, status indicator, and payment rate.

OPPS Payment for Non-Opioid Treatment for Pain Relief Devices

Effective January 1, 2025, HCPCS device codes that describe non-opioid post-surgical pain relief are subject to additional processing if they're identified with an H1 status indicator (SI=H1).

When you appropriately report a non-opioid pain relief HCPCS device code (SI=H1), the I/OCE provides:

- The first device with Payer Value Code QV
- The Value Code amount representing the payment limitation

A payment adjustment flag (PAF) 26 output for the appropriate lines identifies the first non-opioid pain relief device's payment limitation.

When a patient requires a second unique, non-opioid pain relief HCPCS device code (SI=H1), the I/OCE provides:

- The second device with Payer Value Code QP
- The Value Code amount representing the payment limitation

A PAF 27 output for the appropriate lines identifies the second unique non-opioid pain relief device's payment limitation.

See the new and revised indicators and payment adjustment flags below:

- New logic: non-opioid surgical pain relief logic implementation
  - New PAF 26 (payment limitation for first H1 device) to account for first H1 devices subject to payment limitation
  - New PAF 27 (payment limitation for second H1 device) to account for the second H1 devices subject to payment limitation
  - New Value Code QP (second non-opioid surgical pain relief device payment limitation) output by the I/OCE with a value code amount representing the payment limitation
- Logic modification: non-opioid surgical pain relief device logic: modification of Value Code QV (first non-opioid surgical pain relief device payment limitation) to account for the first H1 device)

Drugs, Biologicals & Radiopharmaceuticals

New CY 2025 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals & Radiopharmaceuticals Receiving Pass-Through Status as of April 1, 2025

We created 8 new HCPCS codes for reporting drugs and biologicals in the hospital outpatient setting where there weren't specific codes previously. These codes are available starting April 1, 2025. These drugs and biologicals will receive drug pass-through status starting April 1, 2025. See Table 15 for the list of codes.

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

Pass-through status for 4 existing HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals in the outpatient setting starts on April 1, 2025. See Table 16 for the list of codes. Effective April 1, 2025, the status indicator for these code changes to "G."

Existing HCPCS Codes for Certain Drugs, Biologicals & Radiopharmaceuticals with Pass-Through Status Ending on March 31, 2025

Eight HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals in the outpatient setting will have their pass-through status end on March 31, 2025. See Table 17 for the list of codes. Effective April 1, 2025, we're changing the status indicator for these codes from "G" to either "K" or "K1." Refer to Addendum B to find the codes, short descriptors, and status indicators.

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

We're establishing 31 new drug, biological, and radiopharmaceutical HCPCS codes on April 1, 2025. See Table 18 for the list of new codes.

HCPCS Codes for Drugs, Biologicals & Radiopharmaceuticals Deleted as of March 31, 2025

We're deleting 12 drug, biological, and radiopharmaceutical HCPCS codes on March 31, 2025. See Table 19 for the list of codes.

HCPCS Code for Drugs, Biologicals & Radiopharmaceuticals Changing Payment Status on April 1, 2025

We're changing the payment status indicator for HCPCS code C9173 on April 1, 2025. See Table 20 for this code.

HCPCS Codes for Drugs, Biologicals & Radiopharmaceuticals Changing Payment Status Retroactively

We're changing the payment status indicator for HCPCS code J9074 retroactive to July 1, 2024 – September 30, 2024. We previously changed this status indicator to "K" from "E2" via Transmittal 12816 (CR 13784, August 29, 2024). We're restoring the status indicator for J9074 to "E2" for dates of service effective July 1, 2024 – September 30, 2024, in the April 2025 I/OCE Update. See Table 21 for this code and its correct status indicator.

We're changing the payment status indicator for HCPCS code J1171 retroactive to January 1, 2025. We incorrectly listed the status indicator for J1171 as "K" in the January 2025 Addendum B. The correct status indicator is "N." We'll make this change in the April 2025 I/OCE Update and the April 2025 OPPS Addendum B. See Table 22 for this code and its correct status indicator.

HCPCS Code for Drugs, Biologicals & Radiopharmaceuticals with Descriptor Changes as of April 1, 2025

There's a substantial descriptor change to drug, biological, and radiopharmaceutical HCPCS code J9073 as of April 1, 2025. See Table 23 for the code and its previous long descriptor.

Drugs & Biologicals with Payments Based on Average Sales Price

Medicare pays most non-pass-through drugs, biologicals, and therapeutic radiopharmaceuticals at a single rate of average sales price (ASP) + 6% (or ASP + 6 or 8% of the reference product for biosimilars). This rate provides payment for both the acquisition cost and pharmacy overhead cost of these pass-through items (or ASP + 6 or 8% of the reference product for biosimilars).

We'll update payment rates for drugs and biologicals based on ASPs quarterly as later-quarter ASP submissions become available. Due to new ASP calculations based on sales price submissions from the fourth quarter of CY 2024, payment rates for many drugs and biologicals have changed from values published in the CY 2025 Hospital OPPS and ASC final rule with comment period.

If necessary, we'll incorporate payment rate changes into the April 2025 Fiscal Intermediary Shared System release. We're not publishing the updated payment rates in this CR implementing the April 2025 OPPS update. You can find the updated payment rates, effective April 1, 2025, in the April 2025 update of Hospital OPPS Addendum A and Addendum B.

Drugs, Biologicals & Radiopharmaceuticals with Restated Payment Rates

We're correcting payment rates retroactively for some drugs, biologicals, and radiopharmaceuticals. These corrections typically occur quarterly. Find these payment rate corrections on the first date of each quarter.

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

Skin Substitutes

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

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

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

New Skin Substitute Products as of April 1, 2025

Fourteen new skin substitute HCPCS codes will be active as of April 1, 2025. See Table 24 for the list of new codes.

Skin Substitute Product Codes Deleted Effective March 31, 2025

We're deleting 1 skin substitute product code as of March 31, 2025. See Table 25 for this code.

Skin Substitute Products Reassigned from the Low-Cost to the High-Cost Skin Substitute Group as of April 1, 2025

We're reassigning 1 skin substitute HCPCS code from the low-cost skin substitute group to the high-cost skin substitute group as of April 1, 2025. See Table 26 for this code.

Coverage Determinations

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

Note: Your MAC won't search for incorrectly paid claims for any retroactive changes in this CR. However, they'll adjust claims you bring to their attention.

More Information

We issued CR 13993 to your MAC as the official instruction for this change. For more information, find your MAC's website.

Document History

Date of Change	Description
April 1, 2025	Initial article released.