2024 Charge Master Updates

EDUCATIONAL PROGRAM MANUAL

ChargeAssist® a divison of Panacea® Healthcare Solutions

December, 2023

Thank you for attending the annual ChargeAssist® Charge Master Updates Educational Program. We hope our summary of coding, payment systems, and regulatory updates will help make your charge management changes easier. Use this material in tandem with ChargeAssist® software functions and resources for complete and timely file updates.

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2024 Charge Master Updates Program

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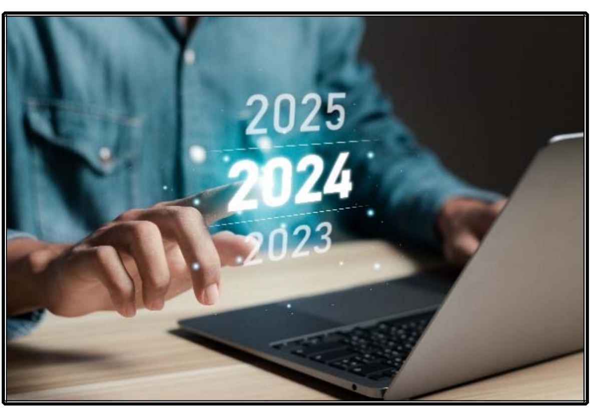
ChargeAssist®
2024 Charge Master Updates Program



Introduction

- Program Instructors
- Program Overview
- Reference Materials
- Year-End Strategies

Program Overview

Program Intent/Use

- This program focuses on Charge Description Master (CDM) and other applicable masterfile updates for the upcoming new year.
- Manual sections & streaming lecture sessions are broken out by clinical or technical areas or by code families when applicable.
- This program should be considered along with your organization's specific masterfile (CDM, EAP, etc.) content within ChargeAssist® & other hospital-endorsed and licensed reference sources.
- Prior to making masterfile changes, be sure to collaborate with your organization's CDM and Revenue Integrity Team for coordinated masterfile update efforts.

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Manual Sections & Streaming Webinar Topics

- OPPS 2024 Highlights (1Q24 Centers for Medicare and Medicaid Services (CMS information)
- MPFS 2024Highlights (1Q24 CMS information)
- 1st quarter 2024 CPT-4 & HCPCS Changes by Code Section
- Annual Charge Master Update Preparation and Plans

Reference Materials

Data & resources CDM/Revenue Integrity teams should consider through ChargeAssist® resources and masterfiles.

- Licensed American Medical Association (AMA) 2024 Current Procedure Terminology (CPT-4®) dataset appended with associated Centers for Medicare and Medicaid Services (CMS) payment indicators and AMA guidelines
- 2024 CMS Healthcare Common Procedure Coding System (HCPCS) Level II master files, HCPCS Workgroup documents, and associated payment system status or payment indicators
- CMS Outpatient Prospective Payment System (OPPS) datafiles (1Q24 data plus analysis of changes from 4Q23 to 1Q24 for impact on health system master files)
- CMS 2024 Medicare Physician Fee Schedule (MPFS) datafiles
- Other CMS 2024 Fee Schedules:
  - Clinical Laboratory Fee Schedule (CLFS)
  - Durable Medical Equipment, Prosthetic, Orthotic Supplies (DMEPOS)
- Source files from CMS for Integrated Outpatient Code Editor (I/OCE) edits
- Medicare National Correct Coding Initiative (NCCI) information (including manuals, CCI code pair look ups, and MUEs)
- AMA CPT® Website: main page https://www.ama-assn.org/amaone/cpt-current-procedural-terminology

Key CPT® Web Page Links	
CPT®	https://www.ama-assn.org/practice-management/cpt
Category III Codes	https://www.ama-assn.org/practice-management/cpt/category-iii-codes
CPT Errata & Technical Corrections	https://www.ama-assn.org/practice-management/cpt/errata-technical-corrections
Vaccine & Immunization Codes	https://www.ama-assn.org/practice-management/cpt/category-i-vaccine-codes
COVID-19 Vaccine & Immunization Codes	https://www.ama-assn.org/practice-management/cpt/covid-19-cpt-vaccine-and-immunization-codes
PLA Codes	https://www.ama-assn.org/practice-management/cpt/cpt-pla-codes
Administrative MAAA Codes	https://www.ama-assn.org/practice-management/cpt/multianalyte-assays-algorithmic-analyses-codes
Molecular Pathology Tier 2 Codes	https://www.ama-assn.org/practice-management/cpt/molecular-pathology-tier-2-codes

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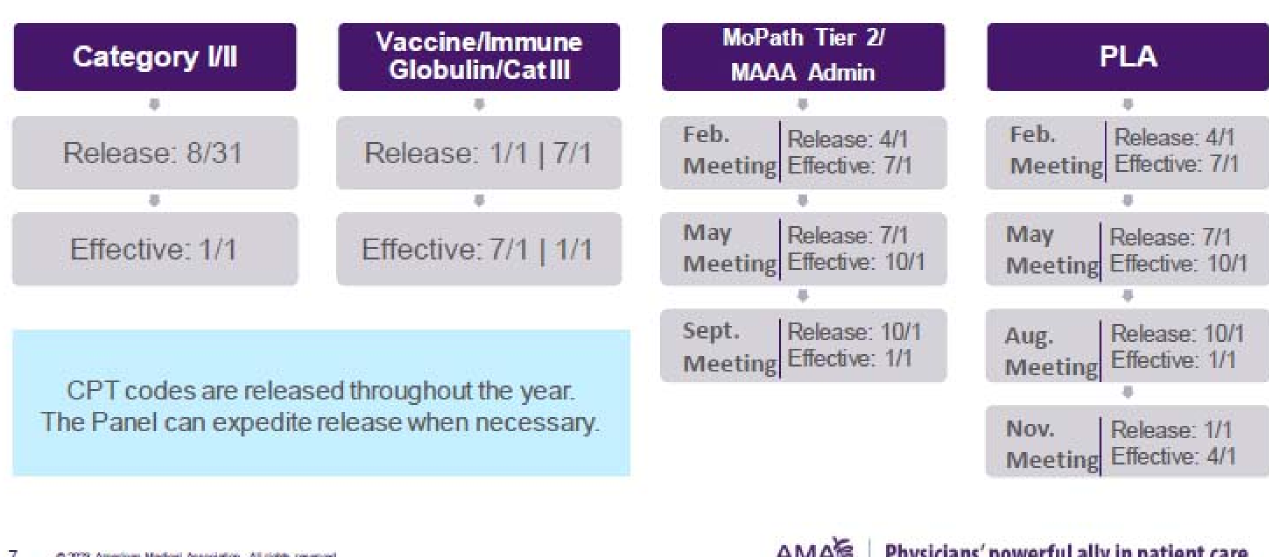
- Other data, publications, and resources to consider include: Commercial insurances, Medicaid programs, Workers Compensation programs, and other payer-specific guidance (based on the organization's payer mix)

Primary CDM Update Reference Documents for CDM/Revenue Integrity Teams

(Many of the documents below are found in the Document Center of ChargeAssist®)

- 2024 Outpatient Prospective Payment System (OPPS) Final Rule
- 2024 Medicare Physician Fee Schedule (MPFS) Final Rule
- Other Final Rule documents or summary transmittals and MLN Matters articles
- Multiple AMA CPT-4® reference sources (all separately licensed from AMA) including code books, 2024 CPT-4® and RBRVS Annual Symposium, CPT® Changes: An Insider's View, CPT® Assistant articles
- National Correct Coding Initiative (NCCI) Policy Manual for 2024
- Medicare "Final Summary of Data Changes" (IOCE) & CMS Specifications document

CPT Code release timelines



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Annual Update Priorities for ChargeAssist® Subscribers

Primary ChargeAssist® modules/functions important for CDM updates include:

- Quarterly Updates modules with the ChargeAssist® Auditor Notes and other Change Notes
- Code Detail (HCPCS Active tab)
    - OPPS SIs, payment rates, and other payment system information are available in ChargeAssist® modules along with integrated coding guidelines, change notes, and resource docs
- Licensed AMA CPT-4® resources (data and publications)
- NCCI module for understanding code pair impact on charge or code capture and potential modifier overrides
- Pricing Studies (Medicare standard analytical file comparative pricing for other providers and Fee schedule data)
- Document Center and Document Search functions

Key CDM Analysis Views Through ChargeAssist® Audit Modules

- Charge items plus Revenue & Usage by Cost Center or activity type to confirm utilization trends and charge item retention
- Charge Master file linked to CMS payment rates and indicators
- Charge Master file linked to CPT codes and guidance
- Charge Master file linked to CMS edits
- Other files (ancillary, Order Entry, etc.) compared to Charge Master
- Charge Master file linked Fee Schedules by locality, OPPS wage adjusted rates, and competitive market pricing information
- Invalid Codes
- Changed Codes (New, Deleted & Revised Codes) (be attentive to change dates)
- Changed OPPS Information (SI changes, OPPS Rate Changes)
- Changed Edits (MUE edit changes)

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Year-End CDM Update Strategies

Using This Program for your Charge Master Updates

This annual program focuses on coding, regulatory, and payment system changes impacting health systems' charge-related information system files (referred to as "datafiles" or "master files" in this program). We may reference charge-related files with the terms "Charge Master", "Charge Description Master", "CDM", "Charge Data", or other master file naming conventions such as "EAP, Fee Schedule", "Bill Item", "FIM", etc. It is important to remember that alternative files, applications, or information systems may require synchronized updates to comply with current coding and payment system data.

The target audience for this educational program includes individuals responsible for master files, charge capture, claims processing, coding, and other processes related to charging workflow processes. We may refer to these individuals as "Charge Master Teams", "Revenue Integrity Teams", or other labels (referred to throughout this program as "CDM/Revenue Integrity Teams"). Department Representatives, Practice Management staff, and various hospital support staff are also involved in the annual CDM update process. Despite the title or role, we expect program participants to understand their responsibilities as well as their unique systems environments and internal processes for file updates. This typically requires leadership and support using a project-oriented structure. (More Charge Management process recommendations are provided in our Charge Management Educational Programs, articles, or CDM Review engagements.)

We advise hospital teams to review all applicable guidance from AMA and CMS sources in tandem with this educational program's content. For interpretive or complex coding, we advise pursuing specialty-specific coding education from our team of certified coding educators.

Importantly, when performing Charge Master updates, always validate data, charges, and any associated systems. Before changing system master files, validate revisions by first confirming what the changed or updated charge items truly represent. This often means involving department staff (clinical, technical, coding, billing, and others). Importantly, ensure that current and future CDM data accurately reflects the associated service and that services are coded to the highest level of specificity.

Charge Master updates are driven by organizations' review, interpretation, and implementation of changes required to comply with applicable coding and payment systems' changes. CDM/Revenue Integrity Teams must understand not only their own systems environment but also the coding and payment systems applicable to their organization.

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The sections below provide some highlights of the payment and coding systems that must be considered for CDM updates.

This program is focused on CDM codes populated within Charge Master files (i.e., 'hard-coded'). It is not intended to serve as an organization's only source of Health Information Management (HIM) or Medical Record (MR) Department coding education. Coding staff who manually interpret documentation and assign CPT-4 and ICD-10 codes will require certified coder-based education on the new year's coding changes. This is especially true for Evaluation & Management updates. *(Contact our offices for information on coding education offered through Panacea Healthcare Solutions.)*

Coding Rules

Charge Master updates require careful interpretation of changes to codes. Changes can occur through the code set itself, code descriptors, coding guidance (introductory code section guidelines or code sub-section guidelines), and coding parentheticals (details that follow each code). AMA provides guidance during their annual CPT Symposium and in written form in the CPT Changes book and CPT Assistant articles.

Note that occasionally, coding guidance for CMS payment system updates may vary from CPT-4 updates. CMS continues to release HCPCS Level II codes intended to override AMA's CPT code set, and often, those codes have differing structures. While some guidance is included in payment systems' Final Rules (Federal Register documents), code-specific guidance is typically summarized in transmittals and other Medicare publications. (Additionally, please note that ChargeAssist® provides a "Medicare Override" code resource functionality that is released in late December once all CMS edit data has been released.)

An important reminder for every organization is "Never replace CDM codes without considering whether there may be new coding or description changes that should be evaluated." Data updates require interpretation of the charge item itself, understanding of the intent and use of the charge item, and strategic decisions on the appropriate replacement codes or other data changes. If a code is incorrect or outdated, first determine whether the charge is still used and active prior to making changes.

Payment System Data for Charge Management

In addition to coding updates, payment system rules, regulations, and data are integral components of charge data management and CDM updates. Use applicable CMS payment system and edit indicators as well as Medicaid, Worker's Compensation, and commercial insurance references to interpret code use for your organization's various payers.

Throughout the program, we discuss code changes and the associated regulatory or payment system nuances that may impact charge master data or charge capture. In tandem with these topics, CDM/Revenue Integrity Teams typically address the reimbursement impact of the associated changes.

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Healthcare reimbursement policy and payment system changes are documented as proposed regulatory changes with a period for public review and comment. After reviewing comments and confirming final policy decisions, the Centers for Medicare and Medicaid Services (CMS) subsequently publishes 'Final Rule' documents on the Federal Register website. Master files for the various payment systems are then made. Also, following the finalization of policies, CMS publishes narrative summaries of the revisions in Transmittals, MLN Matters articles, Medicare Manuals, and other communication channels (most of which have not been released at the time of this program's development).

Payment systems are updated with the largest volume of changes effective annually. Additional updates occur quarterly or on an ad hoc basis based on CMS' operational requirements. Finalized payment system policies (in the absence of any new law or overriding Congressional action) determine new regulatory requirements that impact charging, coding, payment rates, and claims data requirements for the Medicare program. This program focuses on outpatient and physician payment system updates that most commonly impact hospital Charge Master files. Several critical data indicators within Medicare payment systems help CDM/Revenue Integrity Teams fully understand the impact of annual and quarterly payment system updates.

Payment / Pricing Indicators & Edits

CMS embeds various data elements within payment systems to clarify the treatment and classification of items and services represented by codes. These data elements often include pricing indicators, payment indicators, or billing and editing rules. Payment Indicators (PI) and Status Indicators (SI) are related to individual CPT and HCPCS codes. They define an associated charge's coverage, claims requirements, and reimbursement rules. Indicators may identify the payment method for particular codes or limitations on code use (e.g., non-covered codes, non-reportable codes, inpatient-only codes.)

Pricing and Status Indicators should be considered in tandem with other resources to fully understand the impact of changes. This ensures accurate CDM data and appropriate charge practices. The sections below introduce several of the primary payment system indicators we feel are important to your annual CDM updates.

Integrated Outpatient Code Editor (I/OCE) Edits

Medicare outpatient claims edits apply to both OPPS and other outpatient claims and serve as helpful resources for understanding the payment and billing rules surrounding a specific code. For hospitals paid under Medicare's Critical Access Hospital (CAH) methodology, a charge item's associated Integrated Outpatient Code Edit (I/OCE) indicator (when applicable) is critically important for Charge Management. These are typically associated directly with the assigned CPT-4® or HCPCS codes. CDM Teams and departments can determine whether services in their charging files are payable and reportable by referencing select I/OCE edits that correlate to specific CPT or HCPCS Level II codes in their billing system master files. Proactive CAH CDM teams proactively review these edits.

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They develop the necessary claims rules or code overrides to ensure the right codes are reported on Medicare claims with minimal interpretation required at charge capture. This eliminates confusion and claims correction downstream in the billing process. *(I/OCE edits are typically released in late December for annual updates and thus, not included in this training material.)*

OPPS Status Indicators

It is important for Departments and CDM/Revenue Integrity Team members to understand specific hospital outpatient services are reimbursed. Most hospital outpatient services are paid under the Medicare outpatient payment system called outpatient prospective payment system (OPPS). However, some organizations and outpatient services are paid under other methods by Medicare (CAH, IHS, RHC, FQHC, MPFS, etc.).

OPPS Status Indicators (SIs) are assigned in CMS master files to each code recognized in the OPPS payment system and published by CMS each quarter. Status Indicators are displayed as a reference to payment methodology and not included in Charge Master data elements or other hospital charging files. OPPS SIs are based on rules that drive payment systems and claims edit logic. These indicators require interpretation quarterly to fully understand Medicare's treatment of the associated codes.

(Note: Although you will see associated Status Indicators in ChargeAssist®, reference sources, and this program, the CDM/Revenue Integrity Team should define whether the OPPS payment system applies or does not apply to the associated charge items. Also, remember that these fields change quarterly.)

As more OPPS payment packaging occurs (as part of CMS' payment reform strategy), teams need to evaluate the impact on all associated charges as well as encounter-specific total reimbursement changes. Status and payment indicators can help identify which codes and associated charges in your CDM may require revised pricing, charge structure, or charge capture.

Medicare Physician Fee Schedule (MPFS) & Other Fee Schedule Indicators

Services paid under the Medicare Physician Fee Schedule have associated MPFS and RBRVS payment system indicators. These are also helpful indicators for ensuring appropriate CDM data population and claims rules. Most commonly applicable to hospitals, the MPFS data is applicable to physician or non-physician practitioner (NPP) payment, Rehabilitation Services (PT, OT, ST). Also, note that there are some times when CMS has defined MPFS as the applicable payment method for services despite the cost center being a hospital cost center (such as non-excepted remote provider-based clinic settings).

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Healthcare Common Procedure Coding System (HCPCS) Pricing Indicators

Lastly, the CMS Healthcare Common Procedure Coding System (HCPCS) Level II code file also contains payment system indicators. HCPCS Level II codes represent various items and services reportable under multiple CMS payment systems. Specifically, we suggest a thorough review of select HCPCS pricing indicators (PIs) against Charge Master data to evaluate Revenue Code assignment, allowable claims processing for the associated code, and other CMS payment system requirements.

Note: The Charge Master Updates Program Manual Exhibit section provides tables of indicators and their descriptors.

Summary

Payment policy changes should be reviewed in tandem with CPT-4®, HCPCS Level II, claims edits, and other applicable annual update policies.

Be sure the CDM/Revenue Integrity Team differentiates between provider type and payment system policy changes and understands that some insurances may apply their own unique reimbursement, coverage, or claims rules.

Most outpatient payment system changes are effective January 1st. Therefore, it is critical to have an organized process for 1) reviewing all applicable annual updates, 2) conducting strategic sessions with departments or providers to go over changes, and 3) determining actual datafile changes that must be made. If CDM updates are new to your team, or if you are hoping to involve a larger team this year in your efforts, we suggest reviewing our sample work plan.

Finally, remember that CMS and CPT aren't perfect. Mistakes are typically uncovered in their coding and payment system updates. Corrections documents referred to as 'errata', 'corrections', or 'rescinded' communications will be published and warrant your team's immediate attention. Don't forget that ad hoc CDM updates will continue as Average Sales Price (ASP) pharmacy files are updated (thus changing payments for drugs in January) and for newly-approved vaccine and therapeutics coding as EUAs or full FDA approvals are granted. As all program attendees should know, the standard payment systems and coding system updates will require attention throughout the year. Quarterly and ad hoc changes will continue throughout the coming year.

We wish all attendees a successful update process and thank you for participating in this program.

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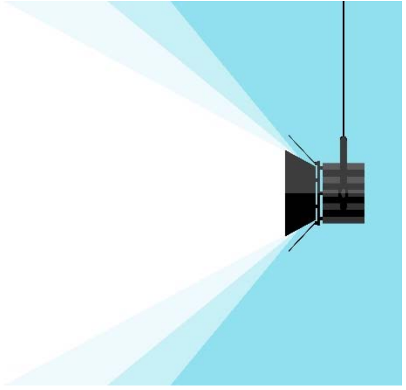
OPPS DATA HIGHLIGHTS



Agenda

- Rate changes
- Status Indicator background
- SI changes overview
- SI analysis action plan
- Pricing & OPPS data

OPPS Changes

A significant number of codes are assigned Status Indicator and rate changes in the OPPS payment system updates (typical to the OPPS masterfile updates we evaluate annually). New benefits are also introduced along with expiration of many COVID-19 PHE flexibilities and waived requirements that impact charge data.

OPPS Rate Change Details by CPT/HCPCS code

As of the date of development of this material, the following quantitative analysis of 1Q24 OPPS rates (compared to 4Q23 OPPS rates) was performed using ChargeAssist® change modules:

2023 to 2024 updates*

- 5,612 codes have OPPS 2024 rate changes
  - 4747 codes have increased OPPS rates
  - 865 codes have decreased OPPS Rates
- 323 codes have no rate change

Last Year's 2022 to 2023 updates

- 5,704 codes had OPPS 2023 rate changes at the time of last year's training manual development.

Due to the many factors affecting quarterly rate revisions under OPPS, a complete review of rate changes includes more than simply looking at single codes. OPPS reimbursement rate change information is available in the ChargeAssist® changes modules allowing unique models and analysis against usage, claims-based market rates, relative values, and fee schedule information.

**Note that counts above are totals at the time of manual development. Additional changes are possible with late-release CMS changes and corrections.*

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OPPS Status Indicator Background

Each code recognized in the Medicare OPPS payment system is assigned an OPPS Status Indicator (SI). Codes without OPPS SIs are not recognized in the Medicare outpatient payment system but may be recognized in other payer systems. Some SIs result in payment rates, and others identify how the code is treated in the OPPS payment system through CMS "Pricer" functions.

The following quantitative analysis of 1Q24 OPPS Status Indicators (compared to 4Q23 OPPS indicators) was performed using ChargeAssist® change modules:

We encourage CDM teams to review these changes against their own CDM/EAP file content for a better understanding of payment systems and claims reporting.

Note: OPPS Status Indicators and descriptions are listed in the program appendices for reference.

OPPS SI Changes

Based on the 2024 CMS OPPS Addendum B file with 1Q24 codes, rates, change indicators, and Status Indicators, 472 codes had OPPS Status Indicator changes for 4Q23 to 1Q24 (as of 11/29/23 program development). This total excludes codes deleted for 1Q24.

Only one SI is changing in 2024. As outlined in the OPPS Final Rule, "P" from "Partial Hospitalization" will change to "Partial Hospitalization or Intensive Outpatient Program". (This update has been included in the SI Description reference document within Exhibit B of this program manual.)

OPPS SI Analysis *(applicable for OPPS-reimbursed hospitals only)*

CDM/Revenue Integrity Teams will want to use this course material and ChargeAssist® software functions to identify charge items significantly impacted by OPPS Status Indicator and associated OPPS payment rate changes. Analyze not only the CDM, coding, and billing protocol but also the potential revenue impact based on a sample period of historic utilization. As you consider the OPPS SI and rate changes, analyze possible revenue code options, claims rules, pricing, or charge structure that may be affected. Remember that many codes with changes are not in the CDM file and are assigned through coding or other systems.

As we noted in previous educational programs, as CMS payment systems continue to increase bundled payments, CDM changes require more than a code-by-code analysis. In addition to changed codes, also ensure the primary procedure, newly bundled procedure codes, and all other related charges (even if packaged in payment) are considered. Accurate and complete claims data (whether the components are paid or not paid) is vital to sustaining the OPPS payment system's long-term accuracy.

Some SI changes are important to analyze for code use, while others simply revise the CMS payment methodology for the code and do not impact coding, charge capture, or CDM data.

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Some SI changes reflect different payments/payment methods, while others restrict reporting on claims. Use ChargeAssist® SI changes modules to view these updates along with the associated codes:

- To see how your Charge Master or CDM section is impacted by the OPPS SI changes, use the CDM Audit Suite Quarterly Changes module.
  - Teams will want to evaluate charges that have codes that changed from an OPPS status of paid to not paid or not reportable and vice-versa.
  - Revenue code or charge practices may change in these instances.
- If interested in a 'big picture' view of all of the CMS OPPS SI changes for every active code in the CPT® and HCPCS universe, use the Research Center Quarterly Updates module:
  - This view is helpful for seeing changes to items you may not have hard-coded in your CDM file.
- Also, consider new CPT®/HCPCS codes and their relative SIs, which may not be set up in your CDM at this time.
- If needed, a Status Indicator index is in the Exhibits section.
- Summarize the grid view by either old or new SI for easier viewing. The summary that follows provides details on CMS OPPS SI changes from 4Q23 to 1Q24.

SI Changes Overview Summary Grid View

- As of the time of development of this content (11/17/23) 472 Codes had OPPS SI changes from 4Q23 to 1Q24 as reflected in the table below (excluding deleted codes):

New SI: A (count: 15)
- **Old SI: E1 (count: 12)** ***previously not covered for OPPS***
- **Old SI: N (count: 3)** ***check for alternative payment oppty***

New SI: C (count: 1)
- **Old SI: E1 (count: 1)** ***ensure inpatient only code use***

New SI: E1 (count: 10)
- **Old SI: M (count: 10)** ***review for rev code/billing edit changes***

New SI: E2 (count: 15)
- **Old SI: N (count: 15)** ***previously no pmt rate; now pkgd***

New SI: G (count: 4)
- **Old SI: E2 (count: 2)** ***review for new payment oppty***
- **Old SI: K (count: 2)**

New SI: J1 (count: 51)
- **Old SI: B (count: 36)** ***previously not reportable***
- **Old SI: E1 (count: 6)** ***review for rev code/billing edit changes***
- **Old SI: S (count: 5)**
- **Old SI: T (count: 4)**

New SI: K (count: 73)
- **Old SI: G (count: 10)**
- **Old SI: N (count: 63)** ***packaging vs separate pmt***

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New SI: L (count: 5)

Old SI: null (count: 5) ***due to OPPS lag with vaccine info***

New SI: M (count: 7)

Old SI: Null (count: 2)

Old SI: E1 (count: 5)

New SI: N (count: 32)

Old SI: B (count: 9) ***previously not reportable***

Old SI: E1 (count: 3) ***previously not covered for OPPS***

Old SI: G (count: 1) ***packaging vs separate pmt***

Old SI: H (count: 8) ***packaging vs separate pmt***

Old SI: K (count: 10) ***packaging vs separate pmt***

Old SI: S (count: 1) ***packaging vs separate pmt***

New SI: Q1 (count: 55)

Old SI: B (count: 48) ***previously not reportable***

Old SI: S (count: 7)

New SI: Q2 (count: 1)

Old SI: T (count: 1)

New SI: S (count: 6)

Old SI: Null (count: 1)

Old SI: E1 (count: 3) ***previously not covered for OPPS***

Old SI: J1 (count: 2)

New SI: T (count: 197)

Old SI: B (count: 148) ***previously not reportable***

Old SI: E1 (count: 3) ***previously not covered for OPPS***

Old SI: J1 (count: 1)

Old SI: M (count: 1) ***previously not reportable***

Old SI: S (count: 44)

Notes:

The above SI changes have SI D (Deleted code) Status Indicator filtered out.

Upon late-notice, several CMS HCPCS Level II new codes were not activated as planned, and the codes continue be in the count above.

Detail of late-release changes from CMS is included in the ***"Quantitative Overview of Code Changes"*** *Chapter under CPT/HCPCS 1Q24 Code Totals.*

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Newly-assigned to SI A (15 total)

- 11 codes were SI E1 for Gradient compression stocking A range codes and now assigned SI A (paid under another method)
- 3 codes were SI N for below knee gradient compression stocking A range codes (only billable for specific clinical conditions with specific coding rules) and now assigned SI A
- 1 code was OPPS SI E1 as a general Q range code for the intravenous immune globulin (IVIG) demonstration project including services, supplies, and accessories used in the home and now assigned SI A (paid under another method)

Newly-assigned SI C (1 total)

- 1 code (0646T) for “transcatheter tricuspid valve implantation replacement with prosthetic valve” was converted from Non-Covered SI E1 to SI C Inpatient Only.

Newly-assigned SI E1 (10 total)

- 10 codes were SI M in 2023 changed to SI E1; all are Category 2 Quality Measure codes (this is a standard SI change we see annually)

Newly-assigned SI E2 (15 total)

- 15 codes were SI N, packaged, in 2023 and now SI E2; all are drug or vaccine codes; no OPPS payment will be available for these codes until CMS has payment data available through ASP or other methods

Newly-assigned SI G (4 total)

- 2 codes were SI E2 (previously unpaid); and now paid under OPPS SI G pass-through payment status:
    - A9601 Flortaucipir f 18 injection, diagnostic, 1 millicurie
    - J9029 Injection, nadofaragene firadenovec-vncg, per therapeutic dose
- 2 codes were SI K (paid as an APC); and now paid under OPPS SI G pass-through payment status:
    - J0174 Injection, lecanemab-irmb, 1mg
    - J0349 Injection, rezafungin, 1 mg

Newly-assigned SI J1 (51 total)

- 36 codes were SI B; all are dental codes
- 6 codes were SI E1; all are Category III codes for transcatheter insertion of permanent dual chamber leadless pacemaker codes
- 5 codes were SI S; 4 are Dental codes and one is G0330 facility services for dental rehab procedures for patients requiring monitored anesthesia
- 4 codes were SI T; three surgical codes and one Category III code

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Newly-assigned SI K (73 total)

- 10 codes were SI G (paid under pass-through payment); these are J range and Q range codes
- 63 codes were SI N (packaged); these codes require HCPCS coding, multiplier accuracy (where needed), and Revenue code 636; these are J range and Q range codes

Newly-assigned SI L (5 total)

- 5 codes had no SI and are all now SI L. These are the new COVID-19 91XXX range vaccine codes that were actually paid upon their effective dates. The OPPS files are typically behind with off-schedule mid-quarter updates.

Newly-assigned SI M (7 total)

- 2 codes were null (no SI)
    - Both are 96XXX range RSV administration codes (96380, 96381) approved during the September 2023 CPT Editorial Panel Meeting and effective October 6, 2023.
- 5 codes were SI E1 Category III codes
    - 2 RSV vaccine codes
    - 3 Category III bone strength and fracture risk interpretation codes 0554T, 0557T, 0743T

Newly-assigned SI N (32 total)

- 9 codes were SI B; all are dental codes
- 3 codes were SI E1 98960-98962 Education and training for patient self-management by a qualified non-physician health care professional
- 1 code was SI G (no longer pass-through drug payment and packaged instead); A9592 Copper cu-64, dotatate, diagnostic, 1 millicurie
- 8 codes were SI H (no longer pass-through device payment and packaged instead); All are C range codes (see update on Pass-Through Device changes in this training content)
- 10 codes were SI K (no longer separate APC drug payment and packaged instead):
    - 1 A range therapeutic radioisotope
    - 1 C range drug code
    - 8 J range drug codes
- 1 code was SI S (no longer separate APC drug payment and packaged instead); this is a Dental code

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Newly-assigned SI Q1 (55 total)

- 48 codes were SI B; all are dental codes
- 7 codes were SI S; all are dental codes

Newly-assigned SI Q2 (1 total)

- 1 code was SI T 0518T Removal of only pulse generator component(s) (battery and/or transmitter) of wireless cardiac stimulator for left ventricular pacing

Newly-assigned SI S (6 total)

- 1 code was blank (null); 90480 Immunization administration COVID vaccine
- 3 codes were SI E1 CT codes:
  - 0555T Bone strength and fracture risk using finite element analysis of functional data and bone-mineral density utilizing data from a computed tomography scan; retrieval and transmission of the scan data
  - 0556T Bone strength and fracture risk using finite element analysis of functional data and bone-mineral density utilizing data from a computed tomography scan; assessment of bone strength and fracture risk and bone-mineral density for bone strength and fracture risk from a CT scan; and 1 CT code
  - 0558T Computed tomography scan taken for the purpose of biomechanical computed tomography analysis
- 2 codes were SI J1 codes two Category III codes:
  - 0266T Implantation or replacement of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)
  - 0620T Endovascular venous arterialization, tibial or peroneal vein, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural road mapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed

Newly-assigned SI T (197 total)

- 148 codes were SI B; all are dental codes
- 3 codes were SI E1 ; all are Category III codes:
  - 0717T Autologous adipose-derived regenerative cell (ADRC) therapy for partial thickness rotator cuff tear; adipose tissue harvesting, isolation and preparation of harvested cells, including incubation with cell dissociation enzymes, filtration, washing, and concentration of ADRCs
  - 0718T Autologous adipose-derived regenerative cell (ADRC) therapy for partial thickness rotator cuff tear; injection into supraspinatus tendon including ultrasound guidance, unilateral
  - 0810T Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies
- 1 code was SI J1; 0101T Extracorporeal shock wave involving musculoskeletal system, not otherwise specified

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- 1 code was SI M; 0640T Noncontact near-infrared spectroscopy (eg, for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), other than for screening for peripheral arterial disease, image acquisition,
- interpretation, and report; first anatomic site
- 44 codes were SI S; all Dental codes

As we have noted in programs before, the CMS OPPS payment system files lag behind actual coverage timelines for vaccines and administration codes. Follow CPT website and ChargeAssist® updates for FDA approval or Emergency Use Authorization dates, then monitor CPT for the date they make the code(s) effective.

Interpreting & Utilizing OPPS Data

It is important to understand how the data should be interpreted and used for a proactive charge management process.

Proactive hospitals have various methods, strategies, and resources to establish the appropriate price for items and services. OPPS Status Indicators and reimbursement data are several of many points of data analytics. OPPS information alone is insufficient for pricing analysis or rate updates, and requires strategic repricing when appropriate.

Beyond the Audit and Change Modules, ChargeAssist® subscribers have several functions in the Pricing Analysis modules to perform first-level price analysis and rate research. Your hospital also has access to a team of Panacea Healthcare Solutions strategic pricing solutions experts when further strategic assistance is needed.

Several considerations related to the use of OPPS data include:

- Department representatives, providers, and charge capture staff must understand how changes in OPPS, as well as other CMS payment systems, should be interpreted related to pricing. Remind departments that packaging of payment for a code does not indicate removing charges or codes from the CDM file.

- ChargeAssist® provides market data for comparisons to itemized prices as well as relative value data and payer fee schedule data. If your hospital uses OPPS payments as a baseline for modeling and analyzing prices, remember that any code assigned a packaged or conditionally packaged payment status will have no specific OPPS payment rates. (OPPS benchmarks are not the ideal pricing method, and more strategic approaches can be suggested by Panacea's pricing experts.) Also, note that there may be supplies and overhead costs associated with additional charges billed along with the code you're researching. We suggest that teams and individual departments consider all claims-based data for common services to see the full range of charged items per encounter.

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- While the review of competitive market data, fee schedule rates, relative values or other benchmarks is helpful, updates to prices should be carefully performed in consideration of cost, markups and other internally-endorsed methods. Pricing update efforts performed in the absence of cost, contract details, or reimbursement calculations create the risk of erroneous financial projections. Seek help with strategic pricing from the Panacea team if your organization does not have the appropriate expertise.

- Finally, when evaluating OPPS reimbursement, watch for CMS OPPS Final Rule corrections and monitor CMS release of updated pharmacy pricing when new ASP is available.

OPPS rate and Status Indicator changes may impact your Charge Master data, charge protocol, and billing significantly or may have little to no impact. However, many of the OPPS changes highlighted in this program require further analysis and are important to review and address with your CDM team, Revenue Integrity Team, and Departments.

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OPPS 2024 Final Rule Highlights

Key Final Rule Topics for Charge Management Teams

OPPS Policy Change Highlights

Background

The OPPS/ASC Final Rule for 2024 follows the standard CMS OPPS Final Rule content and layout with numerous in-depth explanations of payment changes to APCs, and CMS deliberations as well as public comment summary of OPPS payment system policy changes.

CMS released the pre-publication Display Copy of the Outpatient Prospective Payment System (OPPS) Final Rule on November 2, 2023, and formally published the rule on November 22, 2023. The PDF document is located on the CMS Federal Register website Federal Register OPPS Final Rule webpage and within the ChargeAssist® Document Center as a bookmarked Display Copy.

Based on the Social Security Act, the Secretary of the Department of Health and Human Services must revise APC groups, OPPS relative payment weights, and wage adjustments annually. Under the Secretary's (and expanded statutory authorities), CMS performs OPPS payment updates to reflect changes in medical practice, technology, new services, new cost data, and other relevant information and factors. Many of this year's changes are also based on mandates from the Presidential Orders, the Consolidated Appropriations Act of 2023 (CAA, 2023), and other legislated changes from recent years.

For details on applicable sections, we suggest that teams review the Final Rule, CMS Manual sections, and other CMS summaries.The 2024 OPPS/ASC Final Rule includes its standard background summary in each section explaining details of payments and policy under the OPPS payment system for hospital outpatient departments. CMS' OPPS 2024 continues the use of APCs following decades-old CMS payment methodology with mapping of multiple CPT/HCPCS codes to APCs. APCs have relative value weights that are then multiplied by an annual OPPS conversion factor. (Other adjustments and payment variables impact OPPS final payments as well.) APC payment methods are applicable to Acute Care hospital outpatient services. Exceptions for payment are Critical Access Hospital cost-based payment, MPFS payment, statutory rates, and varied other reimbursement methods for different payment systems. For details on the OPPS payment calculations see this document for claims accounting methodology: *https://www.cms.gov/files/document/2024-nfrm-opps-claims-accounting.pdf*

This training program section focuses primarily on CDM-specific OPPS updates. Ambulatory Surgical Center (ASC) sections, Quality Measure program updates, and Price Transparency updates are not included in this program's summaries.

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Key OPPS Changes for 2024

Payment Updates for 2024 OPPS and ASC

- OPPS payment rates will receive a 3.1% increase for 2024
    - The statutory 2% penalty is still in effect for hospitals failing to meet hospital outpatient quality reporting requirements
    - The 2024 *proposed* increase was 2.8% which was subsequently increased
    - CMS estimates that 2024 total payments to OPPS providers (including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case mix) will be approximately $88.9 billion (an increase of approximately $6.0 billion)
- The ASC conversion factor for 2024 is $53.514 if meeting quality requirements ($52.476 otherwise)
- 2022 claims data and pre-pandemic cost report data through 2019 were used for OPPS and ASC rate-setting for 2024

Policy Updates for the 2024 Rule

The 2024 OPPS Final Rule:

- Updates and refines the requirements for hospitals to make public their standard charges in section XVIII.
    - Adds increased CMS enforcement of hospital price transparency regulations
    - Adds data elements, template options, and more specific display requirements
- Implements various expanded benefits following Presidential and legislative directives.
    - Rationale for new benefits are summarized in the OPPS and the MPFS Final Rules.
    - New codes/benefits for hospital outpatient CDM management include:
        - Community health integration services (G0019 & G0022)
        - Social determinants of health services (G0136)
        - Principal illness navigation services (G0023, G0024, G0140, & G0146)
- Caregiver training (96202, 96203, 97550, 97551, 97552); note that some of these codes are not reportable under OPPS
- Finalizes qualifications, service provision, and billing capabilities Mental Health Counselors and Marriage and Family Therapists under Medicare including:
    - Effective 1/1/24, Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs), including eligible Addiction, Alcohol, and Drug Counselors may enroll in the Medicare program for Part B (not OPPS) payment. (Enrollment is available immediately if qualification requirements are met.) CMS link: Provider Enrollment FAQ Sept 2023
    - RHC/FQHC permitted providers are expanded to include MHCs and MFTs
    - Hospice Conditions of Participation (CoPs) are also updated to add MFTs and MHCs as part of the team for Hospice
    - Finalizes the removal of discussion of the IPPS Medicare Code Editor (MCE) from the annual IPPS rule-making (beginning with the FY 2025 rulemaking)
- Outlines outlier policies for CMHCs in Section VIII. E.
- Finalizes a technical correction to the Rural Emergency Hospital (REH) CoPs under the standard for the designation and certification of REHs

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- Updates requirements for Quality Reporting Programs including:
  - The Hospital Outpatient Quality Reporting (OQR) Program
  - The ASC Quality Reporting (ASCQR) Program
  - The Rural Emergency Hospital Quality Reporting (REHQR) Program
- Publishes the 2024 OPPS Inpatient-Only list:
  - Removes no codes
  - Adds four new codes in the 2024 Rule language:
    - Adds one new code between 1Q24 and 4Q23
    - References three other new codes (implemented prior to 1Q24)
  - Discusses six product-specific applications (helpful for review if the products are dispensed/used in your organization)
- Updates Partial Hospitalization with:
  - Changes to the methodology used to calculate the Community Mental Health Center (CMHC) and hospital-based PHP (HB PHP) geometric mean per diem costs
  - Changes to expand PHP payment from two APCs to four APCs
- Establishes payment for intensive outpatient (IOP) services under Medicare beginning January 1, 2024
  - Finalizes changes to the CMHC CoPs to provide requirements for furnishing IOP services
- Updates drug payment policies with:
  - Setting 2024 payment of separately payable drugs at ASP + 6%
  - Setting 2024 payment of 340B-Acquired Drugs at ASP + 6%
  - Excepting biosimilars from the OPPS threshold packaging policy when their reference products are separately paid
- Finalizes clarification that Indian Health System (IHS) and tribal hospitals converting to Rural Emergency Hospital (REH) will:
  - Receive payment under the IHS all-inclusive rate (AIR)
  - Receive the REH monthly facility payment consistent with how this payment is applied to REHs that are not tribally or IHS-operated
- The 2024 OPPS Final Rule updates policies to allow supervision by Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists for Cardiac Rehabilitation, Intensive Cardiac Rehabilitation, and Pulmonary Rehabilitation Services Furnished to Hospital Outpatients
- Effective 1/1/24, CMS will exclude Intensive Cardiac Rehabilitation (ICR) from the 40 percent 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) so that 100 percent of the OPPS rate for CR is paid irrespective of the presence of the “-PN’’ modifier (signifying a service provided in a non-excepted off-campus provider-based department of a hospital) on the claim.
- Section V. C. lists details on requirements in the Physician Fee Schedule applicable to hospital outpatient departments and ASCs for reporting discarded amounts of certain single-dose or single-use package drugs
- The 2024 OPPS Final Rule changes the definition of Status Indicator “P” from “Partial Hospitalization” to “Partial Hospitalization or Intensive Outpatient Program”

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- Cancer Hospital Payment Adjustment 2024 updates:
  - Reduce the target payment-to-cost ratio (PCR) by one percentage point each calendar year until the target PCR equals the PCR of non-cancer hospitals
  - Use the most recently submitted or settled cost report data
  - Finalize a target PCR of 0.88 to determine the CY 2024 cancer hospital payment adjustment to be paid at cost report settlement. (i.e., the payment adjustments will be the additional payments needed to result in a PCR equal to 0.88 for each cancer hospital)

2023 Final Rule Key Topics

- RCH Overview: Last year's 2023 Final Rule key points of the new provider type of "Rural Emergency Hospitals" (REHs) may be helpful to re-review if more background is needed:
  - This provider type is available for hospitals converting from a critical access hospital (CAH) or a rural hospital with less than 50 beds that provides no acute care inpatient services
  - REH services include emergency department services and observation care and may also include other outpatient medical and health services
  - A 5% payment increase over the OPPS rate will be available to REHs
    - Medicare beneficiary copayments will not be influenced by the new 5% payment amount
  - Laboratory and certain other services such as PT, OT, SLP, and Audiology not paid as OPPS would continue to be paid under other CMS methods (CLFS, MPFS, etc.) and not considered REH services
    - These services are excluded from the 5% payment increase
  - CAH cost-based payment and 340B are given up under this new designation
  - A monthly facility payment of $272,866 will be available and will increase yearly based on the hospital market basket percentage increases
  - REHs have specific provider enrollment requirements outlined in the OPPS Final Rule
  - Rules related to REH Physician Self-Referral Laws are outlined in the rule related to compensation arrangements. Exceptions proposed related to investment interest and ownership were not finalized
  - REHs must follow specific quality reporting program requirements published in the rule
  - Payments for opioids and evidence-based non-opioid alternatives for pain management continue to be paid separately by CMS when exceeding the packaging threshold for OPPS. Section VIII. G. of the OPPS 2024 Final Rule discusses Opioid Use Disorder (OUD) modifications and policies.
    - Modifications for Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs) are listed in Section VIII. G.
    - Detailed policy updates are listed related to IOP services by OTPs in the 2024 OPPS Final Rule
  - Telemedicine guidance from the PHE extensions and later regulations continue within the 2024 rule.

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        - Remote (via telecommunications technology) and audio-only regulations for Behavioral Health Services were outlined in 2023 for patients in their homes following specific CMS-stated criteria. More detail related to behavioral health is in the 2024 OPPS Final Rule related to PHP and IOP services
- Provider based department (PBD) regulations continue to be discussed in the 2024 OPPS Final Rule
    - Section VII. discusses outpatient and critical care services in which CMS finalizes its 2024 proposal to continue to exempt excepted off-campus PBDs of rural SCHs from the clinic visit payment policy in CY 2024
        - In the CY 2023 OPPS Final Rule CMS adopted a policy that excepted off-campus provider-based departments (PBDs) (departments that bill the modifier "-PO" on claim lines) of rural Sole Community Hospitals (SCHs), are exempt from the clinic visit payment policy that applies a Physician Fee Schedule-equivalent payment rate for the clinic visit service, as described by HCPCS code G0463, when provided at an off-campus PBD
        - Section VIII. H. includes further language about 'Payment Rates Under the Medicare Physician Fee Schedule for Nonexcepted Items and Services Furnished by Nonexcepted Off-Campus Provider-Based Departments of a Hospital'
        - CMS specifically for 2024 finalized applying the CMHC PHP and IOP per diem rates as the MPFS rates for PHP and IOP services furnished by nonexcepted off-campus PBDs
- Non-physician practitioner supervision for Hospital and CAH diagnostic services to outpatients was clarified in the 2023 OPPS Final Rule with updated 'general' and 'personal' supervision definitions. Additional discussion about supervision is included in multiple parts of the 2024 Final Rules (OPPS and MPFS).
    - As noted in the 2023 quote below, CMS clarified certain regulatory language last year:

      We also are finalizing our proposal to revise § 410.28(e) for clarity so that certain nonphysician practitioners (nurse practitioners, physician assistants, clinical nurse specialists and certified nurse midwives) may supervise the performance of diagnostic tests to the extent they are authorized to do so under their scope of practice and applicable State law.

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- 2023 CMS changes related to Dental Services include the following. More updates and refinements were deployed in 2024:
    - G0330 was created for billing (only for OPPS claims) for the facility fee component of Medicare-covered dental rehab services requiring monitored anesthesia and an OR
    - CMS listed 41899 for covered non-surgical dental services not performed under Monitored anesthesia in an OR (where there is no other existing dental code assigned to an APC)
        - CMS specifically states that the more specific code should be used when available, so hospitals not familiar with Dental codes should be certain to consider them for 2024 and not solely rely on an unlisted surgical range CPT
    - To confirm paid Dental codes for 2024, use ChargeAssist® grids and view APC SIs and rates. I/OCE edits, when available, will also be helpful for masterfile analysis.

Summary

This manual section includes only a high-level overview of 2024 OPPS updates that may influence Charge Management decisions. We refer readers to our OPPS quantitative updates within this manual and suggest the use of the ChargeAssist® quarterly change modules to evaluate how OPPS reimbursement may impact your reimbursement and masterfile content.

All of the 2024 OPPS Final Rule source documentation and files can be accessed on the CMS website, in the Federal Register, or within the applicable ChargeAssist® modules and documentation.

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MPFS 2024 FINAL RULE HIGHLIGHTS

Key Final Rule Topics for Charge Management Teams

Background

CMS released the pre-publication Display Copy of the Medicare Physician Fee Schedule (MPFS) Final Rule on November 2, 2023, and formally published the rule on November 16, 2023. The PDF document is located on the CMS Federal Register website Federal Register MPFS Final Rule webpage and within the ChargeAssist® Document Center as a bookmarked Display Copy. CMS subsequently released its summary of the Final Rule on 11/22/23 as Transmittal 12372 Change Request 13452, also found within the Document Center.

The Final Rule includes the standard background section for those wishing to refresh their knowledge of the payment system fundamentals. The rule clarifies that payments under the Medicare fee schedule are based on Relative Value Units (RVU) for each CPT/HCPCS code multiplied by the annual CMS conversion factor. RVU values drive Medicare and other insurer fee schedule calculations.

Presenters at the CPT Symposium annually present not only CPT updates, but also an overview of the RBRVS payment system and CMS policy updates for the year. CPT Committees, CMS payment system teams, and medical specialty societies collaborate to create a fair and equitable payment and coding system through codes, RVU values, and final payment rules. The RVS Update Committee (RUC) develops and refines recommended weights for three components: work, practice expense (PE), and malpractice (MP) expenses.

Recommended RUC RVU work values and CMS Finalized work values are presented for each updated or new code set at the CPT Symposium. This year, there appeared to be more consistency in weights recommended by RUC and those finalized by CMS. The CMS final rule masterfiles reflect the finalized weights based on CMS' decision-making. CMS finalizes the process by publishing regionally-adjusted payment rates based on national uniform relative value units (RVUs) and a conversion factor based on available funds allocated in the National Budget.

For more background, we suggest that teams review the Final Rule, CMS Manual sections, or CMS website summaries. We also suggest that customers monitor Congressional Action that will modify the 2024 MPFS Payment system.

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2024 MPFS Payment Factors

A lower 2024 MPFS conversion factor of $32.7375 will result in an overall payment decrease of 3.4%, while the Anesthesia conversion factor of $20.4349 will result in a 3.3% decrease. The conversion factors are lower than the Proposed Rule conversion factors. (Note that congressional action may cause the conversion factor to change in late December, as we have seen in prior years.)

2024 MPFS Conversion Factors

2023 MPFS CF	2024 MPFS CF	$ change	% change
$33.8872	$32.7375	-1.1497	-3.4%
2023 Anesthesia CF	**2024 Anesthesia CF**	**% change**	**% change**
$21.1249	$20.4349	-0.6900	-3.3%

Many MPFS payment policies for 2024 are based on prior legislation and Presidential Executive Orders. Some updates extend select COVID-19 PHE flexibilities and congressional actions that extend certain benefits.

Policy Updates

Health Equity Initiatives Background

CMS states that the 2024 MPFS update policies focus on "…advancing health equity, bolstering commitment to behavioral health care, supporting family caregivers, promoting value-based care, and advancing the President's Cancer Moonshot..." As outlined in the 2024 MPFS Final Rule (and other payment system rules), additional codes and payment information are available for the new year, focused on improving health equity and caregiver support (based on Executive Order mandates). These policies are intended to further the agenda of the 2022 Biden Administration's priorities.

Policies supporting expanded benefits were introduced in 2023's MPFS Final Rule. Text from 2023 MLN Matters articles provide a high-level overview of CMS' intentions:

"On July 7, CMS issued the Calendar Year 2023 Physician Fee Schedule (PFS) proposed rule, which would significantly expand access to behavioral health services, Accountable Care Organizations (ACOs), cancer screening, and dental care— particularly in rural and underserved areas. These proposed changes (2023) play a key role in the Biden-Harris Administration's Unity Agenda — especially its priorities to tackle our Nation's mental health crisis, beat the overdose and opioid epidemic, and end cancer as we know it through the Cancer Moonshot — and ensure CMS continues to deliver on its goals of advancing health equity, driving high-quality, whole-person care, and ensuring the sustainability of the Medicare program for future generations."

CMS states: "…proposals expand access to vital medical services like behavioral health care, dental care, and cancer treatment options, all while promoting access, innovation, and cost savings in the Medicare program…Integrated coordinated, whole-person care — which addresses physical health, behavioral health, and social determinants of health — is crucial for people with Medicare, especially those with complex needs."

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The 2024 Final Rule outlines continued health equity initiatives aimed at both team-based and whole-person care under the "CMS Framework for Health Equity" in which the agency seeks to advance health equity as some of the goals comprising the April 2023 CMS National Quality Strategy (NQS) found here: *https://www.cms.gov/files/document/cms-national-quality-strategy-handout.pdf*

CMS explains its team-based direction in this narrative:
"…Community Health Integration, Social Determinants of Health (SDOH) Risk Assessment, and Principal Illness Navigation services to account for resources when clinicians involve certain types of health care support staff such as community health workers, care navigators, and peer support specialists in furnishing medically necessary care".

Codes are included in the new 2024 MPFS Final Rule for additional benefits and extended flexibilities to Medicare coverage policies. Additional payments and codes are summarized in the sections below. *(Note: See the end of this article for reference source links to policy information and programs.)*

Community Health Integration Services

As announced in CMS presentations of the 2024 Final Rule, Community Health Integration (CHI). New coding and payment focus on improving outcomes for the Medicare population to include services of community health workers as they provide:

- person-centered planning
- health system coordination
- promotion of patient self-advocacy
- facilitation of access to community-based resources

CMS states that coding and payment for these services address unmet social needs that interfere with practitioners' diagnoses and treatment of underserved Medicare patients. CMS' focus in regulatory/coverage language targets filling gaps in underserved communities by providing critical health care and social services. CMS hopes to expand equitable access to care through the Community Health Integration Services policies.

Applicable HCPCS Level II codes include: G0019 and G0022.

- G0019 - *Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (sdoh) need(s) that are significantly limiting the ability to diagnose or treat problem(s) addressed in an initiating visit: person-centered assessment, performed to better understand the individualized context of the intersection between the sdoh need(s) and the problem(s) addressed in the initiating visit. ++ conducting a person-centered assessment to understand patient's life story, strengths, needs, goals, preferences and desired outcomes, including understanding cultural and linguistic factors and including unmet sdoh needs (that are not separately billed). ++ facilitating patient-driven goal-setting and establishing an action plan. ++ providing tailored support to the patient as needed to accomplish the practitioner's treatment plan. practitioner, home-, and community-based care coordination. ++ coordinating receipt of needed services from healthcare practitioners,*

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providers, and facilities; and from home- and community-based service providers, social service providers, and caregiver (if applicable). ++ communication with practitioners, home- and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors. ++ coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities. ++ facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) to address the sdoh need(s). health education- helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, and preferences, in the context of the sdoh need(s), and educating the patient on how to best participate in medical decision-making. building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services addressing the sdoh need(s), in ways that are more likely to promote personalized and effective diagnosis or treatment. health care access / health system navigation. ++ helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care and helping secure appointments with them. facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals. facilitating and providing social and emotional support to help the patient cope with the problem(s) addressed in the initiating visit, the sdoh need(s), and adjust daily routines to better meet diagnosis and treatment goals. leveraging lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals (OPPS SI S Natl Rate $85.01; MPFS status code A, Work RVU 1.00)

New Code:

- G0022 - *Community health integration services, each additional 30 minutes per calendar month (list separately in addition to G0019) (OPPS SI N; MPFS status code A, Work RVU 0.70)*

Principal Illness Navigation Services & Social Determinants of Health

The 2024 MPFS Final Rule addresses new codes and payment for Principal Illness Navigation (PIN) services using personnel serving as patient navigators and peer support specialists who provide the patient with assistance with their serious high-risk condition or illness treatment.

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New Codes:

CMS labels the applicable PIN services that auxiliary personnel offer as "person-centered planning", with a focus on "promoting patient self-advocacy", and "facilitating access to community-based resources" to address the beneficiary's unmet social needs and other factors relevant to the diagnosis and treatment.

Other services in this new category of benefits are focused on the beneficiary's Social Determinants of Health (SDOH) needs. CMS created code G0136 for SDOH risk assessment.

- G0136 - *Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5-15 minutes (OPPS SI S National Rate $27.38; MPFS Status Code A, Work RVU 0.18)*

This code must be billed along with qualifying visit charges. Qualifying visits include E/M visits, select behavioral health visits, or the Medicare Annual Wellness Visit (AWV).
PIN services HCPCS Level II codes include G0023, G0024, G0140, and G0146.

- G0023 - *Principal illness navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator; 60 minutes per calendar month, in the following activities: person-centered assessment, performed to better understand the individual context of the serious, high-risk condition. ++ conducting a person-centered assessment to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors and including unmet sdoh needs (that are not separately billed). ++ facilitating patient-driven goal setting and establishing an action plan. ++ providing tailored support as needed to accomplish the practitioner's treatment plan. identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services. practitioner, home, and community-based care coordination. ++ coordinating receipt of needed services from healthcare practitioners, providers, and facilities; home- and community-based service providers; and caregiver (if applicable). ++ communication with practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors. ++ coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities. ++ facilitating access to community-based social services (e.g., housing, utilities, transportation, likely to promote personalized and effective treatment of their condition. health care access / health system navigation. ++ helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care, and helping secure appointments with them. ++ providing the patient with information/resources to consider participation in clinical trials or clinical research as applicable. facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals. facilitating and providing*

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social and emotional support to help the patient cope with the condition, sdoh need(s), and adjust daily routines to better meet diagnosis and treatment goals. leverage knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals (OPPS SI S, National Rate $85.01;MPFS Status Code A, Work RVU 1.00)

- G0024 - *Principal illness navigation services, additional 30 minutes per calendar month (list separately in addition to G0023) (OPPS SI N ; MPFS Status Code A, Work RVU 0.7)*
- G0140 - *Principal illness navigation - peer support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month, in the following activities: person-centered interview, performed to better understand the individual context of the serious, high-risk condition. ++ conducting a person-centered interview to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors, and including unmet sdoh needs (that are not billed separately). ++ facilitating patient-driven goal setting and establishing an action plan. ++ providing tailored support as needed to accomplish the person-centered goals in the practitioner's treatment plan. identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services. practitioner, home, and community-based care communication. ++ assist the patient in communicating with their practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, goals, preferences, and desired outcomes, including cultural and linguistic factors. ++ facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address sdoh need(s). health education. helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and sdoh need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making. building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition. developing and proposing strategies to help meet person-centered treatment goals and supporting the patient in using chosen strategies to reach person-centered treatment goals. facilitating and providing social and emotional support to help the patient cope with the condition, sdoh need(s), and adjust daily routines to better meet person-centered diagnosis and treatment goals. leverage knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals (OPPS SI S, $85.01 National Rate; MPFS Status Code A, Work RVU 1.00)*
- G0146 - *Principal illness navigation - peer support, additional 30 minutes per calendar month (list separately in addition to g0140) (OPPS SI N; MPFS Status Code A, Work RVU 0.70)*

Caregiver Training

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CMS 2024 MPFS summary presentations and Final Rule narrative also introduced another unique benefit for Medicare for caregiver-focused services. New codes were created by CPT to report practitioner (physician, NPP, or therapist) training of one or more of the beneficiary's caregivers to assist the patient with certain diseases or illnesses (e.g., dementia) in carrying out the practitioner's treatment plan. Codes include: 96202, 96203, 97550, 97551, 97552.

2023 New Codes:

- 96202- *Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); initial 60 minutes (OPPS SI; 2024 MPFS Status Code A, Work RVU 0.43)*

  - 96203- *Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); each additional 15 minutes (List separately in addition to code for primary service) (OPPS SI N 2024 MPFS Status Code A, Work RVU 0.12)*

2024 New Codes:

- 97550- *Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; initial 30 minutes (OPPS SI A; MPFS Status A, Work RVU 1.00)*

- 97551- *Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; each additional 15 minutes (List separately in addition to code for primary service) (OPPS SI A; MPFS Status A, Work RVU 0.54)*

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- 97552- *Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face with multiple sets of caregivers (OPPS SI A; MPFS Status A, Work RVU 0.23)*

Providers may include physicians, non-physician practitioners (nurse practitioners, clinical nurse specialists, certified nurse-midwives, physician assistants, and clinical psychologists), or therapists (physical therapist, occupational therapist, or speech language pathologist).

Behavioral Health Care Improvements

Continuing on the path stated in recent CMS rules, congressional bills, and Presidential orders, we see numerous new coding and payment options focused on improving patient access to behavioral health care. For reference to regulatory changes, see the 2023 and 2024 Final Rules for discussion or new benefit categories authorized by section 4121(a)(2) of the Consolidated Appropriations Act, 2023 (CAA).

- Effective 1/1/24, Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs), including eligible Addiction, Alcohol, and Drug Counselors may enroll in the Medicare program. (Enrollment is available immediately if qualification requirements are met.) CMS link: Provider Enrollment FAQ Sept 2023
    - Payment is made for these services at 80 percent of the lesser of the actual charges for the services or 75 percent of the amount determined under the PFS for services of a clinical psychologist (CP)
    - Hospice Conditions of Participation (CoPs) are also updated to add MFTs and MHCs as part of the team for Hospice.

Effective 1/1/24 an increase in payments is available for crisis care, substance use disorder treatment, and psychotherapy (including psychotherapy in conjunction with office visit and Health Behavior Assessment and Intervention.)

- Two new codes will be provided for payment for psychotherapy for crisis services furnished in an applicable site of service:
    - G0017 - *Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting); first 60 minutes (OPPS SI M; MPFS Status Code A, Work RVU 4.70)*
    - G0018 - *Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting); each additional 30 minutes (List separately in addition to code for primary service (OPPS SI M; MPFS Status Code A, Work RVU 2.25)*

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- Health Behavior Assessment and Intervention (HBAI) Services (CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168) will be allowed to be provided by those other than Clinical Psychologists (CPs) (including MFTs and MHCs and Clinical Social Workers (CSWs)).
- Payment increases were finalized for behavioral health services. Payment increases of 19.1% will be implemented over a four-year transition period. Codes impacted include standalone psychotherapy services, psychotherapy codes billed as an add-on to an E/M visit (90833, 90836, and 90838), and HBAI services (90833, 90836, and 90838).
- The payment rate for Substance Use Disorder (SUD) bundled HCPCS codes, G2086 and G2087, (both established 1Q20) have been increased to reflect two psychotherapy sessions per month.
  - There is also an add-on code for each additional 30 minutes not impacted by this change

Code	Description	OPPS SI	OPPS	MPFS Status	Work RVU
G2086	Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month	S	152.07	A	8.36
G2087	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month	S	152.07	A	8.19
G2088	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (list separately in addition to code for primary procedure)	N		A	0.82

Telehealth Extended Flexibilities

We suggest a detailed review of CMS policy updates relating to telemedicine. This program provides limited content on CMS and CPT telemedicine and telehealth rules. During the COVID-19 PHE, telehealth was a highly-successful modality for many patients and healthcare providers. Now that the PHE has ended, legislative updates have allowed the extension of certain flexibilities. The CAA of 2023 included provisions that extend certain Medicare telehealth flexibilities adopted during the COVID-19 PHE for 151 days after the end of the PHE. The MPFS Final Rule addresses both the historical methodologies of maintaining the telehealth benefit and new methodologies for long-term post-pandemic maintenance.

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Medicare Telehealth Services are added or deleted each year for CMS telehealth coverage based on a defined regulatory process. The finalized Telehealth codes are published on the Telehealth Services List. See section II. D. for updates to telehealth policies under the MPFS Final Rule or the CMS Telehealth website:

https://www.cms.gov/medicare/coverage/telehealth/list-services

The list of 2024 Medicare-covered telehealth codes includes CPT/HCPCS codes, short CPT/HCPCS descriptors, 'Audio-Only' indicator, and the regulatory category of 'provisional' or 'permanent'. As seen in the 2024 Final Rule Table 11, new health and well-being coaching codes (0591T-0593T) have been added in addition to the new social determinant of health (SDOH) assessment code G0136 (Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment tool, 5-15 minutes) to the permanent list of codes.

The 2024 Final Rule confirms that CMS will provide payments at the non-facility rate when providers perform telehealth to patients who are located in their homes. Referred to as a 'rate-lock,' the policy will continue through the end of 2024. CMS placed its proposed "home enrollment requirement" on hold until the end of 2024, stating that: *"…we will continue to permit the distant site practitioner to use their currently enrolled practice location instead of their home address when providing telehealth services from their home…"*

"Virtual presence waivers" were also extended to December 31, 2024. The waivers allow a supervising physician to provide direct supervision and a teaching physician to be present by a 2-way audio & video connection. CMS finalized a definition of direct supervision to permit the immediate availability of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2024. The rule states that CMS' intention was to avoid an "abrupt transition from approaches allowed during the COVID PHE's flexibilities and waivers."

Hospital-specific CMS Telehealth Policies

For CY 2024, the final payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or $29.96. As noted in the Final Rule for 2024, physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), diabetes self-management training (DMST) and medical nutrition therapy (MNT) remotely-furnished services that remain on the Medicare Telehealth Services List, shall continue to be allowed to be billed.

Two exceptions to past policy include:

- For outpatient hospital billing, beneficiaries' homes no longer need to be registered as provider-based entities.
- Modifier -95 is required on claims from all providers except Critical Access Hospitals (CAHs) electing Method II.

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DMST Telehealth Services

As of 2024 policies, DSMT telehealth can be provided by RDs and Nutritional Professionals, Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists. The new language specifies that they may bill "on behalf of others who personally provide the services as part of the DSMT entity."

Insulin injection training can continue to be provided by telehealth based on the 2024 policy. Revised criteria for providers are listed in the new CMS policy listed in Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, section 190.3.6, replacing the "in-person hours of training" requirement of the past.

It should also be noted that the 2024 MPFS Final Rule also includes changes to the Medicare Diabetes Prevention Program (MDPP) by enhancing the Expanded Model. Also, to improve access to Diabetes Self-Management Training (DSMT) services, in 2024, CMS is amending its regulations to clarify that an RD or nutrition professional must personally perform MNT services. However, the enrolled RD or nutrition professional may bill for, or on behalf of, the entire DSMT entity as the DSMT-certified provider, regardless of which professional personally delivers the service.

E/M Visit Policy Updates for MPFS

Section F., beginning on page 421 of the Display Copy, outlines background and new policies for Evaluation and Management (E/M) visit coding and payment. Since E/M visits represent nearly 40% of all allowed MPFS charges, CMS has been working with AMA and other groups to make this family of codes more appropriately-paid, more representative of the current practice of medicine, and less complex.

Two primary sections are discussed in the MPFS Final Rule for 2024: E/M visit complexity add-on code for separate payment and 2) definition of split (or shared) visits (delayed in 2023 Final Rule).

Add-on Visit Complexity Code

G2211 became effective in January of 2021. For 2024, this code changes from Bundled to Active status under MPFS. The code and long descriptor are:

G2211 - *Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition (OPPS SI B)*

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The relationship between the practitioner and patient is key for the use of the G2211 code. CMS examples include:

- If the practitioner is the focal point for all needed services, such as a primary care practitioner
- If the practitioner is part of ongoing care for a single, serious and complex condition (such as sickle cell disease)).

CMS notes in the Final Rule that it anticipates this new code to initially be reported on approximately 38% of all office visit codes, rising to over half of all office visit claims when the industry fully-adopts this add-on reporting concept. Professional Fee Charge Master /Fee Schedule files, charge capture tools, and work processes will need to be addressed for immediate reporting of this new code on January 1, 2024, for MPFS payment. Note that when modifier 25 is applicable, G2211 is not payable.

Split or Shared Services Policy

CMS policy language on split or shared E/M visits refers to visits provided partly by physicians and partly by other non-physician practitioners (NPPs). The policy is specific to services provided in hospitals and other institutional settings.

The AMA definition of the “substantive portion” for a split or shared visit will be adopted by CMS. The Final Rule states:

> "*Specifically, for CY 2024, for purposes of Medicare billing for split (or shared) services, the definition of "substantive portion" means more than half of the total time spent by the physician and NPP performing the split (or shared) visit, or a substantive part of the medical decision making [MDM] as defined by CPT".*

The Final Rule notes that split or shared critical care services will follow Medicare's time-based rules.

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Dental /Oral Health Service Payment Changes

The MPFS Final Rule implements prior CY 2023 coverage expansion for dental services in certain circumstances. The 2023 policy expanded coverage to include dental service payment for "Services Inextricably Linked to Other Covered Services". (Remember that prior CMS Part A and Part B policies precluded payment for expenses incurred for items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth.)

Section K of the MPFS Final Rule outlines the expanded CMS dental service coverage policy and further defines the examples of "inextricably linked services". The 2024 MPFS Final Rule finalizes these areas:

- To permit payment for certain dental services inextricably linked to other covered services used to treat cancer prior to or contemporaneously with:
  - Chemotherapy services;
  - Chimeric Antigen Receptor T- (CAR-T) Cell therapy; and,
  - The use of high-dose bone modifying agents (antiresorptive therapy).
- Codification of and amendments to the previously finalized payment policy for dental services prior to, contemporaneously with, and/or after treatment of head and neck cancer using radiation, chemotherapy, surgery, or any combination of these, whether primary or metastatic.

Numerous comments are included in the Final Rule related to policy revisions. In the end, CMS notes that in addition to its clarifications, that MACs have the flexibility to determine whether a patient's circumstances fit in the terms of the expanded policy.

The take-away for CDM and Revenue Integrity teams is to be aware of expanded 2023 coverage rules and additional claims editing that may occur for select dental services. Payment indicators in both the HCPCS file and the MPFS file have been updated due to expanded coverage rules. CMS notes that CDT coding is paid under contractor pricing. The MPFS relative value file indicators will include refinements to accommodate new coverage rules. CMS notes in the Final Rule that in August 2023, it issued guidance (CR 13323) announcing new dental specialty codes that dentists may use beginning on January 2, 2024.

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New specialty codes include:

- E3 – Dental Anesthesiology
- E4 – Dental Public Health
- E5 – Endodontics
- E6 – Oral and Maxillofacial Pathology
- E7 – Oral and Maxillofacial Radiology
- E9 – Oral Medicine
- F1 – Orofacial Pain
- F2 – Orthodontics and Dentofacial Orthopedics
- F3 – Pediatric Dentistry,
- F4 – Periodontics
- F5 – Prosthodontics

MPFS Final Rule Comments on Part B Drug Payment Policies

Section III. A. addresses Drugs and Biologicals under Part B with a lengthy publication of public comments and CMS responses. Select provisions from the August 2022 Inflation Reduction Act impact beneficiary out-of-pocket costs and payment limits for various drug policy areas. Multiple sections of regulatory language will be updated with the finalized language previously proposed in the rule related to drug payments.

Discussion of policy and definitions related to Part B self-administered drug policies are noted in the Final Rule with no specific changes to policy. Another section discusses requiring manufacturers to provide refunds to CMS for waste for single-dose container or single-use package drugs implemented through the 2021 Infrastructure Investment and Jobs Act.

Payment for Vaccines

The MPFS Final Rule announces that pneumococcal, influenza, and hepatitis B vaccines provided in the patient's home will be reimbursed the same amount as the COVID-19 vaccine currently set at $40.

2024 MPFS Therapy Services Updates

Supervision Policy for Private Practice PTs & OTs

As noted in the MPFS Final Rule, private practice therapy assistants have required direct supervision from PTs and OTs since 2005. For 2024, CMS will now allow general supervision in the PT and OT Private Practice setting specifically for Remote Therapeutic Monitoring services. Watch for future expansion of this policy to other therapy services as CMS allows even greater flexibilities over time.

- General supervision- therapists are not required to be present in the office suite while their assistants provide RTM services.
- Direct supervision- therapists not enrolled in Medicare or working as employees of therapists in private practice are still required to provide RTM services under direct supervision

2024 PT & OT Threshold Amounts

The -KX modifier threshold amounts were updated for 2024 at $2,330 for OT and $2,330 for PT and SLP services combined.

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RHC & FQHC

Section III. B. discusses payment policies for Rural Health Clinics and Federally Qualified Health Centers. 2024 MPFS Final Rule mandates the update of Rural Health Clinic (RHC) and Federally Qualified Health Clinic (FQHC) Conditions for Certification and Conditions for Coverage (CfCs). As noted in prior sections and potentially of interest to RHC and FQHCs, the Final Rule codifies provisions for RHC and FQHC allowing MFTs and MHCs to become eligible practitioners (when meeting all requirements). When MFTs and MCH provide the services described in HCPCS code G0323 in an RHC or FQHC, the RHC or FQHC can bill HCPCS code G0511.

CMS policies for RHC and FQHCs extend the definition of direct supervision to permit virtual presence in RHCs and FQHCs through December 31, 2024. (See section II.D.2.a. for discussions on direct supervision for services. (For additional information, the "incident to" policy for RHCs and FQHCs is discussed in Pub. 100-02, chapter 13, section 120.1.) The Final Rule notes direct supervision of RHC and FQHC services does not require the physician to be present in the same room. However, the physician must be in the RHC or FQHC and immediately available to provide assistance and direction throughout the time the incident to service or supply furnished.

CMS also finalized allowing counselors to enroll in Medicare as an MHC if they meet all applicable requirements of clinical supervision experience in mental health counseling (and are licensed or certified by the State).

AUC Pause

Section J. beginning on page 1319 of the Display Copy outlines new policies pausing implementation of the Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging. As noted in the Final Rule, the AUC was required through 2014 PAMA regulations (Protecting Access to Medicare Act). Education and operations testing phases have already begun for AUC. However, as noted in the 2024 Final Rule CMS paused implementation of the AUC program for reevaluation and rescinded its current AUC regulations. The reasoning behind the pause was CMS' inability to manage system editing and difficulty in reaching accurate use of the system by ordering physicians who are often unrelated to the providing department/imaging centers. CMS notes that it welcomes providers to continue using AUC voluntarily to "streamline and enhance decision making in clinical practice and improve quality of care".

Summary

As noted earlier, it is essential to review all regulatory updates for the new year to ensure appropriate implementation of new benefits, new codes, and new payment concepts. The Final Rule and supporting CMS guidance will outline more detailed guidance.
Watch for the typical Congressional challenge to payment cuts finalized by CMS.

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Exhibit - Display Copy Version Contents MPFS 2024 Final Rule

- Background (section II.A.)
- Determination of PE RVUs (section II.B.)
- Potentially Misvalued Services Under the PFS (section II.C.)
- Payment for Medicare Telehealth Services Under Section 1834(m) of the Social Security Act (the Act) (section II.D.)
- Valuation of Specific Codes (section II.E.)
- Evaluation and Management (E/M) Visits (section II.F.)
- Geographic Practice Cost Indices (GPCI) (section II.G.)
- Payment for Skin Substitutes (section II.H.)
- Supervision of Outpatient Therapy Services, KX Modifier Thresholds, Diabetes Self-Management Training (DSMT) Services by Registered Dietitians and Nutrition Professional, and DSMT Telehealth Services (section II.I.)
- Advancing Access to Behavioral Health Services (section II.J.)
- Policies on Medicare Parts A and B Payment for Dental Services Inextricably Linked to Specific Covered Services (section II.K.)
- Drugs and Biological Products Paid Under Medicare Part B (section III.A.)
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (section III.B.)
- Conditions for Certification or Coverage (CfCs) (section III.C.)
- Clinical Laboratory Fee Schedule: Revised Data Reporting Period and Phase-in of Payment Reductions (section III.D.)
- Pulmonary Rehabilitation, Cardiac Rehabilitation and Intensive Cardiac Rehabilitation
- Expansion of Supervising Practitioners (section III.E.)
- Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD)
- Treatment Services Furnished by Opioid Treatment Programs (OTPs) (section III.F.)
- Medicare Shared Savings Program (section III.G.)
- Medicare Part B Payment for Preventive Vaccine Administration Services (section III.H.)
- Medicare Diabetes Prevention Program Expanded Model (section III.I.)
- Appropriate Use Criteria for Advanced Diagnostic Imaging (section III.J.)
- Medicare and Medicaid Provider and Supplier Enrollment (section III.K.)
- Expand Diabetes Screening and Diabetes Definitions (section III.L.)
- Requirement for Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD Plan (section 2003 of the SUPPORT Act) (section III.M.)
- Changes to the Regulations Associated with the Ambulance Fee Schedule and the Medicare Ground Ambulance Data Collection System (GADCS) (section III.N.)
- Hospice: Changes to the Hospice Conditions of Participation (section III.O.)
- RFI: Histopathology, Cytology, and Clinical Cytogenetics Regulations under the Clinical Laboratory Improvement Amendments (CLIA) of 1988 (section III.P.)
- Changes to the Basic Health Program Regulations (section III.Q.)
- Updates to the Definitions of Certified Electronic Health Record Technology (section III.R.)
- Social Determinants of Health Risk Assessment in the Annual Wellness Visit (section III.S.)
- Updates to the Quality Payment Program (section IV.)
- Collection of Information Requirements (section V.)
- Response to Comments (section VI.)
- Regulatory Impact Analysis (section VII.)

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Quantitative Overview of Code Changes

1Q24 Code Totals

18,420	Codes as of 11/19/23 (4Q23)
505	New 1Q24
107	Deleted 1Q24
18,818	Total projected codes for 1Q24
+398	**Variance 1Q24 vs 4Q23**

ChargeAssist® Change Totals

This program's code totals are based on 1Q24 data files as of 11/13/23. ChargeAssist® data included CPT-4® licensed data, all HCPCS Level II codes from CMS, and CDT® (Dental) Codes. *(Note: Later-year changes may occur following program development. Monitor ChargeAssist® for current codes and totals.)*

- **1Q24 Code Additions - 505 Codes**
  - 148 CPT range codes:
    - 66 Category I codes
    - 0 Category II codes
    - 63 Category III codes
    - 19 PLA codes
    - 0 MAAA codes
  - 357 HCPCS Level II codes:
    - 75 new A-range supply codes
    - 21 new C Medicare-specific range codes
    - 14 ADA Dental codes
    - 15 new E-range DME codes
    - 13 new G-range codes*
    - 33 new J-range drug & biological codes
    - 3 new L-range Prosthetic/Orthotic range codes
    - 160 new M range quality measure codes
    - 23 new Q range codes (3 pharmacy supplying fee, 19 skin substitute codes, 1 biosimilar code)
  - Late-publication CMS corrections:
    - Three additional new G range codes were added in late November (G9886, G9887, G9888)
    - One new 1Q24 code, C7561, was identified as not intended to be released by CMS in early December.
    - One new 1Q24 code, J1246, was identified as not intended to be released by CMS in a 12/7/23 HCPCS update.

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1Q24 Code Deletions –118 Codes

- 33 CPT range codes:
  - 1 CPT Level I code
  - 31 Category III codes
  - 0 PLA codes *(note: PLA deletions noted in the CPT Symposium were 2023 deletions; no deletions shown to date in CPT data)*
  - 1 MAAA codes
- 74 deleted HCPCS Level II codes:
  - 11 deleted C Medicare-specific range codes
  - 32 deleted G-range codes
  - 1 deleted J-range drug & biological codes
  - 25 deleted K-range DME codes
  - 3 deleted M-range quality measure codes
  - 2 deleted S-range codes

User tip: Consider ChargeAssist® deleted code X-Ref notes, associated new codes, and any related codes' description changes within the code family.

- **1Q24 Description Changes - 118 Codes**
  - 12 Grammatical
  - 106 Content
    - Content change breakdown:
      - 55 CPT range codes:
        - 41 CPT Level I code
        - 1 Category II code
        - 13 Category III codes
      - 51 HCPCS Level II codes:
        - 7 A-range supply codes
        - 31 G-range codes*
        - 1 J-range drug & biological codes
        - 10 M-range quality measure codes
        - 1 Q-range codes
        - 1 S-range codes
        - 1 T-range code
    - Late-publication CMS corrections:
      - A content description change was added by CMS in late November to G0323
      - Two content description changes were added by CMS in early December (A6593 and Q2052)
      - Two content description changes were added by CMS on 12/7/23 (C7900 and C7901)

User tip: Consider the associated ChargeAssist® Auditor Notes to evaluate verbiage changes from 4Q23 to 1Q24 to code descriptors. Ensure charge data, pricing, associated units, charge capture methods, and associated systems/masterfiles that may be impacted. (Evaluate all related code family changes including new and deleted codes.)

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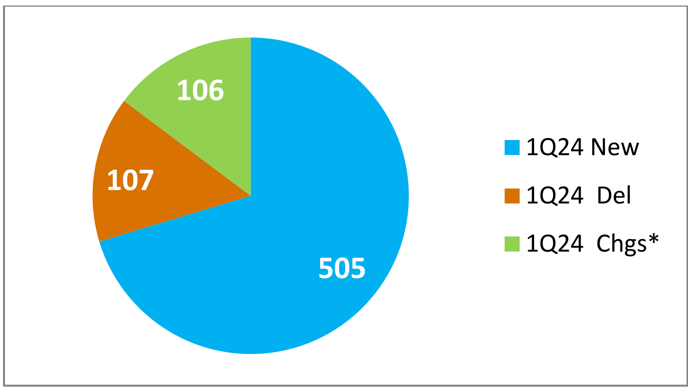
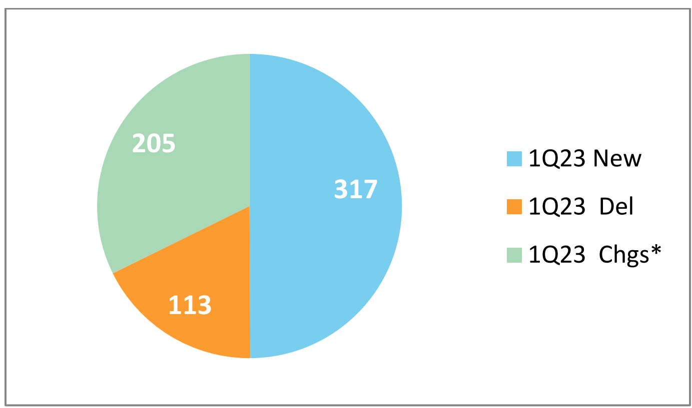
1Q24 vs. 1Q23 Code Updates *(as of mid-November 2023)*

1Q24:



1Q23:



1Q24 vs 1Q23

	CPT	HCPCS (incl Dental)	Total
1Q24 New	148	357	505
1Q24 Del	33	74	107
1Q24 Chgs*	55	51	106
1Q24 Tot	**236**	**482**	**718**
1Q23 New	110	207	317
1Q23 Del	66	47	113
1Q23 Chgs*	93	112	205
1Q23 Tot	**269**	**366**	**635**

*content changes only

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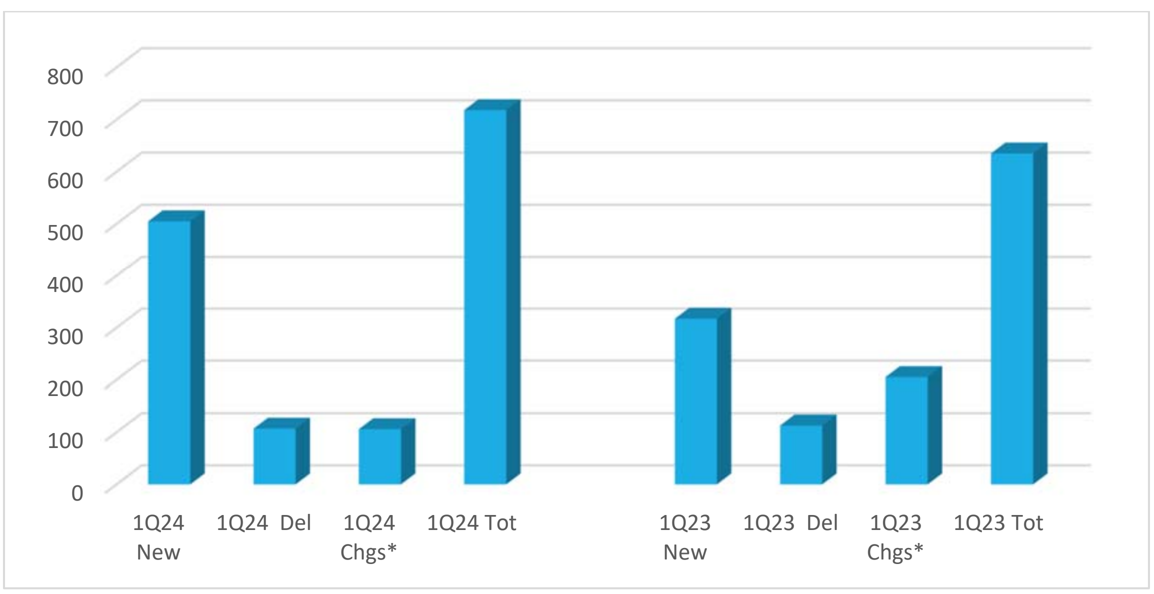
1Q24 vs. 1Q23 Code Updates



CPT
HCPCS (incl Dental)

600
500
400
300
200
100
0

	CPT	HCPCS (incl Dental)
1Q24 New	148	357
1Q24 Del	33	74
1Q24 Chgs*	55	51
1Q24 Tot	236	482
1Q23 New	110	207
1Q23 Del	66	47
1Q23 Chgs*	93	112
1Q23 Tot	269	366

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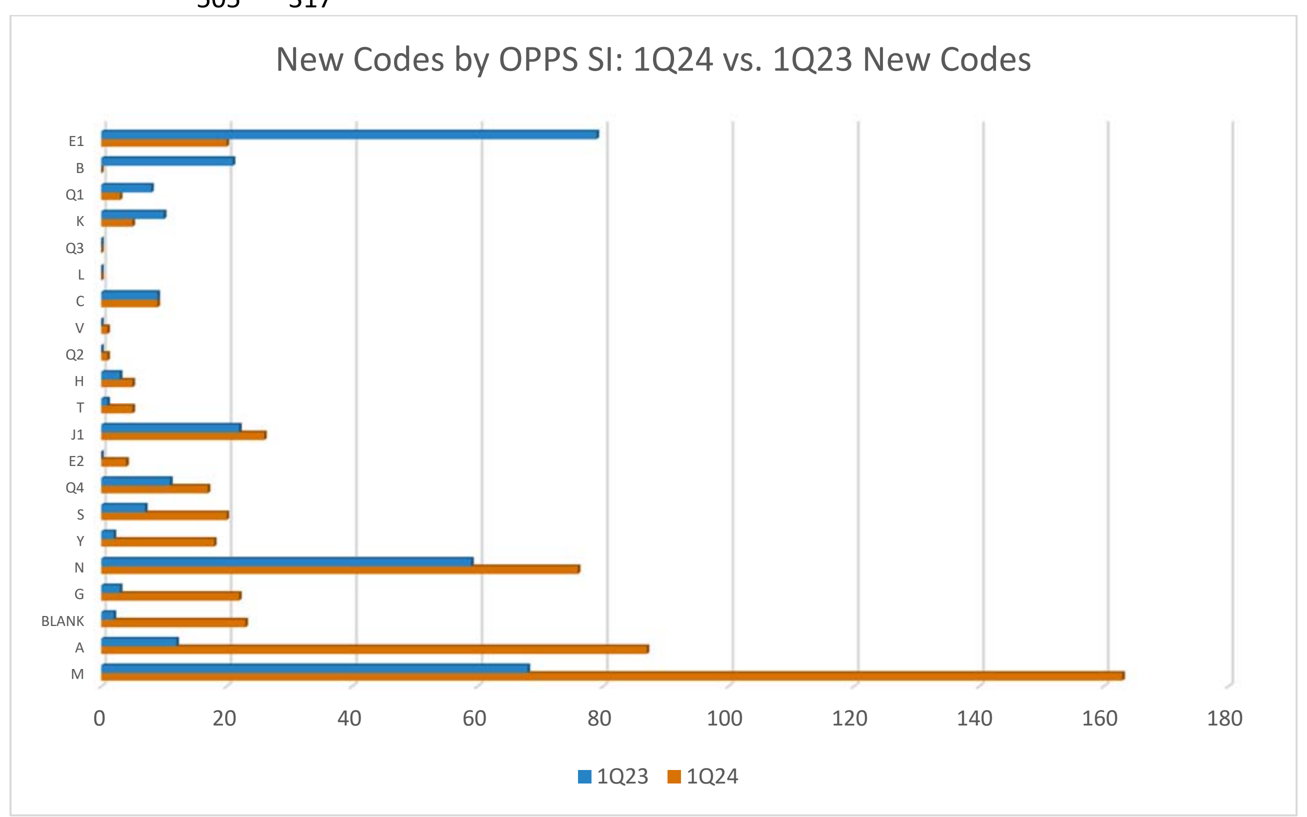
2024 New Codes by OPPS SI

	1Q24	1Q23	Year to Year Variance
M	163	68	95
A	87	12	75
BLANK	23	2	21
G	22	3	19
N	76	59	17
Y	18	2	16
S	20	7	13
Q4	17	11	6
E2	4	0	4
J1	26	22	4
T	5	1	4
H	5	3	2
Q2	1	0	1
V	1	0	1
C	9	9	0
L	0	0	0
Q3	0	0	0
K	5	10	-5
Q1	3	8	-5
B	0	21	-21
E1	20	79	-59
	505	317	



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Code Change Totals

The charted and displayed code change totals are based on annual totals of the active code set as of the first of each year (1Q23 vs 1Q24) (not quarter to quarter). Code updates occur throughout the year, as triannual, quarterly, semiannual, and ad hoc changes. Monitor sources closely for off-schedule code updates, errata documents or corrections from CMS.

As we note multiple times in this educational program, counts and change totals will not coincide with the hardcopy publication cycle of CPT-4® and other publishers' materials.

Coding Update Strategies

Some code changes will be present in your Charge Master file(s), while others may not. Remember that 'hard coded' CPT-4® and HCPCS Level II Codes are the focus of CDM annual updates in CDM tools. However, coding, practice management, and charge capture staff may need to be aware of more general changes to code sections that are not within your CDM.

Changes may or may not impact charge capture, pricing, or CDM data. All code changes that apply to your services, inventory, charging, coding, or claims processing environment require analysis for a complete annual update process.

If new to CDM updates, we advise obtaining orientation to key Charge Management aspects. This can be provided through articles and education provided by the Panacea Healthcare Solutions team. Orientation for staff new to CDM updates should include (at a minimum):

- HIS applications and master file orientation
- CPT-4®/HCPCS coding basics
    - Code usage guidelines
    - Strategies for coding changes and charge data
    - CPT publication considerations
- Proper use of AMA resources
- Understanding payer mix and claims requirements
- Understanding various insurers' payment policies
- Payer claims edits and rules
    - Understanding when certain codes are used/not used or overridden by alternative codes
- Orientation to ChargeAssist® resources for Charge Master data and overall Charge Management

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CPT-4® / HCPCS Level II Code Changes

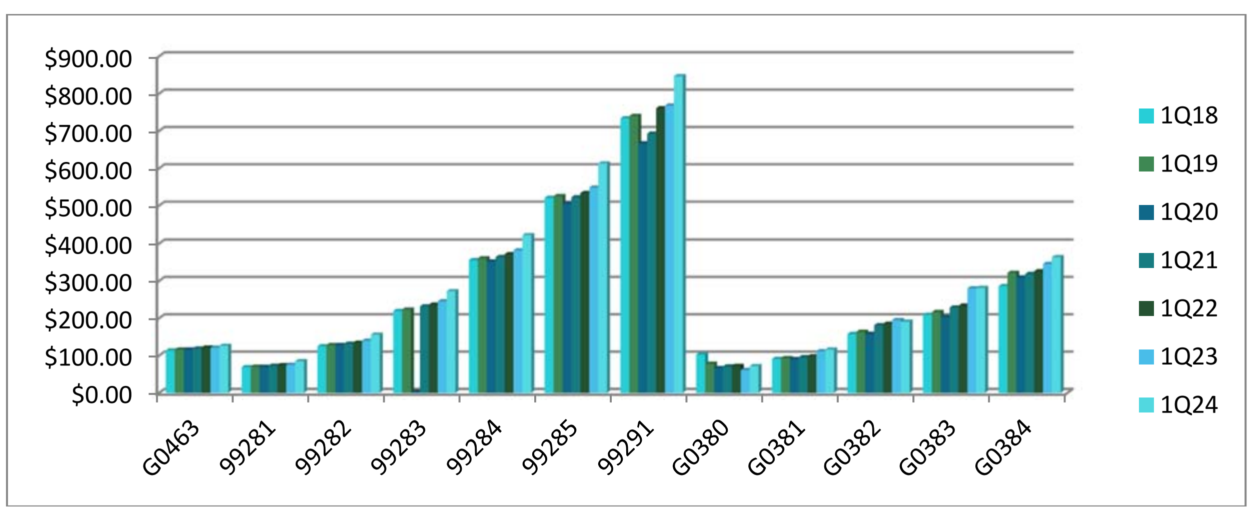
Code Section & Department-Specific 1Q24 Code Changes

Evaluation & Management

Agenda

- Trends for OPPS payment for ER and outpatient visits
- E/M and other visit code updates
- Payment for Visit Complexity (G2211) begins 01/01/2024
- Other E/M code description revisions

Trends for National OPPS Rates for Visit Codes for Hospitals



OPPS National Rates for E/M Facility Codes

E/M Facility Codes	1Q17	1Q18	1Q19	1Q20	1Q21	1Q22	1Q23	1Q24
G0463	$106.56	$113.68	$115.85	$115.92	$118.74	$121.35	$120.86	126.08
99281	$61.34	$68.66	$69.73	$69.61	$72.60	$74.08	$75.09	84.68
99282	$111.42	$124.65	$127.96	$127.95	$131.59	$134.15	$139.69	155.99
99283	$201.17	$219.10	$222.99	$3.00	$231.60	$236.35	$245.03	272.14
99284	$332.27	$355.50	$360.37	$351.75	$363.74	$371.52	$381.61	422.44
99285	$488.53	$520.81	$525.30	$504.46	$522.12	$533.27	$548.11	612.63
99291	$686.87	$733.58	$740.02	$666.58	$692.68	$760.74	$767.72	846.36
G0380	$85.09	$102.49	$77.84	$66.06	$70.54	$72.14	$61.17	71.54
G0381	$75.54	$90.81	$92.84	$90.38	$95.41	$97.75	$111.43	116.17
G0382	$124.95	$157.65	$163.66	$157.82	$180.97	$184.86	$194.71	190.78
G0383	$178.47	$209.00	$216.40	$202.91	$228.59	$233.55	$279.72	280.95
G0384	$367.73	$285.86	$321.27	$308.94	$318.39	$325.47	$345.14	363.55

Source: ChargeAssist® OPPS rate file. The above rates are National OPPS rates. Providers should view wage-adjusted rates for exact reimbursement information.

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Evaluation and Management Code Updates

- As noted in the past training materials, changes in the Evaluation and Management (E/M) code set date back to the 2020 MPFS Final Rule and have continued annually.
- 2024 Final updates from the American Medical Association (AMA) include;
    - Removing the time ranges from the office and outpatient (O/O) code set to a single time of X minutes must be met or exceeded. This now provides consistency between the AMA code set and CMS Policy.
    - The definition “substantive portion” of a split/shared E/M visit in which a physician and a non-physician practitioner work jointly to furnish all the work related to the visit has been refined.
    - Instructions for reporting hospital inpatient or observation care services and admission and discharge services using codes 99234-99236 when the patient stay crosses two calendar dates.
- During the CPT Symposium, the AMA staff and the Medicare Medical Directors reminded everyone that a medically appropriate history and/or physical examination is required for all E/M code sets.
- There are numerous guideline updates in these sections, and we encourage users to review them carefully in order to properly select the E/M code.

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Office or Other Outpatient Services

99202-99215

- This section has time range revisions and code deletions for CDM maintenance.

Code	Description
★▲99202	**Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15~~-29 minutes of total time is spent on the date of the encounter~~ minutes must be met or exceeded.
★▲99203	**Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30~~-44 minutes of total time is spent on the date of the encounter~~ minutes must be met or exceeded.
★▲99204	**Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45~~-59 minutes of total time is spent on the date of the encounter~~ minutes must be met or exceeded.
★▲99205	**Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60~~-74 minutes of total time is spent on the date of the encounter~~ minutes must be met or exceeded.
★▲99212	**Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10~~-19 minutes of total time is spent on the date of the encounter~~ minutes must be met or exceeded.
★▲99213	**Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20~~-29 minutes of total time is spent on the date of the encounter~~ minutes must be met or exceeded.
★▲99214	**Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30~~-39 minutes of total time is spent on the date of the encounter~~ minutes must be met or exceeded.
★▲99215	**Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40~~-54 minutes of total time is spent on the date of the encounter~~ minutes must be met or exceeded.

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Initial & Subsequent Nursing Facility Care

99306 & 99308

- This section has total time revisions.
- The total-time threshold for codes 99306 & 99308 have been revised based on feedback from the AMA/Specialty Society Relative Value Scale (RVS) Update Committee (RUC).

Code	Description
▲99306	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, ~~45~~50 minutes must be met or exceeded.
★▲99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, ~~15~~20 minutes must be met or exceeded.

Other Evaluation and Management Services

- A new code was created to report pelvic examinations.
- This is an Add-on code to be used in conjunction with 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99383, 99384, 99385, 99386, 99387, 99393, 99394, 99395, 99396, 99397.
- This code represents the practice expense (additional resources) for the exam.

#+● 99459 Pelvic examination (List separately in addition to code for primary procedure)

►(Use 99459 in conjunction with 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99242, 99243, 99244, 99245, 99383, 99384, 99385, 99386, 99387, 99393, 99394, 99395, 99396, 99397)◄

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Medicare Visit Complexity Add-on Payment

(Code G2211)

Beginning 01/01/2024, Medicare will begin paying for visit complexity with a code for Office/Outpatient Evaluation and Management (O/O E/M).

G2211 was established in 2021. However, CMS assigned RVU status B at that time.

- G2211 - Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established).
- This is an Add-on code to be used with O/O E/M visit primary service codes (99202-99205, 99211-99215)
- The A/B MACs (A & B) shall not pay code G2211 on the same date of service as an office/outpatient evaluation and management visit (codes 99202-99205, 99211-99215) reported with Modifier 25 to the same beneficiary by the same practitioner or nonphysician practitioner.
- See https://www.cms.gov/files/document/mm13272-edits-prevent-payment-g2211-office/outpatient-evaluation-and-management-visit-and-modifier.pdf for more detailed information.

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Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service

- This section has guideline revisions only.
- Code 99417 is used to report prolonged total time (i.e., combined time with and without direct patient contact) provided by the physician or other qualified health care professional on the date of office or other outpatient services, office consultation, or other outpatient evaluation and management services an additional CPT code was added to the published guidelines – 99483, Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home.
- The guideline for calculating the time for 99417 and 99418 now states, "may be added once the time threshold required for the primary E/M code has been surpassed by 15 minutes". This aligns with the O/O time change from a range to a threshold.

Reporting Prolonged Services

Primary Code	Prolonged Services Code	Total Time to Report Initial Unit of Prolonged Services	Total Time to Report Second Unit of Prolonged Services
99205	99417	75	90
99215	99417	55	70
99223	99418	90	105
99233	99418	65	80
99236	99418	100	115
99245	99417	70	85
99255	99418	95	110
99306	99418	65	80
99310	99418	60	75
99345	99417	90	105
99350	99417	75	90
99483	99417	75	90◄

Note: See below for Medicare coding and reporting Prolonged Services

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Medicare Prolonged Services Coding and Reporting

Medicare Prolonged Services – Office or Outpatient - with or without direct patient contact

- No change for HCPCS Code G2212: Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional. AMA and CMS are now using the same time standard.
  - List separately in addition to CPT codes 99205, 99215, 99483 for office or other outpatient E/M services.
  - Don't report G2212 for less than 15 additional minutes.

Medicare Prolonged Services – Inpatient or Observation or Nursing Facility

Primary E/M Service	Prolonged Code*	Time Threshold to Report Prolonged	Count physician/NPP time spent within this time period (surveyed timeframe)
Initial IP/Obs. Visit (99223)	G0316	90 minutes	Date of visit
Subsequent IP/Obs. Visit (99233)	G0316	65 minutes	Date of visit
IP/Obs. Same-Day Admission/Discharge (99236)	G0316	110 minutes	Date of visit to 3 days after
IP/Obs. Discharge Day Management (99238-9)	N/A	N/A	N/A
Emergency Department Visits	N/A	N/A	N/A
Initial NF Visit (99306)	G0317	95 minutes	1 day before visit + date of visit + 3 days after
Subsequent NF Visit (99310)	G0317	85 minutes	1 day before visit + date of visit + 3 days after
NF Discharge Day Management	N/A	N/A	N/A

Primary E/M Service	Prolonged Code*	Time Threshold to Report Prolonged	Count physician/NPP time spent within this time period (surveyed timeframe)
Home/Residence Visit New Pt (99345)	G0318	140 minutes	3 days before visit + date of visit + 7 days after
Home/Residence Visit Estab. Pt (99350)	G0318	110 minutes	3 days before visit + date of visit + 7 days after
Cognitive Assessment and Care Planning (99483)	G2212	100 minutes	3 days before visit + date of visit + 7 days after
Consults	N/A	N/A	N/A

* You must use time to select your visit level.
NPP= non-physician practitioner
IP/Obs. = inpatient/observation

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CPT-4® / HCPCS Level II Code Changes

Code Section & Department-Specific 1Q24 Code Changes

Surgery-Range Code Updates

Surgical Range Code Changes

Consider surgical codes 'hard coded' in master files as well as those assigned by Coders when performing annual coding and payment system update analysis. Correct and compliant charge capture requires knowledge of current coding rules. HCPCS Level II codes and Category III codes are also potentially applicable to surgical services.

Note: In-depth coding education may be needed for charge capture or coding staff interpreting, selecting, or assigning surgical range CPT coding. (This program is focused on typical Charge Master updates and is not intended to be a coding educational program.)

Musculoskeletal System - Spine

This section includes code parenthetical revisions, three new Category I codes, one new Category III and two Category III code description changes for CDM maintenance.

- Due to the increased use of vertebral body tethering (VBT) procedures, several codes were revised to reflect the current practice.
- Parenthetical revisions in this section include new codes 22836, 22837, 22838 for anterior thoracic vertebral body tethering, which corrects scoliosis without fusion using a tether (cord) to compress the vertebral growth plates on the convex side of the curve to inhibit their growth, while allowing the growth plates on the concave side of the curve to continue to grow.
- Codes 22836-22838 OPPS SI of C, Inpatient only and MPFS Work Relative Value Unites are:
  - 22836 - Work RVU 32.00
  - 22837 - Work RVU 35.50
  - 22838 - Work RVU 36.00

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#● 22836 Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments

►(For anterior lumbar or thoracolumbar vertebral body tethering, up to 7 vertebral segments, use 0656T)◄

#● 22837 8 or more vertebral segments

►(Do not report 22836, 22837 in conjunction with 22845, 22846, 22847, 32601)◄

►(For anterior lumbar or thoracolumbar vertebral body tethering, 8 or more vertebral segments, use 0657T)◄

#● 22838 Revision (eg, augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed

►(Do not report 22838 in conjunction with 22849, 22855, 32601)◄

- Category III code changes for this code range include two description changes and one new code.
- 0790T has an OPPS SI of C, Inpatient only and is Contractor-priced for MPFS purposes.

▲ 0656T Anterior lumbar or thoracolumbar vertebral body tethering; up to 7 vertebral segments

▲ 0657T 8 or more vertebral segments

(Do not report 0656T, 0657T in conjunction with 22800, 22802, 22804, 22808, 22810, 22812, 22818, 22819, 22845, 22846, 22847)

►(For vertebral body tethering of the thoracic spine, see 22836, 22837)◄

#● 0790T Revision (eg, augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed

►(For revision, replacement, or removal of thoracic vertebral body tethering, use 22838)◄

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Musculoskeletal System – Pelvis and Hip Joint

This section includes revised guidelines, code parenthetical revisions, one new Category I code and one deleted Category III code for CDM maintenance.

- Category I code 27278 has been created to replace Category III code 0775T.
- 27278 has an OPPS SI of J1 and Work RVU 7.86.

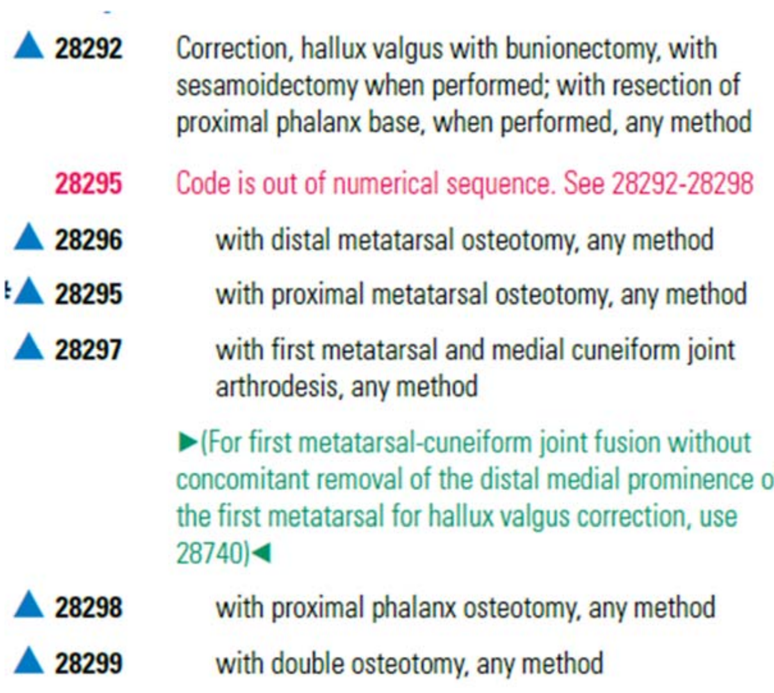
● **27278** Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s]), without placement of transfixation device

►(For arthrodesis, sacroiliac joint, with placement of a percutaneous transfixation device, use 27279)◄

►(For bilateral procedure, report 27278 with modifier 50)◄

Musculoskeletal System – Foot and Toes

This section includes six CPT code description changes for CDM maintenance and code parenthetical revisions.



▲ **28292** Correction, hallux valgus with bunionectomy, with sesamoidectomy when performed; with resection of proximal phalanx base, when performed, any method

28295 Code is out of numerical sequence. See 28292-28298

▲ **28296** with distal metatarsal osteotomy, any method

▲ **28295** with proximal metatarsal osteotomy, any method

▲ **28297** with first metatarsal and medial cuneiform joint arthrodesis, any method

►(For first metatarsal-cuneiform joint fusion without concomitant removal of the distal medial prominence of the first metatarsal for hallux valgus correction, use 28740)◄

▲ **28298** with proximal phalanx osteotomy, any method

▲ **28299** with double osteotomy, any method

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Respiratory System – Accessory Sinuses

This section includes two new CPT codes for CDM maintenance.

- Two new CPT codes were created to report energy-based destruction of the posterior nasal nerve.
- The new codes are intended for bilateral use. If performed unilaterally, append modifier 52.
- Review other parenthetical notes for additional coding guidance.
- 31242 and 31243 have an OPPS SI of J1, and both codes have Work RVUs of 2.7

31237 Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)

(Do not report 31237 in conjunction with 31238, 31253, 31254, 31255, 31256, 31257, 31259, 31267, 31276, 31287, 31288, 31290, 31291, 31292, 31293, 31294, when performed on the ipsilateral side)

#● **31242** with destruction by radiofrequency ablation, posterior nasal nerve

#● **31243** with destruction by cryoablation, posterior nasal nerve

Cardiovascular System – Phrenic Nerve Stimulation System

This section includes eight new CPT codes, four new Category III for CDM maintenance, and the deletion of twelve Category III codes.

- These new CPT codes identify phrenic nerve stimulation system services.
- CPT 33276 describes the device placement (accomplished intravascularly) and includes imaging guidance and pulse generator initial analysis with diagnostic mode activation.
- The guidelines should be carefully reviewed as they contain exclusion and frequency limitations in the new codes.
- 33276 has an OPPS SI of S, 33277 has an SI of N, and the remaining new codes have an SI of J1.

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New Codes:

#● 33276 Insertion of phrenic nerve stimulator system (pulse generator and stimulating lead[s]), including vessel catheterization, all imaging guidance, and pulse generator initial analysis with diagnostic mode activation, when performed

►(Do not report 33276 in conjunction with 93150, 93151, 93152, 93153)◄

#+● 33277 Insertion of phrenic nerve stimulator transvenous sensing lead (List separately in addition to code for primary procedure)

►(Use 33277 in conjunction with 33276, 33287)◄

►(For insertion of a phrenic nerve sensing lead other than at initial insertion of the phrenic nerve stimulator system, use 33999)◄

#● 33278 Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; system, including pulse generator and lead(s)

#● 33279 transvenous stimulation or sensing lead(s) only

►(Use 33279 once for removal of one or more lead[s])◄

#● 33280 pulse generator only

►(Do not report 33278, 33279, 33280 in conjunction with 33276, 33277, 33281, 33287, 33288)◄

#● 33281 Repositioning of phrenic nerve stimulator transvenous lead(s)

►(Do not report 33281 in conjunction with 33276, 33277)◄

►(Report 33281 only once per patient per day)◄

#● 33287 Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator

►(Do not report 33287 in conjunction with 33276, 33278)◄

#● 33288 transvenous stimulation or sensing lead(s)

►(Use 33288 once for removal of one or more lead[s])◄

►(Do not report 33288 in conjunction with 33277, 33279, 33281)◄

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Deleted Category III Codes:

Code	Description
~~0424T~~	~~Insertion or replacement of neurostimulator system for treatment of central sleep apnea; complete system (transvenous placement of right or left stimulation lead, sensing lead, implantable pulse generator)~~
~~0425T~~	~~sensing lead only~~
~~0426T~~	~~stimulation lead only~~
~~0427T~~	~~pulse generator only~~
~~0428T~~	~~Removal of neurostimulator system for treatment of central sleep apnea; pulse generator only~~
~~0429T~~	~~sensing lead only~~
~~0430T~~	~~stimulation lead only~~
~~0431T~~	~~Removal and replacement of neurostimulator system for treatment of central sleep apnea, pulse generator only~~
~~0432T~~	~~Repositioning of neurostimulator system for treatment of central sleep apnea; stimulation lead only~~
~~0433T~~	~~sensing lead only~~
~~0434T~~	~~Interrogation device evaluation implanted neurostimulator pulse generator system for central sleep apnea~~
~~0435T~~	~~Programming device evaluation of implanted neurostimulator pulse generator system for central sleep apnea; single session~~
~~0436T~~	~~during sleep study~~

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Cardiovascular System – Pacemaker Systems

This section includes new Category III (some added mid-year 2023) for CDM maintenance, as well as the deletion of Category III codes.

- Nine new Category III codes were created for Dual-Chamber Leadless Pacemaker 0795T-0804T, which were added mid-year on 07/01/2023 and are listed in CPT as new codes for 2024.
- Many of the 07/01/2023 additions underwent OPPS SI changes for 01/01/2024. This is good news for facilities as most of the codes went from E1 to J1. See the table below for the details.
- MPFS is contractor-priced for these nine codes.

	C	Det...	HCPCS Desc	New SI	Old SI	SI Change Notes
Q1	2024	0795T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right...	J1	E1	Quarter Q1, 2024: SI changed from E1 to J1.
Q1	2024	0796T	Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right...	J1	E1	Quarter Q1, 2024: SI changed from E1 to J1.
Q1	2024	0798T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right...	J1	E1	Quarter Q1, 2024: SI changed from E1 to J1.
Q1	2024	0799T	Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right...	J1	E1	Quarter Q1, 2024: SI changed from E1 to J1.
Q1	2024	0801T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial...	J1	E1	Quarter Q1, 2024: SI changed from E1 to J1.
Q1	2024	0802T	Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial...	J1	E1	Quarter Q1, 2024: SI changed from E1 to J1.

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New Category III codes (0823T – 0826T) are for Right Atrial Leadless Pacemaker. MPFS is contractor-priced.

C	C...		HCPCS Desc	SI
Q1	2024	0823T	Transcatheter insertion of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) an...	J1
Q1	2024	0824T	Transcatheter removal of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography),...	J1
Q1	2024	0825T	Transcatheter removal and replacement of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral...	J1
Q1	2024	0826T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician ...	Q1

- Radiological supervision and interpretation, fluoroscopy (76000, 77002), ultrasound guidance for vascular access (76937), right ventriculography (93566), and femoral venography (75820) are included in leadless pacemaker procedures when performed.

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New Category III Codes:

● **0795T** Transcatheter insertion of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; complete system (ie, right atrial and right ventricular pacemaker components)

►(Do not report 0795T in conjunction with 75820, 76000, 76937, 77002, 93566, 0796T, 0797T)◄

● **0796T** right atrial pacemaker component (when an existing right ventricular single leadless pacemaker exists to create a dual-chamber leadless pacemaker system)

● **0797T** right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)

►(Do not report 0795T, 0796T, 0797T in conjunction with 33274, 75820, 76000, 76937, 77002, 93566)◄

►(Do not report 0795T, 0796T, 0797T in conjunction with 93451, 93453, 93456, 93457, 93460, 93461, 93593, 93594, 93596, 93597, 93598, unless complete right heart catheterization is performed for indications distinct from the leadless pacemaker procedure)◄

● **0798T** Transcatheter removal of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography), when performed; complete system (ie, right atrial and right ventricular pacemaker components)

● **0799T** right atrial pacemaker component

● **0800T** right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)

►(Do not report 0798T, 0799T, 0800T in conjunction with 75820, 76000, 76937, 77002, 93451, 93453, 93456, 93457, 93460, 93461, 93566, 93593, 93594, 93596, 93597)◄

►(Do not report 0799T, 0800T in conjunction with 33275, 0798T)◄

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● **0801T** Transcatheter removal and replacement of permanent dual-chamber leadless pacemaker, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography, right ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed; dual-chamber system (ie, right atrial and right ventricular pacemaker components)

● **0802T** right atrial pacemaker component

● **0803T** right ventricular pacemaker component (when part of a dual-chamber leadless pacemaker system)

►(Do not report 0801T, 0802T, 0803T in conjunction with 33274, 33275, 75820, 76000, 76937, 77002, 93451, 93453, 93456, 93457, 93460, 93461, 93566, 0795T, 0796T, 0797T, 0798T, 0799T, 0800T)◄

►(Do not report 33274, 33275 when right ventricular single-chamber leadless pacemaker is part of a dual-chamber leadless pacemaker system)◄

● **0804T** Programming device evaluation (in person) with iterative adjustment of implantable device to test the function of device and to select optimal permanent programmed values, with analysis, review, and report, by a physician or other qualified health care professional, leadless pacemaker system in dual cardiac chambers

►(Do not report 0804T in conjunction with 0795T, 0796T, 0797T, 0798T, 0799T, 0800T, 0801T, 0802T, 0803T)◄

● **0823T** Transcatheter insertion of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (eg, interrogation or programming), when performed

►(Do not report 0823T in conjunction with 33274, 0795T, 0796T, 0797T, 0802T)◄

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● **0824T** Transcatheter removal of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography), when performed

▶(Do not report 0824T in conjunction with 33275, 0799T)◀

● **0825T** Transcatheter removal and replacement of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (eg, interrogation or programming), when performed

▶(Do not report 0825T in conjunction with 33274, 0795T, 0796T, 0797T, 0802T)◀

● **0826T** Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional, leadless pacemaker system in single-cardiac chamber

▶(Do not report 0826T in conjunction with 0823T, 0824T, 0825T)◀

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Wireless Cardiac Stimulation System for Left Ventricular Pacing

This section includes three new Category III codes and four Category III code description changes for CDM maintenance.

- 0861T-0863T has been established to identify reporting for removal and relocation services of components of a wireless cardiac stimulator of the left ventricle.
- Category III codes 0517T-0520T have undergone description changes.
- Review the parenthetical guidelines carefully for the restrictions referenced for these codes.
- 0861T has an OPPS SI of Q2, and 0862T-0863T have an SI of T. MPFS lists the code as contractor-priced.

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0515T Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; complete system (includes electrode and generator [transmitter and battery])

0516T electrode only

▲ **0517T** both components of pulse generator (battery and transmitter) only

►(Do not report 0515T, 0516T, 0517T in conjunction with 0518T, 0519T, 0520T, 0521T, 0522T, 0861T, 0862T, 0863T)◄

#● **0861T** Removal of pulse generator for wireless cardiac stimulator for left ventricular pacing; both components (battery and transmitter)

►(Do not report 0861T in conjunction with 0515T, 0516T, 0517T, 0518T, 0519T, 0520T, 0521T, 0522T, 0862T, 0863T)◄

▲ **0518T** battery component only

►(Do not report 0518T in conjunction with 0515T, 0516T, 0517T, 0519T, 0520T, 0521T, 0522T, 0861T, 0862T, 0863T)◄

#● **0862T** Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; battery component only

►(Do not report 0862T in conjunction with 0515T, 0517T, 0518T, 0519T, 0520T, 0521T, 0522T, 0861T)◄

#● **0863T** transmitter component only

►(Do not report 0863T in conjunction with 0515T, 0517T, 0518T, 0519T, 0520T, 0521T, 0522T, 0861T)◄

▲ **0519T** Removal and replacement of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; both components (battery and transmitter)

▲ **0520T** battery component only

►(Do not report 0519T, 0520T in conjunction with 0515T, 0516T, 0517T, 0518T, 0521T, 0522T, 0861T, 0862T, 0863T)◄

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Urinary System

This section includes one new CPT code, three new Category III codes, and the deleting of one Category III code (0499T) for CDM maintenance.

- Category III code 0499T has been deleted and replaced with CPT 52284.
- New code 52284 specifically includes the drug-delivery mechanism of using a drug-coated balloon catheter and fluoroscopy when used. This is a male-only procedure.
- Category III codes 0811T and 0812T have been established to report remote multiday complex uroflowmetry.
- Review the parenthetical guidelines carefully for the restrictions referenced for these codes.
- 0864T has been established to report low-energy, low-intensity extracorporeal shock wave therapy (Li-ESWT) involving the corpus cavernosum.
- 52284 has an OPPS SI of J1 and MPFS Work RVU 3.10.
- 0811T has an OPPS SI of V, and 0812T has an SI of Q1. MPFS lists both codes as contractor-priced.
- 0864T has an OPPS SI of T, and 0812T has an SI of Q1. MPFS lists the code as contractor-priced

● **52284** Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug delivery by drug-coated balloon catheter for urethral stricture or stenosis, male, including fluoroscopy, when performed

▶(Do not report 52284 in conjunction with 51610, 52000, 52281, 52283, 74450, 76000)◀

● **0811T** Remote multi-day complex uroflowmetry (eg, calibrated electronic equipment); set-up and patient education on use of equipment

● **0812T** device supply with automated report generation, up to 10 days

▶(Do not report 0811T, 0812T more than once per episode of care)◀

▶(Do not report 0811T, 0812T in conjunction with 51736, 51741, 99453, 99454)◀

● **0864T** Low-intensity extracorporeal shock wave therapy involving corpus cavernosum, low energy

▶(Do not report 0864T in conjunction with 0101T when treating the same area)◀

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Female Genital System

This section includes one new CPT code and the deletion of one Category III code (0404T) for CDM maintenance.

- CPT 58580 has been established to report transcervical radiofrequency ablation of uterine fibroid(s), including intraoperative ultrasound guidance and monitoring.
- Review the parenthetical guidelines carefully for the restrictions listed for this code.
- 58580 has an OPPS SI of J1 and MPFS Work RVU 7.21.

● **58580** Transcervical ablation of uterine fibroid(s), including intraoperative ultrasound guidance and monitoring, radiofrequency

▶(Do not report 58580 in conjunction with 58561, 58674, 76830, 76940, 76998)◀

▶(For laparoscopic radiofrequency ablation of uterine fibroid[s], including intraoperative ultrasound guidance and monitoring, use 58674)◀

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Nervous System

This section includes three new CPT codes for CDM maintenance.

- Three new codes (61889-61892) have been added to report insertion, revision, or replacement and removal of a skull-mounted neurostimulator pulse generator or receiver.
- Review the parenthetical guidelines carefully for the restrictions and exclusions referenced for these new codes.
- 61889 has and OPPS SI of C, and 61891 and 61892 have an OPPS SI of J1.
- The MPFS Work RVU for 61889 is 25.75, 61891 is 11.25, and 61895 is 15.00.

● **61889** Insertion of skull-mounted cranial neurostimulator pulse generator or receiver, including craniectomy or craniotomy, when performed, with direct or inductive coupling, with connection to depth and/or cortical strip electrode array(s)

▶(For insertion of cranial neurostimulator pulse generator or receiver other than skull mounted, see 61885, 61886)◀

● **61891** Revision or replacement of skull-mounted cranial neurostimulator pulse generator or receiver with connection to depth and/or cortical strip electrode array(s)

▶(For replacement of cranial neurostimulator pulse generator or receiver other than skull mounted, see 61885, 61886)◀

▶(For revision of cranial neurostimulator pulse generator or receiver other than skull mounted, use 61888)◀

● **61892** Removal of skull-mounted cranial neurostimulator pulse generator or receiver with cranioplasty, when performed

▶(Do not report 61892 in conjunction with 61891 for the same pulse generator)◀

▶(For removal of cranial neurostimulator pulse generator or receiver other than skull mounted, use 61888)◀

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Spine and Spinal Cord

This section includes two CPT code revisions for CDM maintenance.

- Review the parenthetical guidelines carefully for the restrictions and exclusions referenced in these revisions.

▲ **63685** Insertion or replacement of spinal neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver

▶(Do not report 63685 in conjunction with 63688 for the same neurostimulator pulse generator or receiver)◀

▶(For insertion or replacement of spinal percutaneous electrode array with integrated neurostimulator, use 0784T)◀

▲ **63688** Revision or removal of implanted spinal neurostimulator pulse generator or receiver, with detachable connection to electrode array

▶(For electronic analysis with programming, when performed, of implanted spinal cord neurostimulator, see 95970, 95971, 95972)◀

▶(For revision or removal of spinal percutaneous electrode array and integrated neurostimulator, use 0785T)◀

▶(For revision or removal of sacral percutaneous electrode array and integrated neurostimulator, use 0787T)◀

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Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System

This section includes three new CPT codes, two code revisions, and six new Category III codes for CDM maintenance.

- This code section has had a major overhaul and warrants careful review.
- Review the parenthetical guidelines carefully for the restrictions and exclusions referenced in these new and revised codes.
- CPTs 64596-64598 have an OPPS SI of J1 and are Contractor-priced for MPFS purposes.
- Category III codes 0784T-0787T have an OPPS SI of J1, 0788T – 0789T are SI S, and all of these codes are Contractor-priced for MPFS purposes.

▲ **64590** Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver

(Do not report 64590 in conjunction with 64595)

►(Do not report 64590 in conjunction with 64596, 64597, 64598)◄

►(For insertion or replacement of percutaneous electrode array with integrated neurostimulator, use 64596)◄

►(For neurostimulators without a named target nerve [eg, field stimulation], use 64999)◄

▲ **64595** Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, with detachable connection to electrode array

►(For revision or removal of percutaneous electrode array with integrated neurostimulator, use 64597)◄

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● **64596** Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; initial electrode array

+● **64597** each additional electrode array (List separately in addition to code for primary procedure)

►(Use 64597 in conjunction with 64596)◄

►(Do not report 64596, 64597 in conjunction with 64555, 64561, 64590, 64595)◄

►(For percutaneous implantation of electrode array only, peripheral nerve, use 64555)◄

►(For implantation of trial or permanent electrode arrays or pulse generators for peripheral subcutaneous field stimulation, use 64999)◄

►(For neurostimulators without a named target nerve [eg, field stimulation], use 64999)◄

►(For percutaneous implantation or replacement of integrated neurostimulation system for bladder dysfunction, posterior tibial nerve, use 0587T)◄

►(For open implantation or replacement of integrated neurostimulator system, posterior tibial nerve, see 0816T, 0817T)◄

● **64598** Revision or removal of neurostimulator electrode array, peripheral nerve, with integrated neurostimulator

►(For revision or removal of electrode array only, use 64585)◄

►(For revision or removal of integrated neurostimulation system, posterior tibial nerve, see 0588T, 0818T, 0819T)◄

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● **0784T** Insertion or replacement of percutaneous electrode array, spinal, with integrated neurostimulator, including imaging guidance, when performed

● **0785T** Revision or removal of neurostimulator electrode array, spinal, with integrated neurostimulator

● **0786T** Insertion or replacement of percutaneous electrode array, sacral, with integrated neurostimulator, including imaging guidance, when performed

● **0787T** Revision or removal of neurostimulator electrode array, sacral, with integrated neurostimulator

● **0788T** Electronic analysis with simple programming of implanted integrated neurostimulation system (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, spinal cord or sacral nerve, 1-3 parameters

►(Do not report 0788T in conjunction with 43647, 43648, 43881, 43882, 61850-61888, 63650, 63655, 63661, 63662, 63663, 63664, 63685, 63688, 64553-64595, 64596, 64598, 95970, 95971, 95972, 95976, 95977, 95983, 95984, 0587T, 0588T, 0589T, 0590T, 0784T, 0785T, 0786T, 0787T, 0789T)◄

● **0789T** Electronic analysis with complex programming of implanted integrated neurostimulation system (eg, electrode array and receiver), including contact group(s), amplitude, pulse width, frequency (Hz), on/off cycling, burst, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters, when performed by physician or other qualified health care professional, spinal cord or sacral nerve, 4 or more parameters

►(Do not report 0789T in conjunction with 43647, 43648, 43881, 43882, 61850-61888, 63650, 63655, 63661, 63662, 63663, 63664, 63685, 63688, 64553-64595, 64596, 64598, 95970, 95971, 95972, 95976, 95977, 95983, 95984, 0587T, 0588T, 0589T, 0590T, 0784T, 0785T, 0786T, 0787T, 0788T)◄

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● **0816T** Open insertion or replacement of integrated neurostimulation system for bladder dysfunction including electrode(s) (eg, array or leadless), and pulse generator or receiver, including analysis, programming, and imaging guidance, when performed, posterior tibial nerve; subcutaneous

● **0817T** subfascial

● **0818T** Revision or removal of integrated neurostimulation system for bladder dysfunction, including analysis, programming, and imaging, when performed, posterior tibial nerve; subcutaneous

● **0819T** subfascial

►(Do not report 0816T, 0817T, 0818T, 0819T in conjunction with 64555, 64566, 64575, 64590, 64596, 95970, 95971, 95972, 0588T, 0589T, 0590T)◄

►(For percutaneous implantation or replacement of integrated neurostimulation system including electrode array and receiver for bladder dysfunction, posterior tibial nerve, use 0587T)◄

►(For revision or removal of percutaneous integrated neurostimulation system for bladder dysfunction, posterior tibial nerve, use 0588T)◄

►(For electronic analysis with programming of integrated or leadless neurostimulation system for bladder dysfunction, posterior tibial nerve, performed on a day subsequent to the device insertion, replacement, or revision, see 0589T, 0590T)◄

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Eye and Ocular Adnexa

This section includes one new CPT code, one new Category III code added on 07/01/2023, and the deletion of two codes for CDM maintenance.

- CPT 67516 has been established to report a suprachoroidal injection of a pharmacologic agent.
- This code is designed as a separate procedure.
- 67516 has an OPPS SI of T and MPFS Work RVU 1.53
- 0810T has had an OPPS SI update from E1 to T and is contractor-priced for MPFS purposes.
- Codes C9770 and 0465T have been deleted.

● **67516** Suprachoroidal space injection of pharmacologic agent (separate procedure)

►(Report medication separately)◄

Code 67516 identifies the administration of a drug into the suprachoroidal space between the sclera and choroid, which compartmentalizes the drug within the posterior segment of the eye.

● **0810T** Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies

►(Report medication separately)◄

►(Do not report 0810T in conjunction with 67036, 67039, 67040, 67041, 67042, 67043)◄

Category III code 0810T has been established to report subretinal injection of a pharmacologic agent, including vitrectomy and one or more retinotomies.

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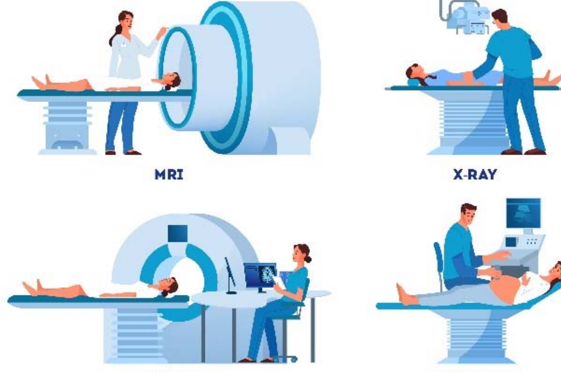
CPT-4® / HCPCS Level II Code Changes

Code Section & Department-Specific 1Q24 Code Changes

Diagnostic Imaging & Radiation Therapy



CPT Updates

Diagnostic Imaging CPT Updates

Deleted Codes:

- 74710 *Pelvimetry, with or without placental localization,* has been deleted due to low utilization. No replacement code options are provided.

- Four Category III codes, 0501T-0504T, have been deleted and replaced with Category I codes for 1Q24.
  - The codes were used to report noninvasive estimated coronary fractional flow reserve derived from coronary CT angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease.

	Deleted Code Desc	All Replacement Codes
0501T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to...	75580
0502T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to...	75580
0503T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to...	75580
0504T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to...	75580

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New Codes:

- Five new 7XXXX range codes have been released for 1Q24 and discussed within this training manual section:

↑	HCPCS Desc	SI	Payment Rate
75580	Noninvasive estimate of coronary fractional flow reserve (FFR) derived from augmentative software analysis of the data set from a coronary computed tomography angiography, with interpretation and report by a physician or other qualified health care professional	S	$997.22
76984	Ultrasound, intraoperative thoracic aorta (eg, epiaortic), diagnostic	C	
76987	Intraoperative epicardial cardiac ultrasound (ie, echocardiography) for congenital heart disease, diagnostic; including placement and manipulation of transducer, image acquisition, interpretation and report	C	
76988	Intraoperative epicardial cardiac ultrasound (ie, echocardiography) for congenital heart disease, diagnostic; placement, manipulation of transducer, and image acquisition only	C	
76989	Intraoperative epicardial cardiac ultrasound (ie, echocardiography) for congenital heart disease, diagnostic; interpretation and report only	C	

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Diagnostic Radiology

Heart

- 75580 was added to replace 0501T-0504T, describing the components of data preparation and transmission, analysis of fluid dynamics and simulated maximal coronary hyperemia, generation of estimated FFR model, and anatomical data review in comparison with estimated FFR model to reconcile discordant data.

● **75580** Noninvasive estimate of coronary fractional flow reserve (FFR) derived from augmentative software analysis of the data set from a coronary computed tomography angiography, with interpretation and report by a physician or other qualified health care professional

►(Use 75580 only once per coronary computed tomography angiogram)◄

►(When noninvasive estimate of coronary FFR derived from augmentative software analysis of the data set from a coronary computed tomography angiography with interpretation and report by a physician or other qualified health care professional is performed on the same day as the coronary computed tomography angiography, use 75580 in conjunction with 75574)◄

  - CPT determined that the procedure components should be bundled into one Category I code and described as augmentative software analysis of the data set from a CCTA.
  - This code is OPPS SI S, paid a national rate of $997.22.
  - 75580-26 is MPFS Status A, Work RVU 0.75

Other Procedures

- Multiple exclusionary parentheticals were revised for Imaging Guidance codes. The revisions are associated with the establishment of 0795T-0803T, 0823T-0825T, and 0861T-0863T.

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Diagnostic Ultrasound

Other Procedures

- Four new codes were created in the Diagnostic Ultrasound section for reporting intraoperative ultrasound (IOUS) diagnostic procedures.
  - All codes are currently assigned OPPS SI C, Inpatient Only.
  - RUC determined that 76998 *Ultrasonic guidance, intraoperative,* was utilized by many different specialties for various procedures. They determined that there were significant variations in the time it takes to perform the ultrasound guidance.
  - CPT created more specific intraoperative codes to describe ultrasound of the thoracic aorta (76984) and epicardial cardiac ultrasound for congenital heart disease (76987-76989).
    - Code 76998 *Ultrasonic guidance, intraoperative* was retained with expanded exclusionary parenthetical notes, including the four new, more specific codes.
    - CDM Teams will need to update files to ensure CPT coding is at the greatest level of specificity.

● **76984** Ultrasound, intraoperative thoracic aorta (eg, epiaortic), diagnostic

▶(For diagnostic intraoperative epicardial cardiac ultrasound [ie, echocardiography], see 76987, 76988, 76989)◀

● **76987** Intraoperative epicardial cardiac ultrasound (ie, echocardiography) for congenital heart disease, diagnostic; including placement and manipulation of transducer, image acquisition, interpretation and report

● **76988** placement, manipulation of transducer, and image acquisition only

● **76989** interpretation and report only

▶(For diagnostic intraoperative thoracic aorta (eg, epiaortic) ultrasound, use 76984)◀

- 76984-26 is MPFS Status A, Work RVU 0.60
- 76987-26 is MPFS Status A, Work RVU 1.90
- 76988-26 is MPFS Status A, Work RVU 1.20
- 76989-26 is MPFS Status A, Work RVU 0.70

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Category III Updates

New Codes:

Diagnostic Ultrasound Category III

- New code 0815T is an ultrasound-based code for bone density evaluation and assigned OPPS SI E1.
- This code was created for reporting non-ionizing energy, ultrasound-based radiofrequency echographic multi-spectrometry (REMS).

	HCPCS Desc	SI
0815T	Ultrasound-based radiofrequency echographic multi-spectrometry (REMS), bone-density study and fracture-risk assessment, 1 or more sites, hips, pelvis, or spine	E1

- ● **0815T** Ultrasound-based radiofrequency echographic multi-spectrometry (REMS), bone-density study and fracture-risk assessment, 1 or more sites, hips, pelvis, or spine
  - The code is used for bone-density study for fracture-risk assessment.
  - Code 0815T includes the assessment of one or more sites (hips, pelvis, or spine).

Other Category III

- Add-on code 0857T has been created to report opto-acoustic (OA) imaging for breast masses and replaces C9788 noted above.

	HCPCS Desc	SI	Payment Rate
0857T	Opto-acoustic imaging, breast, unilateral, including axilla when performed, real-time with image documentation, augmentative analysis and report (List separately in addition to code for primary procedure)	S	$104.87

+● **0857T** Opto-acoustic imaging, breast, unilateral, including axilla when performed, real-time with image documentation, augmentative analysis and report (List separately in addition to code for primary procedure)

▶(Use 0857T in conjunction with 76641, 76642)◀

- This code is to be charged and reported with 76641 or 76642 *Ultrasound of the breast* unilateral; complete and limited.
- 0857T is MPFS Status C, Carrier Priced, thus listed with 0.00 Work RVU.

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MRI Category III

- Codes 0865T and 0866T have been created as new codes for 1Q24 to report quantitative MRI analysis of the brain.

	HCPCS Desc	SI	Payment Rate
0865T	Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study(ies), including lesion identification, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data...	S	$233.71
0866T	Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study(ies), including lesion detection, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data...	S	$233.71

● **0865T** Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study(ies), including lesion identification, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the brain during the same session

▶(Do not report 0865T in conjunction with 70551, 70552, 70553)◀

+● **0866T** Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study(ies), including lesion detection, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the brain (List separately in addition to code for primary procedure)

▶(Use 0866T in conjunction with 70551, 70552, 70553)◀

▶(For quantitative MR for analysis of tissue composition, see 0648T, 0649T, 0697T, 0698T)◀

▶(For quantitative computed tomography tissue characterization, see 0721T, 0722T)◀

▶(For quantitative MRI analysis of the brain without comparison to prior MR study, report 0865T, 0866T with modifier 52)◀

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- Both 0865T and 0866T are listed as “Carrier Priced” on the MPFS Fee schedule and assigned 0.00 Work RVUs.
- CPT guidelines in the form of parentheticals and exclusionary parentheticals direct the user to proper code selection.
  - 0865T is not to be reported with 70551, 70552, or 70553.
  - 0866T is an add-on code reported with 70551, 70552, or 70553.
- Service overview from CPT:
  - This new service provides analysis of brain lesions via software by identifying diseased areas of the brain compared with the use of multiple MRI images that are overlayed and analyzed. The software then quantifies the lesion volume(s), number, and locations with a comparison to prior studies, when possible, to provide results that may be analyzed by the physician to direct patient care. (This service does not analyze the composition of the tissue.)
  - Existing codes 0648T and 0649T describe quantitative magnetic resonance for analysis of tissue composition.
  - Existing codes 0721T and 0722T describe quantitative tissue characterization using CT without (0721T) and with (0722T) concurrent CT imaging.

Other CPT

- Numerous updates are included in the 2024 code set that bundle fluoroscopy or other imaging guidance into the codes.
  - Watch for verbiage “including imaging guidance” and monitor exclusionary parentheticals to ensure charge practices are accurate.
    - Improper unbundling of component services presents a compliance risk even when the guidance code is packaged under OPPS.
    - Over twenty of the new 1Q24 codes have description verbiage indicating that guidance is included.
      - When implementing new codes, it is essential that the CDM Team reviews coding parentheticals, introductory guidelines and the code descriptors themselves for procedures that include imaging guidance of any type.
      - Ensure no separate charge items are captured for the associated guidance work effort.
      - Adjust pricing accordingly if costs for activities need to be incorporated into other charge items.

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HCPCS Level II Codes for Imaging

Deleted Codes:

Nuclear Medicine

- C9156 was deleted in 1Q24 has been replaced with new code A9608:

	Deleted Code Desc	All Replacement Codes
C9156	Flotufolastat f 18, diagnostic, 1 millicurie	A9608

Other Diagnostic Imaging

- Two catheter placement codes for coronary angiography, C7557 and C7558, (both SI E1) are new for 1Q24 and only used in the ASC environment. (See ASC Section of this manual.)

	HCPCS Desc	SI
C7557	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation with left heart catheterization including intraprocedural injection(s) fo...	E1
C7558	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation with right and left heart catheterization including intraprocedural...	E1

- C9788 has been deleted in 1Q24 and replaced with a Category III code
  - 0857T information is listed in the section that follows for Category III code updates.

	Deleted Code Desc	All Replacement Codes
C9788	Opto-acoustic imaging, breast (including axilla when performed), unilateral, with image documentation, analysis and report, obtained with ultrasound examination	0857T

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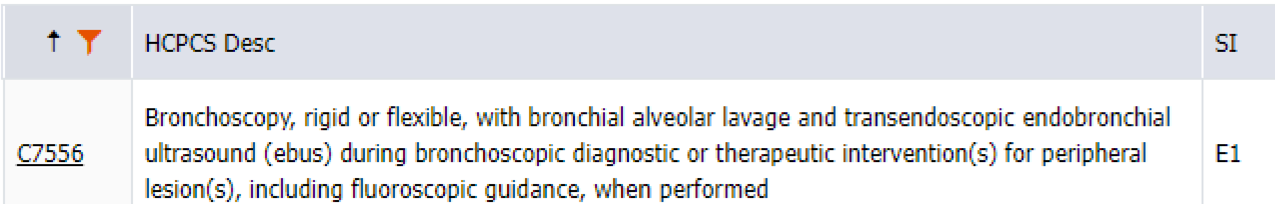
- New code C7556 was created for bronchoscopy with bronchial alveolar lavage and transendoscopic endobronchial ultrasound (ebus) for peripheral lesions and includes imaging guidance.



	HCPCS Desc	SI
C7556	Bronchoscopy, rigid or flexible, with bronchial alveolar lavage and transendoscopic endobronchial ultrasound (ebus) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s), including fluoroscopic guidance, when performed	E1

  - This code is included in the imaging section of this manual for organizations that perform this procedure in imaging special procedures areas.
  - This code should not be confused with C7510 *Bronchoscopy, rigid or flexible, with bronchial alveolar lavage(s), with computer-assisted image-guided navigation, including fluoroscopic guidance when performed.*

New Codes:

Nuclear Medicine

- New code A9608, representing a radioisotope, is assigned OPPS SI G.

	HCPCS Desc	SI	Payment Rate
A9608	Flotufolastat f 18, diagnostic, 1 millicurie	G	$614.78

  - Be sure to use the proper Revenue Code, 0343, for this charge item to pass CMS claims edits.

CTA

New code C9793 is one of many predictive codes. This code might belong in other cost centers, so confirm who is performing the services. This code is not found in MPFS.

	HCPCS Desc	SI	Payment Rate
C9793	3d predictive model generation for pre-planning of a cardiac procedure, using data from cardiac computed tomographic angiography with report	S	$997.22

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PET Imaging

- New code A9609 Fludeoxyglucose F 18 Injection (fdg) is a positron-emitting radiopharmaceutical used for diagnostic purposes in conjunction with Positron Emission Tomography and used to assist assessment of cancer, coronary artery disease, or epileptic seizures. This code is assigned OPPS SI N.

	HCPCS Desc	SI	Payment Rate
A9609	Fludeoxyglucose f18 up to 15 millicuries	N	

  - This item is not a radioisotope for Nuclear Medicine procedures, so we will watch payer edits and instructional updates to see what Revenue Code guidance is provided.

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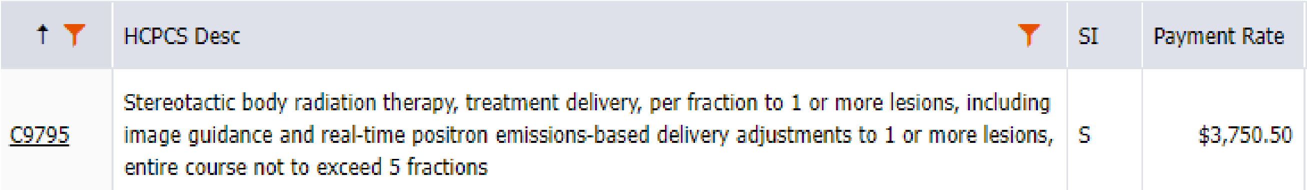
Radiation Therapy

- C9794 was created as a new radiation therapy treatment planning code for 1Q24. Watch for CMS guidance on this code in upcoming transmittals or MLN articles.

	HCPCS Desc	SI	Payment Rate
C9794	Therapeutic radiology simulation-aided field setting; complex, including acquisition of pet and ct imaging data required for radiopharmaceutical-directed radiation therapy treatment planning (i.e., modeling)	S	$1,950.50

  - The above code should not be confused with radiotherapy planning codes 77280-77290 and code 77295 since the above code includes the acquisition of PET and CT imaging data.

- C9795 was created as a new code for radiation therapy for 1Q24. Watch for CMS guidance on this code in upcoming transmittals or MLN articles.



	HCPCS Desc	SI	Payment Rate
C9795	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions	S	$3,750.50

  - The "real-time positron emissions-based delivery adjustments" differentiates C9795 code from existing code 77373 *Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions*, which is paid $1701.89 under OPPS, and assigned OPPS SI S.

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Imaging-Specific Regulatory Updates from the OPPS Final Rule

AUC Pause

- Section J. on page 1319 of the Display Copy outlines new policies pausing implementation of the Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging. As noted in the Final Rule, the AUC was required through 2014 PAMA regulations (Protecting Access to Medicare Act). Education and operations testing phases have already begun for AUC. However, as noted in the 2024 Final Rule, CMS paused implementation of the AUC program for reevaluation and rescinded its current AUC regulations. The reasoning behind the pause was CMS' inability to manage system editing and difficulty in reaching accurate use of the system by ordering physicians who are often unrelated to the providing department/imaging centers. CMS welcomes providers to continue using AUC voluntarily to "streamline and enhance decision making in clinical practice and improve quality of care".

Non-HEU Uranium

- Radioisotopes from non-highly enriched Uranium (non-HUE) sources are discussed in the 2024 OPPS Final rule (page 617).
    - Since 2013, CMS has provided a $10 additional payment for the applicable radioisotopes.
    - HCPCS Q9969 *Tc-99m from non-highly enriched uranium source, full cost recovery add-on per study dose* is reported once per dose along with scan codes.
    - CMS notes that there is now a sufficient supply of non-HEU-sourced Mo-99 in the United States, and there is no available supply of HEU-sourced Mo-99 in the United States. As a result, states that they believe there is no longer a need for the additional $10 add-on payment for CY 2025 or future years.
        - CMS statement: "This policy was based on the Secretary of Energy's certification that the last HEU reactor that produces Mo-99 for medical providers in the United States would finish its conversion to a non-HEU reactor by December 31, 2022, and that all Tc-99m used for radiopharmaceuticals in 2023 would be produced from non-HEU sources. However, we understand that the conversion of the last HEU reactor that produces Tc-99m to a non-HEU reactor did not occur until March 2023, so it is possible that some claims for diagnostic radiopharmaceuticals in CY 2023 would report the cost of HEU-sourced Tc-99m."
        - CMS finalized that the additional $10 payment will end after December 31, 2025. They project that beginning with CY 2026, Medicare claims data will reflect the full cost of non-HEU-sourced Tc-99m.

Drug Waste

- In 2024 drug waste narratives, CMS clarifies that contrast agents are excluded from the definition of refundable single-dose container or single-use package drug.

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CPT-4® / HCPCS Level II Code Changes

Code Section & Department-Specific 1Q24 Code Changes

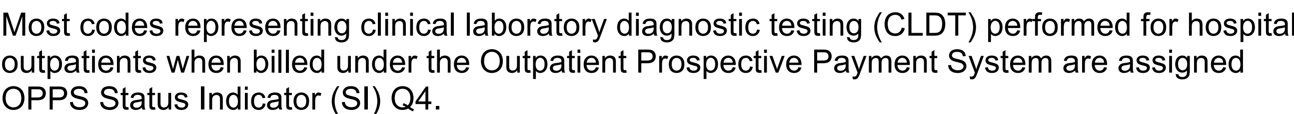
Laboratory, Pathology & Blood Bank

CLFS Regulatory Updates

As a brief summary, CMS released a transmittal update on the 2024 "Annual Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to Reasonable Charge Payment". MPFS Final Rule Section D. (p.795 of the Display Copy) "

Clinical Laboratory Fee Schedule: Revised Data Reporting Period and Phase-in of Payment

Reduction" provides background on the Clinical Fee Schedule and data collection processes.



Most codes representing clinical laboratory diagnostic testing (CLDT) performed for hospital outpatients when billed under the Outpatient Prospective Payment System are assigned OPPS Status Indicator (SI) Q4.

For background, in CY 2016, CMS implemented conditional packaging and introduced Status Indicator "Q4" for packaged laboratory services. Status Indicator "Q4" designates packaged APC payment if billed on the same claim as codes assigned Status Indicator "J1," "J2," "S," "T," "V," "Q1," "Q2," or "Q3". The "Q4" Status Indicator was created to identify 13X bill type claims where there are only laboratory CPT/HCPCS codes found in the CLFS. CMS edits automatically change the Q4 SI codes to SI A when applicable, and pays them separately at the CLFS payment rates.

Some laboratory codes are not reportable or not covered. Review of lab codes against their associated Status Indicators is important each quarter.

The payment basis for hospital outpatient claims is stated in CMS guidance as "reasonable charge" methodology when the laboratory service is paid and not packaged.

- In accordance with 42 CFR 405.502 through 42 CFR 405.508, the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable Consumer Price Index (CPI) for the 12-month period ending June 30 of each year as set forth in 42 CFR 405.509(b)(1). The CPI update for CY 2024 is 3.0 percent.

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Physicians and other laboratory providers are paid on a fee-for-service basis based on the Clinical Laboratory Fee Schedule (CLFS).

- CMS announced in its update that the CY 2024 CLFS Public Use File (PUF) will be available on the CMS website in the last week of December.
- The Part B deductible and coinsurance do not apply for services paid under the CLFS.

Under the revised lab fee schedule methodology, the CLFS payment amount for a test furnished on or after January 1, 2018, is equal to the weighted median of private payor rates determined for the test. The rate is based on information collected by applicable laboratories during a data collection period. Data is reported by entities to CMS during a specified data reporting period. For most laboratory tests, the private payor rate-based CLFS is updated every three years, with the next private payor rate-based CLFS update effective January 1, 2024.

CMS Transmittal R12389CP, released 11/30/23, describes the process and price mapping procedures utilized to determine the payment updates for new CLDTs, advanced diagnostic laboratory tests (ADLTs), and other laboratory services subject to reasonable charge payment.

- The annual update to payments made on a reasonable charge basis is linked to the Consumer Price Index -Urban (CPI-U) which is calculated at 3.0 percent for CY 2024.
- Testing services subject to payment made on a reasonable charge basis include:
  - Blood Products, Transfusion Medicine, and Reproductive Medicine Procedures
  - New Codes - Proprietary Laboratory Analysis (PLAs)
- Biologic products not paid on a cost or prospective payment basis are listed in Part B files.
- The payment limits for codes P9041, P9045, P9046, and P9047, can be found in the Medicare Part B drug pricing files as well.

Pricing Information

- The CY 2024 CLFS includes separately payable fees for certain specimen collection methods (codes 36415, P9612, P9615, and G0471).
- For CY 2024, CMS will issue a separate instruction on the clinical laboratory travel fees reported with HCPCS P9603-P9604.
- The CY 2024 national minimum payment amount for pap smear codes is $17.76.
  - The affected pap smear codes for the national minimum payment amount are: 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174, 88175, G0123, G0143, G0144, G0145, G0147, G0148, Q0111, Q0115, and P3000.

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Data Reporting Delayed
Clinical Laboratory Fee Schedule (CLFS) data reporting requirements for entities under PAMA requires the reporting of certain private payer rate information from claims of specified timeframes. However, CMS announced a delay in reporting. CMS has also postponed the implementation of the phase-in of payment reductions under the CLFS from private payor rates.

- The next data reporting period will be from January 1, 2025 – March 31, 2025.
- A 0% payment reduction will be applied for CY 2024 so that a CDLT that is not an ADLT may not be reduced compared to the payment amount for that test in CY 2023 and for calendar years 2025-2027.
- Background information on data reporting requirements is found in the 2016 Final Rule linked here: *https://www.govinfo.gov/content/pkg/FR-2016-06-23/pdf/2016-14531.pdf*

1Q24 CPT & HCPCS Level II Coding Updates

Guideline Revisions

- Multiple sections in the Laboratory/Pathology section of CPT are updated to reflect revisions to the instructions for use of the CPT codebook for unlisted codes.
    - For a full explanation, reference either the CPT Guidelines document in ChargeAssist® or the CPT manual to review the revised text in the "Rationale for the Unlisted Procedure or Service" subsection of the Introduction section.

Tier 1 & Tier 2 Molecular Pathology Procedures

- 9 codes have description revisions (all OPPS SI A codes) in these two families are revised to replace the term "mental retardation" with "syndrome, X-linked intellectual disability [XLID]" including:
- 81171, 81172, 81243, and 81244 in the Tier 1 MoPath procedures section.
- 81403-81407 in the Tier 2 MoPath procedures section.
    - Changes are consistent with the Human Genome Organization (HUGO) updates based on 2010 laws.
- All of these codes also have content changes in the listing of genes tested to reflect the HUGO full gene names. Revised descriptors are listed in the ChargeAssist® Code Description Changes Auditor notes field and should be reviewed for any necessary masterfile updates.

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Genomic Sequencing Procedures & Other Molecular Multianalyte Assays

- Extensive introductory guidelines were added to this code family section. Definitions are added, and a new table is provided in the introductory guidelines. The "GSPs & Other Molecular Multianalyte Assays" coding summary table layout from the CPT Symposium is easier to interpret than the one in the CPT code book and displayed below:

GSPs & Other Molecular Multianalyte Assays
(Coding Summary Table)

Code	Specimen Source			Gene Count	Nucleic Acid	Sequence Variants	Copy# Variants	MSI	TMB	Rearrange-ments
	Solid Organ	Hemato-lymphoid	Cell Free							
81445	•		No	5-50	DNA, DNA/RNA	•	•			•
81449	•		No	5-50	RNA	•				•
81450		•	No	5-50	DNA, DNA/RNA	•	•			•
81451		•	No	5-50	RNA	•				•
81455	•	•	No	51+	DNA, DNA/RNA	•	•			•
81456	•	•	No	51+	RNA	•				•
81457	•		No	N/A	DNA	•		•		
81458	•		No	N/A	DNA	•	•	•		
81459	•		No	N/A	DNA, DNA/RNA	•	•	•	•	•
81462	•		Yes	N/A	DNA, DNA/RNA	•	•			•
81463	•		Yes	N/A	DNA	•	•	•		
81464	•		Yes	N/A	DNA, DNA/RNA	•	•	•	•	•

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- Six codes were revised, and six new codes were added:
  - 81445-81456 are revised to reflect more current clinical practice nomenclature in genomic sequencing technology.
    - Parentheticals are revised for a number of these codes as well
  - 81457, 81458, 81459, and 81462, 81463, 81464 are added as new codes
    - CPT includes a table defining code use and specimen type for Tumor Tissue or Cell Free Nucleic Acid to help with code selection. (As presented at the CPT Symposium, analysis that is performed on cell-free nucleic acid is also known as a liquid biopsy.) CPT clarifies that all of these codes include interrogation for sequence variants. The six new codes are structured based on the additional analytic technologies. (The new codes' reference table from CPT is listed below.)

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Specimen: Tumor Tissue		Specimen: Cell-free Nucleic Acid	
81457	■ Interrogation for sequence variants ■ DNA analysis ■ MSI	81462	■ Interrogation for sequence variants ■ DNA analysis or combined DNA and RNA analysis ■ Copy number variants ■ Rearrangements
81458	■ Interrogation for sequence variants ■ DNA analysis ■ Copy number variants ■ MSI	81463	■ Interrogation for sequence variants ■ DNA analysis ■ Copy number variants ■ MSI
81459	■ Interrogation for sequence variants ■ DNA analysis or combined DNA and RNA analysis ■ Copy number variants ■ MSI ■ TMB ■ Rearrangements	81464	■ Interrogation for sequence variants ■ DNA analysis or combined DNA and RNA analysis ■ Copy number variants ■ MSI ■ TMB ■ Rearrangements

- The CPT Symposium presenter outlined the joint Tumor Genomics Workgroup and CPT Panel actions to refine the genomic testing code set. They stated that this rapidly-growing area requires refinement for more granular and accurate coding.
  - Watch for future changes to the GSP section in 2025 with additional molecular testing codes.
- All of these codes noted in the above section are OPPS SI A.

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Multianalyte Assays with Algorithmic Analyses (MAAA)

- 81517 (OPPS SI Q4) is added as a new code to replace 0014M:

● **81517** Liver disease, analysis of 3 biomarkers (hyaluronic acid [HA], procollagen III amino terminal peptide [PIIINP], tissue inhibitor of metalloproteinase 1 [TIMP-1]), using immunoassays, utilizing serum, prognostic algorithm reported as a risk score and risk of liver fibrosis and liver-related clinical events within 5 years

  - CPT also created a guideline for this code stating this code should not be coded in conjunction with 83520 *Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; quantitative, not otherwise specified* for identification of biomarkers included for liver disease analysis.
  - CPT states this code is used to report an assay that uses individual biomarkers that reflect integral extracellular matrix components of dynamic fibrogenesis and fibrolysis processes in real-time.

Chemistry

- One new Chemistry code has been created for 1Q24:

● **82166** Anti-mullerian hormone (AMH)

- No former analyte-specific code existed for this hormone test.

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Hematology and Coagulation

- This code section has two updated cross-reference notes to accommodate new add-on Category III digitization codes:

85060 Blood smear, peripheral, interpretation by physician with written report

►(Use 0854T in conjunction with 85060, when the digitization of glass microscope slides is performed)◄

85097 Bone marrow, smear interpretation

►(Use 0855T in conjunction with 85097, when the digitization of glass microscope slides is performed)◄

- The above-referenced cross-reference codes within the instructional parentheticals are part of an extensive group of new “Digitization” Category III add-on codes.
    - The Category III “Digital Pathology Digitization Procedures” section of CPT has guidelines about these codes, instructions for proper reporting, and thirty new codes with detailed instructional parentheticals specific to the correlating laboratory 8XXXX code.
        - New Category III codes in this family range from 0827T to 0856T.
            - All new Category III Digital Pathology Digitization codes are OPPS SI N.

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Immunology

- Four new resequenced codes are added to this code family for 1Q24:

#● 86041 Acetylcholine receptor (AChR); binding antibody

#● 86042 blocking antibody

#● 86043 modulating antibody

  - The three new Immunology codes above are for reporting testing for acetylcholine receptor antibodies.

#● 86366 Muscle-specific kinase (MuSK) antibody

  - The one new Immunology code above is for reporting testing muscle-specific kinase antibody.
    - CDM teams will want to be sure files are updated with the more specific coding from past codes that may have been reported by your lab or reference lab (e.g., 86255 or 86256) for any of the above four tests.

- Two codes in this family have new parenthetical cross-reference notes including:
  - 87380 for hepatitis delta agent, antigen
  - 87523 (new 2024 code) for hepatitis D [delta], quantification
    - Both of the codes referenced are in the Microbiology section.
    - Both of the above notes are important to consider for correct coding in the CDM or other masterfiles.

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Microbiology

- One new code, 87523, is included for 1Q24 in this code family:
    - Hepatitis D coding updates:

87301 Infectious agent antigen detection by immunoassay technique (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]), qualitative or semiquantitative; adenovirus enteric types 40/41

87380 hepatitis, delta agent

▶(For hepatitis delta agent, antibody, use 86692)◀

▶(For hepatitis D [delta], quantification, use 87523)◀

87468 Infectious agent detection by nucleic acid (DNA or RNA); Anaplasma phagocytophilum, amplified probe technique

87522 hepatitis C, quantification, includes reverse transcription when performed

● **87523** hepatitis D (delta), quantification, including reverse transcription, when performed

- The new code 87523 has been created to report quantitative infectious agent antigen detection of hep D (a quantification of the antigen.)
    - Be sure CDM files are using the new code, where appropriate, rather than less-specific codes. (This change may be easily missed if not involving laboratory staff who are knowledgeable about whether the testing is specifically for antigen quantification.)

- One additional new code is published in the CPT code book, but was already effective:
    - The Orthopoxvirus amplified probe technique testing code was released and effective July 26, 2022 and now being included in the CPT manual for 2024:

● **87593** Orthopoxvirus (eg, monkeypox virus, cowpox virus, vaccinia virus), amplified probe technique, each

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Cytopathology

- Eleven Category III cross-reference parentheticals are added for digitization of glass microscope slides.

Surgical Pathology

- Seventeen Category III cross-reference parentheticals are added for digitization of glass microscope slides.

Proprietary Laboratory Analyses (PLA)

- Due to CPT update and publication timelines, the CPT manual will not be current with active codes in the PLA family. Consider timelines for codes when reviewing CPT publications against code update listings from real-time updates such as those within ChargeAssist®.
- PLA code descriptions are often duplicated within the CPT descriptors in the CPT codebook. The distinction in coding is the test developer, laboratory or manufacturer name. Be sure to consider Appendix O content to verify the code assignment for CDM and charge auditing.
  - ChargeAssist® routinely appends the names to the front of the codes for auditing support purposes.
  - CPT standard code syntax does not allow proprietary content in formal CPT descriptors and relies on appendices.

New PLA codes:
- 19 new PLA codes are effective 1Q24 (0420U – 0438U)
  - 2023 PLA new codes *(for historic reference)*
    - 9 new PLA codes were released in Q1
    - 23 new PLA codes were released in Q2
    - 15 new PLA codes were released in Q3
    - 18 new PLA codes were released in Q4

Deleted PLA codes:
- No 1Q24 deleted codes are included in CPT content at the time of this material development. This is due to the PLA maintenance schedule and timeline for this code family.
  - 2023 PLA deleted codes *(for historic reference)*
    - 2 PLA codes were deleted in Q2
    - 9 PLA codes were deleted in Q3
    - 4 PLA codes were deleted in Q4

Revised PLA codes:
Appendix O contains updates to the Proprietary Name and Clinical Laboratory or Manufacturer, the code, and the code descriptor. Review of this Appendix is suggested in addition to analysis of changes to the codes themselves.

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Digital Pathology Digitization Procedures

This code family and the associated Category III codes were added in 2023 with only two codes at the time. 2024 introduces thirty more codes 0751T-0763T, 0827T-0856T making the section thirty-two codes. CPT provides this explanation of this code family in last year's introductory language:

"Digital pathology is a dynamic, image-based environment that enables the acquisition, management, and interpretation of pathology information generated from digitized glass microscope slides."

As noted in the new and expanded introductory text, the technology enables the pathologist to perform remote examination. Additionally, AI algorithms can be used with this technology.

New introductory language was added for 2024, further explaining code usage and technical details about digitization codes.

The family of add-on codes may be reported in addition to the appropriate Category I service code when the digitization procedure of glass microscope slides is performed and reported in conjunction with the Category I code for the primary service. CPT clarifies for 2024 that each Category III add-on code is reported as a one-to-one unit of service for each primary pathology service code. The coding protocol is supported by the new add-on codes' instructional parentheticals.

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Crosswalk of Digitation Add-On Codes to Primary Pathology Procedures

PRIMARY CPT	PRIMARY CPT-4 DESCRIPTION (ABBREVIATED)	ADD-ON CODE	ADD-0N CODE LONG DESCRIPTION
88302	Level II - Surgical pathology, gross and microscopic examination	0751T	Digitization of glass microscope slides for level II, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)
88304	Level III - Surgical pathology, gross and microscopic examination	0752T	Digitization of glass microscope slides for level III, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)
88305	Level IV - Surgical pathology, gross and microscopic examination	0753T	Digitization of glass microscope slides for level IV, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)
88307	Level V - Surgical pathology, gross and microscopic examination	0754T	Digitization of glass microscope slides for level V, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)
88309	Level VI - Surgical pathology, gross and microscopic examination	0755T	Digitization of glass microscope slides for level VI, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)
88312	Special stain including interpretation and report; Group I	0756T	Digitization of glass microscope slides for special stain, including interpretation and report, group I, for microorganisms (eg, acid fast, methenamine silver) (List separately in addition to code for primary procedure)
88313	Special stain including interpretation and report; Group II	0757T	Digitization of glass microscope slides for special stain, including interpretation and report, group II, all other (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry (List separately in addition to code for primary procedure)
88314	Special stain including interpretation and report; histochemical stain on frozen tissue block	0758T	Digitization of glass microscope slides for special stain, including interpretation and report, histochemical stain on frozen tissue block (List separately in addition to code for primary procedure)
88319	Special stain including interpretation and report; Group III	0759T	Digitization of glass microscope slides for special stain, including interpretation and report, group III, for enzyme constituents (List separately in addition to code for primary procedure)

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88341	Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)	0761T	Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry, per specimen, each additional single antibody stain procedure (List separately in addition to code for primary procedure)
88342	Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure	0760T	Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry, per specimen, initial single antibody stain procedure (List separately in addition to code for primary procedure)
88344	Immunohistochemistry or immunocytochemistry, per specimen; each multiplex antibody stain procedure	0762T	Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry, per specimen, each multiplex antibody stain procedure (List separately in addition to code for primary procedure)
88360	Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; manual	0763T	Digitization of glass microscope slides for morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure, manual (List separately in addition to code for primary procedure)

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Regulatory / Payment System updates from 2023

- The statutory phase-in of payment reductions for laboratories resulting from private payor rate implementation is extended through CY 2024.
    - There was a 0.0 percent reduction for CYs 2021 and 2022, and payment may not be reduced by more than 15 percent for CYs 2023 through 2025.
        - Reference https://www.cms.gov/medicare/medicare-fee-for-service-payment/clinicallabfeesched

New Digital Pathology Digitization Procedure Codes

For several decades, pathologists have typically performed a microscopic exam of tissue sections that have been processed, cut and mounted on glass slides. Over time, cameras were mounted on the microscopes so pathologists could photograph specific areas of interest on a tissue slide. Photos taken were for inclusion in the medical record in support of findings and/or for sharing with other pathologists for consultative or teaching purposes.

With technology advances, tissues mounted on glass microscope slides can now be scanned by clinical staff to capture images for digital examination and archival purposes. Digital examination for pathologic diagnosis is distinct from direct visualization through the microscope and enables a pathology case to be examined remotely by a pathology and/or in conjunction with artificial intelligence.

- As noted elsewhere in this training manual, new Category III CPT code series 0751T-0763T has been established in the 2023 code set to describe the digitization of glass microscope slides.
    - The codes may be reported with the code(s) for the primary pathology services(s).
    - The codes may not be reported if the digitization is solely for archival purposes (when services are not used for individual patient reporting) or solely for developing databases for training or validation of AI algorithms or clinical conferences.
    - The OPPS Status Indicator for each of the new digitization codes is ‘N’.

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Rural Emergency Hospital (REH) Laboratory Services

- Conditions of Participation (CoPs) for rural emergency hospitals (REH) requirements
  - Provision of emergency clinical laboratory services 24 hours per day
    - Laboratory services must be available either directly or through a contractual agreement with a certified laboratory
    - Laboratory service provided must be performed in accordance with the CLIA requirements
  - Provision of basic laboratory services essential to the immediate diagnosis and treatment of the patient consistent with nationally recognized standards of care for emergency services, patient population, and services offered
  - CMS suggested laboratory services for REH include:
    - complete blood count
    - basic metabolic panel (also known as a “chem 7”)
    - magnesium
    - phosphorus
    - liver function tests
    - amylase
    - lipase
    - cardiopulmonary tests (troponin, brain natriuretic peptide, and d-dimer)
    - lactate
    - coagulation studies (prothrombin time, partial thromboplastin time, and international normalized ratio)
    - arterial blood gas, venous blood gas
    - quantitative human chorionic gonadotropin
    - urine toxicology
    - Provision of blood and blood products
- Payment for REH Laboratory services falls under the OPPS C-APC payment packaging policy and will be packaged into the REH payment for the analogous primary service or services.
- If the lab service would have been paid separately under the CLFS if furnished by a hospital that is paid under OPPS, it likewise will be paid under the CLFS at the CLFS rate when furnished by a REH.(Pages 1330- 1331 and 1707)
- For more on the Conditions of Participation for REH laboratories, see heading “§ 485.518 Condition of participation: Laboratory services” in the 2023 OPPS Final Rule.

Reference Source: 2023 OPPS Final Rule (Page 1428)

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COVID-related codes

We have included a table of current 2024 COVID testing codes, including the lab testing. (See separate manual section).

One collection code applicable to laboratory departments, C9809, is now deleted in the CPT/HCPCS masterfile updates for 1/1/24:

- C9803 *Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), any specimen source*

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CPT-4® / HCPCS Level II Code Changes

Code Section & Department-Specific 1Q24 Code Changes

Medicine-Range Code Updates

Special Otorhinolaryngologic Services

This section includes two new CPT codes for CDM maintenance.

- These two codes were developed to provide specificity and capture the service provided to patients for disorders such as conductive or mixed-hearing disorders or single-sided deafness.
- These assessments are performed in a Sound Room.
- Review the guidelines carefully, as there are many revisions in this code family.
- 92622 has an OPPS SI of S, and 92623 is status N. MPFS Work RVU is 1.25 for 92622 and 0.33 for 92623.

● **92622** Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes

+● **92623** each additional 15 minutes (List separately in addition to code for primary procedure)

▶(Use 92623 in conjunction with 92622)◀

▶(Do not report 92622, 92623 in conjunction with 92626, 92627)◀

▶(For diagnostic analysis of cochlear implant, with programming or subsequent reprogramming, see 92601, 92602, 92603, 92604)◀

▶(For evaluation of auditory function for surgically implanted device[s] candidacy or postoperative status of a surgically implanted device[s], use 92626)◀

▶(For aural rehabilitation services following auditory osseointegrated implant, see 92630, 92633)◀

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Cardiovascular

This section includes one new CPT code and one deleted Category III code (0715T) for CDM maintenance.

- 92972 has been established for the CPT 2024 code set to describe percutaneous transluminal coronary lithotripsy procedures.
- This procedure is performed using pulsatile sonic pressure waves that pass-through soft tissue and selectively interact strongly with high-density calcium, producing significant shear stresses that can fracture the calcium.
- Review the guidelines carefully, as there are many revisions in this code family.
- The OPPS SI for 29272 is status N. MPFS Work RVU is 2.97.

Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)

▶(Use 92972 in conjunction with 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92975)◀

Phrenic Nerve Stimulation System

This section includes four new CPT codes and twelve deleted Category III codes for CDM maintenance.

- Four new Category I codes (93150-93153) have been established to report programming for a phrenic nerve stimulation system.
- Review the guidelines carefully, as there are many revisions in this code family that also refer back to the earlier new codes discussed in the Surgical Section Cardiovascular System – Phrenic Nerve Stimulation System.
- The OPPS SI for the new codes are all status S. MPFS Work RVU is 0.85 for 93150, 0.80 for 93151, 1.82 for 93152 and 0.43 for 93153.

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#● **93150** Therapy activation of implanted phrenic nerve stimulator system, including all interrogation and programming

▶(Do not report 93150 in conjunction with 33276, 33277, 33278, 33279, 33280, 33281, 93151, 93152, 93153)◀

#● **93151** Interrogation and programming (minimum one parameter) of implanted phrenic nerve stimulator system

▶(Do not report 93151 in conjunction with 93150, 93152, 93153)◀

▶(For interrogation without programming of implanted phrenic nerve stimulator system, use 93153)◀

#● **93152** Interrogation and programming of implanted phrenic nerve stimulator system during polysomnography

▶(Do not report 93152 in conjunction with 33276, 93150, 93151, 93153)◀

▶(For polysomnography, see 95808, 95810, 95811, 95782, 95783)◀

#● **93153** Interrogation without programming of implanted phrenic nerve stimulator system

▶(Do not report 93153 in conjunction with 33276, 93150, 93151, 93152)◀

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Category III Codes - Noncontact Near-Infrared Spectroscopy

This section includes two new codes, two deleted codes and one code revision for CDM maintenance.

- Category III codes (0859T, 0860T) have been established to report services for noncontact near-infrared spectroscopy.
- Code 0640T has been revised; codes 0641T and 0642T have been deleted.
- Code 0859T is OPPS SI N, and 0860T is SI E1. MPFS lists 0859T as contractor-priced and 0680T as status N.

#▲ **0640T** Noncontact near-infrared spectroscopy (eg, for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), other than for screening for peripheral arterial disease, image acquisition, interpretation, and report; first anatomic site

►(Do not report 0640T in conjunction with 0860T)◄

#+● **0859T** each additional anatomic site (List separately in addition to code for primary procedure)

►(Use 0859T in conjunction with 0640T)◄

►(Report 0640T, 0859T only once, when performing noncontact near-infrared spectroscopy of multiple wounds in one anatomic site)◄

►(For noncontact near-infrared spectroscopy studies for screening for peripheral arterial disease, use 0860T)◄

►(0641T, 0642T have been deleted)◄

►(For noncontact near-infrared spectroscopy studies other than for screening for peripheral arterial disease, see 0640T, 0859T)◄

#● **0860T** Noncontact near-infrared spectroscopy (eg, for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), for screening for peripheral arterial disease, including provocative maneuvers, image acquisition, interpretation, and report, one or both lower extremities

►(Do not report 0860T in conjunction with 0640T)◄

►(For noncontact near-infrared spectroscopy studies other than for screening for peripheral arterial disease, see 0640T, 0859T)◄

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Cardiac Catheterization for Congenital Heart Defects

This section includes five new CPT add-on codes for CDM maintenance.

- Five new Category I codes (93584-93588) have been established for reporting venography services to treat congenital heart defects.
- Review the guidelines carefully, as there are many revisions in this code family.
- Radiological supervision and interpretation are included, and codes 93584-93588 are reported once per session.
- The OPPS SI for the new codes are all Status Indicator N. MPFS Work RVU is 1.20 for 93584, 1.13 for 93585, 1.43 for 93586, 2.11 for 93587 and 2.13 for 93588.

#+● **93584** Venography for congenital heart defect(s), including catheter placement, and radiological supervision and interpretation; anomalous or persistent superior vena cava when it exists as a second contralateral superior vena cava, with native drainage to heart (List separately in addition to code for primary procedure)

►(Use 93584 in conjunction with 93593, 93594, 93596, 93597)◄

►(Report 93584 once per session)◄

#+● **93585** azygos/hemiazygos venous system (List separately in addition to code for primary procedure)

►(Use 93585 in conjunction with 93593, 93594, 93596, 93597)◄

►(Report 93585 once per session)◄

#+● **93586** coronary sinus (List separately in addition to code for primary procedure)

►(Use 93586 in conjunction with 93593, 93594, 93596, 93597)◄

►(Report 93586 once per session)◄

#+● **93587** venovenous collaterals originating at or above the heart (eg, from innominate vein) (List separately in addition to code for primary procedure)

►(Use 93587 in conjunction with 93593, 93594, 93596, 93597)◄

►(Report 93587 once per session)◄

#+● **93588** venovenous collaterals originating below the heart (eg, from the inferior vena cava) (List separately in addition to code for primary procedure)

►(Use 93588 in conjunction with 93593, 93594, 93596, 93597)◄

►(Report 93588 once per session)◄

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HCPCS Level II Codes - Coronary Angiography

- Two Catheter placement codes for coronary angiography, C7557 and C7558 (both SI E1), are new for 1Q24. (See ASC Section of this manual.)
  - o Reference ChargeAssist® code additions or active HCPCS grids for full descriptors.

	HCPCS Desc	SI
C7557	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation with left heart catheterization including intraprocedural injection(s) fo...	E1
C7558	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation with right and left heart catheterization including intraprocedural...	E1

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Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration

This section includes two new CPT add-on codes and one code revision for CDM maintenance.

- Codes 96547-96548 describe hyperthermic intraperitoneal chemotherapy (HIPEC).
- HIPEC is performed intraoperatively with a catheter is placed in the abdomen for chemotherapy administration.
- These new codes are time-based.
- Review the guidelines carefully, as there are many revisions in this code family.
- Radiological supervision and interpretation are included, and codes 93584-93588 are reported once per session.
- The OPPS SI for the new codes are all status N. MPFS lists both codes as Contractor-priced.

▲ **96446** Chemotherapy administration into the peritoneal cavity via implanted port or catheter

►(For intraoperative hyperthermic intraperitoneal chemotherapy [HIPEC], see 96547, 96548)◄

+● **96547** Intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) procedure, including separate incision(s) and closure, when performed; first 60 minutes (List separately in addition to code for primary procedure)

+● **96548** each additional 30 minutes (List separately in addition to code for primary procedure)

►(Use 96547, 96548 in conjunction with 38100, 38101, 38102, 38120, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 44010, 44015, 44110, 44111, 44120, 44121, 44125, 44130, 44139, 44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44155, 44156, 44157, 44158, 44160, 44202, 44203, 44204, 44207, 44213, 44227, 47001, 47100, 48140, 48145, 48152, 48155, 49000, 49010, 49203, 49204, 49205, 49320, 58200, 58210, 58575, 58940, 58943, 58950, 58951, 58952, 58953, 58954, 58956, 58957, 58958, 58960)◄

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Special Dermatological Procedures

This section includes three code revisions for CDM maintenance.

- Parent code 96920 has been revised to include the term “Excimer” to identify the type of ultraviolet laser used to perform the service.

▲ **96920** Excimer laser treatment for psoriasis; total area less than 250 sq cm

▲ **96921** 250 sq cm to 500 sq cm

▲ **96922** over 500 sq cm

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CPT-4® / HCPCS Level II Code Changes

Code Section & Department-Specific 1Q24 Code Changes

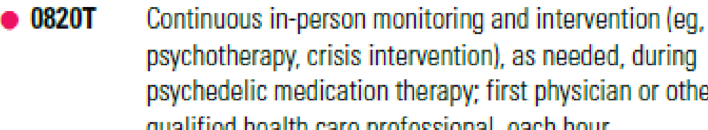
Psychiatry/Behavioral Health

New Subsection

A new subsection titled “Continuous In-Person Monitoring and Intervention During Psychedelic Medication Therapy” and three new Category III codes were created for 1Q24.

- Medicare payment indicators:
    - All three codes are MPFS Status Code C (carrier-priced) and 0.00 Work RVUs.
    - Monitor commercial coverage guidance and MAC-specific LCDs for future coverage details.
    - The primary code 0820T is OPPS SI M, not reportable for hospitals.
    - 0821T and 0822T are OPPS SI N.

New Codes:



● **0820T** Continuous in-person monitoring and intervention (eg, psychotherapy, crisis intervention), as needed, during psychedelic medication therapy; first physician or other qualified health care professional, each hour

►(Do not report 0820T in conjunction with 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 96116, 96121, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 99415, 99416, on the same date of service)◄

+● **0821T** second physician or other qualified health care professional, concurrent with first physician or other qualified health care professional, each hour (List separately in addition to code for primary procedure)

+● **0822T** clinical staff under the direction of a physician or other qualified health care professional, concurrent with first physician or other qualified health care professional, each hour (List separately in addition to code for primary procedure)

►(Use 0821T, 0822T in conjunction with 0820T)◄

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- Introductory Guidelines are important to review for proper code interpretation for this code family. We also researched this topic for a better understanding of the services summarized below:
  - CPT outlines codes that may not be reported on the same date of service in the guidelines and in exclusionary parentheticals.
  - Service background:
    - The codes are for in-person monitoring and intervention during psychedelic medication therapy in which the patient self-administers the drug in a therapeutic setting. The physician or other qualified health care professional then supports the patient's physical, emotional, and psychological safety to optimize treatment outcomes.
    - CPT notes that a typical session will last 5 to 7 hours.
    - The research into psychedelic-assisted therapy for mental health conditions was temporarily halted in the U.S. in the 1970s. However, recent studies suggest that some psychedelics may help treat mental health conditions (including depression, PTSD, alcohol use disorder, and other conditions).
    - The National Institutes of Health conducted a 2022 workshop to discuss the possible role of hallucinogens in healthcare. They studied how certain drugs may have an effect "on the perception of the exterior world and an individual's concept of their role within it," as well as the ability to "influence mood, stress management, memory, and social functioning."
    - The FDA released Draft Guidance in June 2023 for research for the use of psychedelic drugs as a potential treatment for psychiatric or substance use disorders, and will advise on the clinical design of these studies as it pertains to drug development of psychedelic medicines.

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Behavioral Health Care Improvements in MPFS Final Rule

Continuing on the path stated in recent CMS rules, congressional bills, and Presidential orders, we see numerous new coding and payment options focused on improving patient access to behavioral health care. For reference to regulatory changes, see the 2023 and 2024 Final Rules for discussion or new benefit categories authorized by section 4121(a)(2) of the Consolidated Appropriations Act, 2023 (CAA).

- Effective 1/1/24, Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs), including eligible Addiction, Alcohol, and Drug Counselors may enroll in the Medicare program. (Enrollment is available immediately if qualification requirements are met.) CMS link: Provider Enrollment FAQ Sept 2023
    - Payment is made for these services at 80 percent of the lesser of the actual charges for the services or 75 percent of the amount determined under the PFS for services of a clinical psychologist (CP)
    - Hospice Conditions of Participation (CoPs) are also updated to add MFTs and MHCs as part of the team for Hospice.

Effective 1/1/24, an increase in payments is available for crisis care, substance use disorder treatment, and psychotherapy (including psychotherapy in conjunction with an office visit and Health Behavior Assessment and Intervention.)

New Codes:

- Two new codes will be provided for payment for psychotherapy for crisis services furnished in an applicable site of service:
    - G0017 - *Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting); first 60 minutes (OPPS SI M; MPFS Status Code A, Work RVU 4.70)*
    - G0018 - *Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting); each additional 30 minutes (List separately in addition to code for primary service (OPPS SI M; MPFS Status Code A, Work RVU 2.25)*
- Health Behavior Assessment and Intervention (HBAI) Services (CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168) will be allowed to be provided by those other than Clinical Psychologists (CPs) (including MFTs and MHCs and Clinical Social Workers (CSWs)).
- Payment increases were finalized for behavioral health services. Payment increases of 19.1% will be implemented over a four-year transition period. Codes impacted include standalone psychotherapy services, psychotherapy codes billed as an add-on to an E/M visit (90833, 90836, and 90838), and HBAI services (90833, 90836, and 90838).

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- The payment rate for Substance Use Disorder (SUD) bundled HCPCS codes, G2086 and G2087, (both established 1Q20), have been increased to reflect two psychotherapy sessions per month.
  - There is also an add-on code for each additional 30 minutes not impacted by this change.

Code	Description	OPPS SI	OPPS	MPFS Status Cd	Work RVU
G2086	Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month	S	152.07	A	8.36
G2087	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month	S	152.07	A	8.19
G2088	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (list separately in addition to code for primary procedure)	N		A	0.82

- Another code, C7903, is listed in the 1Q24 updates and OPPS guidance for group therapy. CMS notes that this new code is an untimed code.

↑	HCPCS Desc	SI	Payment Rate
C7903	Group psychotherapy service for diagnosis, evaluation, or treatment of a mental health or substance use disorder provided remotely by hospital staff who are licensed to provide mental health services under applicable state law(s), when the patient is in their home, and there is no...	S	$27.38

  - Full description: "Group psychotherapy service for diagnosis, evaluation, or treatment of a mental health or substance use disorder provided remotely by hospital staff who are licensed to provide mental health services under applicable state law(s), when the patient is in their home, and there is no associated professional service"

Principal Illness Navigation Services & Social Determinants of Health

The 2024 MPFS Final Rule addresses new codes and payment for Principal Illness Navigation (PIN) services using personnel serving as patient navigators and peer support specialists who provide the patient with assistance with their serious high-risk condition or illness treatment.

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New Codes:
CMS labels the applicable PIN services that auxiliary personnel offer as “person-centered planning”, with a focus on “promoting patient self-advocacy”, and “facilitating access to community-based resources” to address the beneficiary’s unmet social needs and other factors relevant to the diagnosis and treatment.

Other services in this new category of benefits are focused on the beneficiary’s Social Determinants of Health (SDOH) needs. CMS created code G0136 for SDOH risk assessment.

- G0136 - *Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5-15 minutes (OPPS SI S National Rate $27.38; MPFS Status Code A, Work RVU 0.18)*

This code must be billed along with qualifying visit charges. Qualifying visits include E/M visits, select behavioral health visits, or the Medicare Annual Wellness Visit (AWV).

PIN services HCPCS Level II codes include G0023, G0024, G0140, and G0146.
- G0023 - *Principal illness navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator; 60 minutes per calendar month, in the following activities: person-centered assessment, performed to better understand the individual context of the serious, high-risk condition. ++ conducting a person-centered assessment to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors and including unmet sdoh needs (that are not separately billed). ++ facilitating patient-driven goal setting and establishing an action plan. ++ providing tailored support as needed to accomplish the practitioner's treatment plan. identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services. practitioner, home, and community-based care coordination. ++ coordinating receipt of needed services from healthcare practitioners, providers, and facilities; home- and community-based service providers; and caregiver (if applicable). ++ communication with practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors. ++ coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities. ++ facilitating access to community-based social services (e.g., housing, utilities, transportation, likely to promote personalized and effective treatment of their condition. health care access / health system navigation. ++ helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care, and helping secure appointments with them. ++ providing the patient with information/resources to consider participation in clinical trials or clinical research as applicable. facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals. facilitating and providing social and emotional support to help the patient cope with the condition, sdoh need(s),*

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and adjust daily routines to better meet diagnosis and treatment goals. leverage knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals (OPPS SI S, National Rate $85.01;; MPFS Status code A, Work RVU 1.00)

- G0024 - *Principal illness navigation services, additional 30 minutes per calendar month (list separately in addition to G0023) (OPPS SI N; MPFS Status Code A, Work RVU 0.7)*
- G0140 - *Principal illness navigation - peer support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month, in the following activities: person-centered interview, performed to better understand the individual context of the serious, high-risk condition. ++ conducting a person-centered interview to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors, and including unmet sdoh needs (that are not billed separately). ++ facilitating patient-driven goal setting and establishing an action plan. ++ providing tailored support as needed to accomplish the person-centered goals in the practitioner's treatment plan. identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services. practitioner, home, and community-based care communication. ++ assist the patient in communicating with their practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, goals, preferences, and desired outcomes, including cultural and linguistic factors. ++ facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address sdoh need(s). health education. helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and sdoh need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making. building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition. developing and proposing strategies to help meet person-centered treatment goals and supporting the patient in using chosen strategies to reach person-centered treatment goals. facilitating and providing social and emotional support to help the patient cope with the condition, sdoh need(s), and adjust daily routines to better meet person-centered diagnosis and treatment goals. leverage knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals (OPPS SI S, $85.01 National Rate; MPFS Status Code A, Work RVU 1.00)*
- G0146 - *Principal illness navigation - peer support, additional 30 minutes per calendar month (list separately in addition to g0140) (OPPS SI N; MPFS Status Code A, Work RVU 0.70)*

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Caregiver Training

CMS 2024 MPFS summary presentations and Final Rule narrative also introduced another unique benefit for Medicare for caregiver-focused services. New codes were created by CPT to report practitioner (physician, NPP, or therapist) training of one or more of the beneficiary's caregivers to assist the patient with certain diseases or illnesses (e.g., dementia) in carrying out the practitioner's treatment plan. Codes include: 96202, 96203, 97550, 97551, 97552.

Codes introduced 1Q23:

- 96202- *Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); initial 60 minutes (OPPS SI; MPFS Status Code A, Work RVU 0.43)*

- 96203- *Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); each additional 15 minutes (List separately in addition to code for primary service) (OPPS SI N; MPFS Status Code A, Work RVU 0.12)*

New Codes:

- 97550- *Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; initial 30 minutes (OPPS SI A; MPFS Status A, Work RVU 1.00)*

- 97551- *Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; each additional 15 minutes (List separately in addition to code for primary service) (OPPS SI A; MPFS Status A, Work RVU 0.54)*

- 97552- *Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face with multiple sets of caregivers (OPPS SI A; MPFS Status A, Work RVU 0.23)*

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Providers may include physicians, non-physician practitioners (nurse practitioners, clinical nurse specialists, certified nurse-midwives, physician assistants, and clinical psychologists), or therapists (physical therapist, occupational therapist, or speech language pathologist).

Additional MPFS Updates

- The MPFS 2024 Final Rule updates Partial Hospitalization with:
    - Changes to the methodology used to calculate the Community Mental Health Center (CMHC) and hospital-based PHP (HB PHP) geometric mean per diem costs and changes to expand PHP payment from two APCs to four APCs.
- The 2024 rule also establishes payment for intensive outpatient (IOP) services under Medicare beginning January 1, 2024.
- We also suggest review of regulatory information that finalizes changes to the CMHC CoPs to provide requirements for furnishing IOP services.

OPPS information

Section VIII (starting on p. 639 of the OPPS Final Rule Display Copy) discusses 2024 OPPS language that finalizes changes to the community mental health center (CMHC) Conditions of Participation (CoPs) and information on requirements for furnishing intensive outpatient (IOP) services. The OPPS rule also includes the language on personnel qualifications for mental health counselors (MHCs) and marriage and family therapists (MFTs) as discussed in MPFS rulemaking.

- Page 647 provides the Intensive Outpatient Program Services Final Rule language established for coverage in 2023, effective 1/1/24. CMS explains IOP services in this section below:

  Intensive outpatient services are furnished under an intensive outpatient program (IOP). Similar to PHP, an IOP is a distinct and organized outpatient program of psychiatric services provided for individuals who have an acute mental illness, which includes, but is not limited to, conditions such as depression, schizophrenia, and SUD. Generally speaking, an IOP is thought to be less intensive than a PHP, and the statutory definition of IOP services reflects this difference in intensity.

  CMS Definition of Intensive Outpatient Services: Intensive outpatient services means a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care other than in an individual's home or in an inpatient or residential setting and furnishes the services as described in § 410.44. Intensive outpatient services are not required to be provided in lieu of inpatient hospitalization. Based on Final Rule comments, CMS will also add reference to Substance Use Disorder (SUD) to the definition in codified language.

CAA, 2023 established IOP within the continuum of care, and the statute makes reference to weekly hour requirements. Specifically, IOP patients are required to be certified by a physician as needing at least 9 hours of services per week, while PHP patients are required to be certified by a physician as needing at least 20 hours of services per week.

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Section C. (page 671) discusses C. Coding and Billing for PHP and IOP Services under the OPPS. See this section for a discussion of Condition Code 92 and HCPCS requirements for IOP claims. Table 98 and Table 99 (beginning on page 693) provide the Final HCPCS applicable for PHP and IOP. These may be helpful references for populating charging systems, order menus, or other software application needs.

The PHP and IOP Per Diem cost-related payment is discussed in the Final Rule on page 709. Review the applicable APC current rates in ChargeAssist® for final payment information under OPPS.

> *The calculated CY 2024 hospital-based IOP APC geometric mean per diem cost for hospital-based IOP providers that provide 3 services per service day is $266.35, which we will use for calculating the payment rate for the 3-service day hospital-based IOP APC 5861. The calculated CY 2024 hospital-based IOP APC geometric mean per diem cost for hospital-based IOP providers that provide 4 services per day is $367.79, which we proposed to use for calculating the payment rate for the 4-service day hospital-based IOP APC 5862.*

We suggest a review of this entire Final Rule section by any organization offering Partial Hospitalization or IOP services to fully understand CMS guidance. We anticipate summarized information in Transmittal and MLN publications in the coming weeks.

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CPT-4® / HCPCS Level II Code Changes

Code Section & Department-Specific 1Q24 Code Changes

Ophthalmology

Surgical Code CPT Update (in previous manual section)

New Codes:

Eye and Ocular Adnexa (from Surgery Code manual section)

This section includes one new CPT code, one new Category III code added July 1, 2023, and the deletion of two codes.

- CPT 67516 has been established as a new Level I CPT code to report the suprachoroidal injection of a pharmacologic agent.
  - This code is designed as a separate procedure.
  - 67516 has an OPPS SI of T and MPFS Work RVU 1.53

	HCPCS Desc	SI	Payment Rate
67516	Suprachoroidal space injection of pharmacologic agent (separate procedure)	T	$323.02

● **67516** Suprachoroidal space injection of pharmacologic agent (separate procedure)

►(Report medication separately)◄

Code 67516 identifies the administration of a drug into the suprachoroidal space between the sclera and choroid, which compartmentalizes the drug within the posterior segment of the eye.

- This code replaces Category III code 0465T.

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Deleted Code:

0465T has been deleted 1Q24 and replaced by new code, 67516.

Current ...	Deleted Code Desc	All Replacement Codes
0465T	Suprachoroidal injection of a pharmacologic agent (does not include supply of medication)	67516

New Code: (3Q23)

● **0810T** Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies

▶(Report medication separately)◀

▶(Do not report 0810T in conjunction with 67036, 67039, 67040, 67041, 67042, 67043)◀

New Category III code 0810T was established in 3Q23 to report subretinal injection of a pharmacologic agent, including vitrectomy and one or more retinotomies.

- This replaces C9770 (see the following HCPCS Level II section for details).
- 0810T *Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies* was effective July 1, 2023, and for 1Q24, will be assigned OPPS SI T and paid $4250.50 National OPPS Rate.
  0810T has had an OPPS SI update from E1 to T
- This code has an involved code change history, as noted below in ChargeAssist:

Name	Change Desc	Qtr	Yr	Old Value	New Value
Replaces	C9770: Vitrectomy, mechanical, pars plana approach, with subretinal injection of pharmacologic/biologic...	Q1	2024	C9770	0810T
OPPS SI Changes	Quarter Q1, 2024: SI changed from E1 to T.	Q1	2024	E1	T
OPPS Rate Changes	Quarter Q1, 2024: APC Payment Rate changed from NULL to 4250.50.	Q1	2024		4250.50
Additions	Code 0810T added.	Q3	2023		
OPPS SI Changes	Quarter Q3, 2023: SI changed from NULL to E1.	Q3	2023		E1

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Deleted Code:

Code C9770 has been deleted 1Q24 and is replaced by 0810T.

- CMS recognized the similarity between HCPCS code C9770 and 0810T. It proposed deletion of HCPCS code C9770 and recognition of CPT code 0810T.
  - C9770 was assigned a New Technology APC in 2021 when it was established.
  - See discussion of this procedure and the associated gene therapy product in the OPPS Final Rule p. 189 Display Copy.
    - Drug discussed in OPPS Final Rule: Brand Name Luxturna®, J3398 *Injection, voretigene neparvovec-rzyl, 1 billion vector genomes;* (OPPS SI K, $2907.93 National Rate)
    - CPT 0810T *Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies* was effective July 1, 2023, and for 1Q24 will be assigned OPPS SI T and paid $4250.50 National OPPS Rate.

Current ...	Deleted Code Desc	All Replacement Codes
C9770	Vitrectomy, mechanical, pars plana approach, with subretinal injection of pharmacologic/biologic agent	0810T

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CPT-4® / HCPCS Level II Code Changes

Code Section & Department-Specific 1Q24 Code Changes

Physical Medicine & Rehabilitation

Modalities

- For proper reporting of transcutaneous magnetic stimulation, Category III code deletions are referenced in several cross-reference parentheticals of the 97XXX CPT range, replacing 0768T and 0769T with 0766T and 0767T in the guideline.
- CPT released for 2024 a code for reporting low-level laser therapy (non-thermal) for postoperative pain reduction. New code, 97037, is listed as a resequenced code and a child code that falls under 97032 *Application of a modality to 1 or more areas.*

#● 97037 low-level laser therapy (ie, nonthermal and non-ablative) for post-operative pain reduction

▶(Do not report 97037 in conjunction with 0552T)◀

▶(For dynamic thermokinetic energies therapy, infrared, use 97026)◀

- A new Category II Code, 0791T, added during 3Q23, is listed in the 2024 CPT publication versions with instructional parenthetical notes added to the gait training therapeutic procedure code 97116. This code is used when motor-cognitive, semi-immersive virtual reality-facilitated gait training is performed.
    - Remember that this new add-on code will not appear within 1Q24 changes modules since it was a 2023 update.

+● 0791T Motor-cognitive, semi-immersive virtual reality–facilitated gait training, each 15 minutes (List separately in addition to code for primary procedure)

▶(Use 0791T in conjunction with 97116)◀

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Special Otorhinolaryngologic Services

Evaluative and Therapeutic Services

- Auditory system middle ear codes for osseointegrated implants in the 697XX CPT range have new guidelines for the diagnostic analysis, programming and verification of an auditory osseointegrated sound processor, pointing the user to 92622 and 92623.
- New codes 92622 and 92623 are included in this section for the Rehab Department's potential reference needs for CDM updates. See the Surgical Code section for more discussion of these codes.

● **92622** Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes

+● **92623** each additional 15 minutes (List separately in addition to code for primary procedure)

▶(Use 92623 in conjunction with 92622)◀

▶(Do not report 92622, 92623 in conjunction with 92626, 92627)◀

▶(For diagnostic analysis of cochlear implant, with programming or subsequent reprogramming, see 92601, 92602, 92603, 92604)◀

▶(For evaluation of auditory function for surgically implanted device[s] candidacy or postoperative status of a surgically implanted device[s], use 92626)◀

▶(For aural rehabilitation services following auditory osseointegrated implant, see 92630, 92633)◀

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Caregiver Training Without the Patient Present

- A new code family subsection has been created for 2024, which includes new codes and guidelines. The rationale for the services represented by these codes is included in the MPFS Fee Schedule section of this program.
  - Introductory guidelines have been created to define Caregiver Training, explain the medical scenarios of how the codes are used, and clarify how the codes are used.
    - Caregiver training is direct, skilled intervention for the caregiver(s) to provide strategies and techniques to equip caregiver(s) with knowledge and skills to assist patients living with functional deficits.

►Caregiver Training Without the Patient Present◄

►Caregiver training is direct, skilled intervention for the caregiver(s) to provide strategies and techniques to equip caregiver(s) with knowledge and skills to assist patients living with functional deficits. Codes 97550, 97551 are used to report the total duration of face-to-face time spent by the qualified health care professional providing training to the caregiver(s) of an individual patient without the patient present. Code 97552 is used to report group caregiver training provided to multiple sets of caregivers for multiple patients with similar conditions or therapeutic needs without the patient present.

During a skilled intervention, the caregiver(s) is trained using verbal instructions, video and live demonstrations, and feedback from the qualified health care professional on the use of strategies and techniques to facilitate functional performance and safety in the home or community without the patient present. Skilled training supports a caregiver's understanding of the patient's treatment plan, ability to engage in activities with the patient in between treatment sessions, and knowledge of external resources to assist in areas such as activities of daily living (ADLs), transfers, mobility, safety practices, problem solving, and communication.

These services do not represent therapeutic interventions requiring direct one-to-one patient contact.◄

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New Codes:

● **97550** Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; initial 30 minutes

+● **97551** each additional 15 minutes (List separately in addition to code for primary service)

▶(Use 97551 in conjunction with 97550)◀

● **97552** Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face with multiple sets of caregivers

MPFS Status and Work RVU Values

CPT/ HCPCS	Mod	Status	DESCRIPTION	Work RVU
97550		A	Caregiver training 1st 30 min	1.00
97551		A	Caregiver training ea addl 15	0.54
97552		A	Group caregiver training	0.23

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Category III codes

▲ **0766T** Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve

+▲ **0767T** each additional nerve (List separately in addition to code for primary procedure)

- Two Category III codes, 0766T and 0767T, created 1Q23, are revised for 1Q24 for transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse. The procedure is performed to treat chronic nerve pain. The change is that the term 'initial treatment' has been deleted from both codes.
    - Primary code 0766T for the first nerve is OPPS SI Q1 and has a payment amount under OPPS of $145.43.
    - The add-on code 0767T for each additional nerve is OPPS SI N due to policy packaging of add-on coding and has no separate payment amount under OPPS.

	New Description	Old Description	Auditor Notes
0766T	Transcutaneous magnetic stimulation by focused low-frequency...	Transcutaneous magnetic stimulation by focused low-frequency...	Description revised by deleting 'initial treatment'
0767T	Transcutaneous magnetic stimulation by focused low-frequency...	Transcutaneous magnetic stimulation by focused low-frequency...	Description revised by deleting 'initial treatment'

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- New coding guidelines explain how these codes are to be reported:

  ▶Codes 0766T, 0767T describe transcutaneous magnetic stimulation that is performed to treat chronic nerve pain and provided by a physician or other qualified health care professional. The selected nerve is mapped and localized using magnetic stimulation at the time of each treatment and the appropriate amplitude of magnetic stimulation is defined. Noninvasive electroneurography (nerve conduction) may be used as guidance to confirm the precise localization of the selected nerve and, when performed, should not be separately reported as a diagnostic study. A separate diagnostic nerve conduction study performed prior to the decision to treat with transcutaneous magnetic stimulation may be separately reported.◀

- The above changes to code descriptions correlate to the deletion of 0768T and 0769T for 1Q24, and the deleted code cross-references point to the above two revised codes as noted in the parenthetical notes.
- Changes to this code family are due to the evolution of the service. CPT determined there is no longer a difference between the initial and subsequent treatment.
- The procedure change per CPT was *"prior markation of the skin and obtaining photographs"* which are no longer a differentiator of the service to warrant separate codes.

▶(0768T, 0769T have been deleted)◀

▶(For transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, see 0766T, 0767T)◀

Deleted code full descriptions:

Current HCPCS	Deleted Code Desc
0768T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, subsequent treatment, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve
0769T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, subsequent treatment, including noninvasive electroneurographic localization (nerve conduction localization), when performed; each additional nerve (List separately in addition to code for primary procedure)

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CMS Payment System Updates

2024 MPFS Therapy Services Updates

Supervision Policy for Private Practice PTs & Ots

As noted in the MPFS Final Rule, private practice therapy assistants have required direct supervision from PTs and OTs since 2005. For 2024, CMS will now allow general supervision in the PT and OT Private Practice setting specifically for Remote Therapeutic Monitoring services. Watch for future expansion of this policy to other therapy services as CMS allows even greater flexibilities over time.

- General supervision- therapists are not required to be present in the office suite while their assistants provide RTM services.
- Direct supervision- therapists not enrolled in Medicare or working as employees of therapists in private practice are still required to provide RTM services under direct supervision.

2024 PT & OT Threshold Amounts

The -KX modifier threshold amounts were updated for 2024 at $2,330 for OT and $2,330 for PT and SLP services combined.

Payment System Regulations 2024

- Telehealth updates are summarized in this training program manual's section titled "MPFS 2024 Final Rule Highlights". We suggest that teams review updates to telehealth lists code codes and modifier use.
- Rehab departments may need to be oriented to new CMS benefits and services in the event their scope of work, licensure, and participation in the care team include the rehab department staff. The 2024 MPFS and 2024 OPPS Final Rules implement various expanded benefits following Presidential and legislative directives, including:
  - Community health integration services (G0019 and G0022)
  - Social determinants of health services (G0136)
  - Principal illness navigation services (G0023, G0024, G0140, and G0146)
  - Caregiver training (96202, 96203, 97550, 97551, 97552); note that some of these codes are not reportable under OPPS

Payment System Regulations 2023

- For historical reference, CY 2023 KX threshold amount of $2,230 for PT and SLP services combined and $2,230 for OT services. Section 1833(g)(7)(B) of the Act was also added by section 50202 of the BBA of 2018, and it retains the targeted medical review process, but at a lower threshold amount of $3,000 (until CY 2028 when it is updated by the MEI). Accordingly, for CY 2023, the MR threshold is $3,000 for PT and SLP services combined and $3,000 for OT services.

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CPT-4® / HCPCS Level II Code Changes

Code Section & Department-Specific 1Q24 Code Changes

Neurology Diagnostic Services

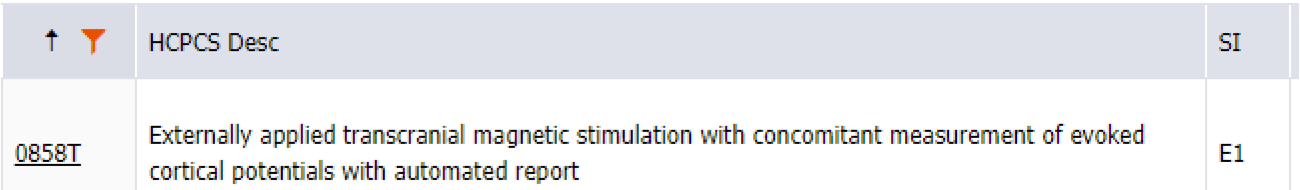
Category III Code

New Code:

Code 0858T is new for 1Q24 services for which no codes existed. This procedure may belong in varied cost center CDM files such as Neurology Clinics, or EEG Departments, so confirm who may be involved in performing it when applicable to your clinical environment.

● **0858T** Externally applied transcranial magnetic stimulation with concomitant measurement of evoked cortical potentials with automated report

▶(Do not report 0858T in conjunction with 95836, 95957, 95961, 95965, 95966)◀



	HCPCS Desc	SI
0858T	Externally applied transcranial magnetic stimulation with concomitant measurement of evoked cortical potentials with automated report	E1

- This procedure is for the measurement of evoked cortical potentials associated with transcranial magnetic stimulation.
    -
    - The procedure involves two or more cortical areas using external scalp electrode channels. When stimulated, the device performs automated signal processing which indicates brain physiological features of connectivity, excitability, and plasticity. The objective is to see whether there may be impairment with structural or functional brain deficits. Review Category III code guidelines and clinical examples from CPT for more clinical details.

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CPT-4® / HCPCS Level II Code Changes

Code Section & Department-Specific 1Q24 Code Changes

Supply Codes

General Supplies

New Codes:

- 75 A-range supply codes were released for 1Q24.
  - 66 codes are OPPS SI A, paid under another method.
    - All new codes listed as SI A represent gradient compression bandaging or wraps.
  - 3 codes are OPPS SI Y, DME
  - 4 codes are non-covered OPPS SI E1
  - 2 of the A range new codes are radioisotopes summarized in the Radiology section

Description Changes:

- 7 A range HCPCS codes representing gradient compression stocking codes have description revisions.
  - Review of each code's description change suggested through the ChargeAssist® change module by looking at old and dew descriptors and the correlating Auditor Notes.

CMS Coverage Updates

Transmittal 12359, issued November 9, 2023, was rescinded and replaced by Transmittal 12379 CR 13286, dated November 22, 2023, to reflect the final policies in the Calendar Year (CY) 2024 Home Health Prospective Payment System Final Rule published in November. The transmittal's subject is: "Implementation of New Benefit Category for Lymphedema Compression Treatment Items" with regulations effective January 1, 2024.

The Consolidated Appropriations Act (CAA), 2023, created a new Medicare DMEPOS benefit category for "standard and custom fitted compression garments and additional lymphedema compression treatment items that are primarily and customarily used to serve a medical purpose, for the treatment of lymphedema, and are prescribed by an authorized practitioner". The new coverage is effective for items furnished on or after January 1, 2024. CMS notes in the transmittal guidance that compression garments for the treatment of lymphedema have been non-covered since there has not been a prior benefit category.

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CMS states that the general scope of the new lymphedema compression treatment items benefit includes the following categories of items:

- Standard daytime gradient compression garments;
- Custom daytime gradient compression garments;
- Nighttime gradient compression garments;
- Gradient compression wraps;
- Accessories (e.g., zippers, linings, padding or fillers, etc.) necessary for the effective use of a gradient compression garment or wrap; and
- Compression bandaging systems/supplies.

Medicare will cover and pay for three daytime garments or wraps every six months and two nighttime garments or wraps every two years.

HCPCS Level II codes included under the new benefit category are found in the transmittal Attachment. The following Final Rule is included in the ChargeAssist® document center for review or found through the Federal Register here:

https://www.federalregister.gov/documents/2023/11/13/2023-24455/medicare-program-calendar-year-cy-2024-home-health-hh-prospective-payment-system-rate-update-hh

Within the above rule, section B. 2. Background and subsequent sections provide a detailed explanation of lymphedema and treatments. The Rule language is beneficial to review for more clinical background.

As stated in the Rule, the amount paid for lymphedema compression treatment items defined in section 1861(mmm) of the Act shall be equal to 80 percent of the lesser of the actual charge or the amount determined using the payment basis established by HHS. We will monitor the DMEPOS Fee Schedule for these rates when released.

New HCPCS PI 40 will be used to represent these items.

OPPS Updates

As noted in the OPPS section of this training manual, several supply codes have been newly-assigned to SI A.

- 11 codes were SI E1 for Gradient compression stocking A range codes and now assigned SI A (paid under another method)

- 3 codes were SI N for below knee gradient compression stocking A range codes (only billable for specific clinical conditions with specific coding rules) and now assigned SI A

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DME & DME Supplies

New Codes:

- 18 new codes were released for 1Q24 that are assigned DME OPPS SI Y
  - 3 A-range codes
  - 12 E-range codes
  - 3 L-range codes
    - Watch for Pricing Indicators in the final versions of 2024 data to see the HCPCS categorization of these items as either Prosthetic Orthotic (PI 38) or DME. We suspect the SI Y from OPPS may be incorrectly assigned, and the L codes may be changed to SI A.
- There are 15 new E-range codes
  - 3 E-range codes are non-covered
  - 12 E-range codes are OPPS SI Y

Deleted Codes:

- 25 K range codes are deleted for 1Q24. Use of the replacement code field in the Code Change master in ChargeAssist® is suggested.
  - 15 codes are replaced with E-range codes
  - 7 codes are replaced with A-range codes
  - 3 codes are replaced with L-range codes.

Implanted Devices

- C-range device codes are discussed in the following section.

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CPT-4® / HCPCS LEVEL II CODE CHANGES

Code Section & Department-Specific 1Q24 Code Changes

Skin Substitutes

OPPS Final Rule

Updates from OPPS Final Rule 2024

As in past years, CMS addresses products classified as "Skin Substitutes" in the OPPS Final Rule.

- Background information on the Skin Substitute coding and payment treatment from OPPS:
  - These graft application products are unconditionally packaged into surgical procedure costs under OPPS.
  - High-cost and low-cost groups are assigned by CMS and shown in I/OCE edits.
  - Skin substitutes assigned to the high-cost group are described by HCPCS codes 15271 through 15278, while those assigned to the low-cost group are described by HCPCS codes C5271 through C5278.
  - Table 95 of the OPPS Final Rule (beginning on page 613) of the Display Copy lists the high and low classification for 2024 by HCPCS code that will also be reflected in I/OCE edits when released.
    - The High and Low classifications are discussed in section V.B.7. " High-Cost/Low-Cost Threshold for Packaged Skin Substitutes," beginning on page 598 of the OPPS Final Rule Display Copy.
- Many hospitals fail to charge correctly for these products, and under-report the units of service by centimeter as represented by the codes.

Updates from MPFS Final Rule 2024

- In 2024, CMS clarified that for CY 2023 and 2024, it was finalizing that JW units of skin substitutes would not be used for the discarded drug refund calculations. CMS will not issue reports to manufacturers with respect to skin substitutes.

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Code updates

New Codes:

19 new Q range skin substitute codes are added. No new codes were added in the 1527X range.

	HCPCS Desc	SI
Q4279	Vendaje ac, per square centimeter	N
Q4287	Dermabind dl, per square centimeter	N
Q4288	Dermabind ch, per square centimeter	N
Q4289	Revoshield + amniotic barrier, per square centimeter	N
Q4290	Membrane wrap-hydro, per square centimeter	N
Q4291	Lamellas xt, per square centimeter	N
Q4292	Lamellas, per square centimeter	N
Q4293	Acesso dl, per square centimeter	N
Q4294	Amnio quad-core, per square centimeter	N
Q4295	Amnio tri-core amniotic, per square centimeter	N
Q4296	Rebound matrix, per square centimeter	N
Q4297	Emerge matrix, per square centimeter	N
Q4298	Amnicore pro, per square centimeter	N
Q4299	Amnicore pro+, per square centimeter	N
Q4300	Acesso tl, per square centimeter	N
Q4301	Activate matrix, per square centimeter	N
Q4302	Complete aca, per square centimeter	N
Q4303	Complete aa, per square centimeter	N
Q4304	Grafix plus, per square centimeter	N

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Deleted Codes:

No Skin Substitute codes are deleted.

Description Changes:

One Skin Substitute code has a description change for 1Q24.

	New Description	Old Description	Auditor Notes	Desc Change Type	SI
Q4225	Amniobind or dermabind tl, per square centimeter	Amniobind, per square centimeter	Description revised by adding 'or dermabind tl'	Content	N

- Last year's 2023 OPPS Final Rule includes dialogue about CMS treatment for Skin Substitutes. CMS payment objectives noted on page 689 of the Display copy include this language:

  "We outlined our HCPCS Level II coding and payment policy objectives in the CY 2023 OPPS/ASC proposed rule as we believed it would be beneficial for interested parties to understand, as we work to create a consistent approach for treatment of the suite of products we have referred to as skin substitutes. We have a number of objectives related to refining Medicare policies in this area, including: 1) ensuring a consistent payment approach for skin substitute products across the physician office and hospital outpatient department settings; 2) ensuring that appropriate HCPCS codes describe skin substitute products; 3) using a uniform benefit category across products within the physician office setting, regardless of whether the product is synthetic or comprised of human or animal based material, so we can incorporate payment methodologies that are more consistent; and 4) maintaining clarity for interested parties on CMS skin substitutes policies and procedures."

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CPT-4® / HCPCS Level II Code Changes

Code Section & Department-Specific 1Q24 Code Changes

OPPS Pass-Through Devices

C-Range Device Pass-Through Status Codes

Effective January 1, 2024, CMS will pay for the following 12 devices under transitional pass-through status.

Hcpcs	CPT/HCPCS Long Desc	OPPS SI
C1600	Catheter, transluminal intravascular lesion preparation device, bladed, sheathed (insertable)	H
C1601	Endoscope, single-use (i.e. disposable), pulmonary, imaging/illumination device (insertable)	H
C1602	Orthopedic/device/drug matrix/absorbable bone void filler, antimicrobial-eluting (implantable)	H
C1603	Retrieval device, insertable, laser (used to retrieve intravascular inferior vena cava filter)	H
C1604	Graft, transmural transvenous arterial bypass (implantable), with all delivery system components	H
C1747	Endoscope, single-use (i.e. disposable), urinary tract, imaging/illumination device (insertable)	H
C1761	Catheter, transluminal intravascular lithotripsy, coronary	H
C1826	Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system	H
C1827	Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller	H
C1831	Interbody cage, anterior, lateral or posterior, personalized (implantable)	H
C1832	Autograft suspension, including cell processing and application, and all system components	H
C1833	Monitor, cardiac, including intracardiac lead and all system components (implantable)	H

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- OPPS Payment for Devices is in Section IV. A. of the 2024 OPPS Final Rule beginning on page 395 of the Display Copy.
- CMS requires the category of devices to be eligible for transitional pass-through payments for at least 2 years, but not more than 3 years. Page 399 includes the criteria for receiving pass-through payment classification under OPPS.
- Table 84 on page 397 lists Pass-Through devices and expiration dates.

TABLE 84: DEVICES WITH PASS-THROUGH STATUS EXPIRING IN 2023, IN 2024, OR IN 2025

HCPCS Code	Long Descriptor	Effective Date	Pass-Through Expiration Date
C1824*	Generator, cardiac contractility modulation (implantable)	1/1/2020	12/31/2023
C1982*	Catheter, pressure-generating, one-way valve, intermittently occlusive	1/1/2020	12/31/2023
C1839*	Iris prosthesis	1/1/2020	12/31/2023
C1734*	Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue-to bone (implantable)	1/1/2020	12/31/2023
C2596*	Probe, image-guided, robotic, waterjet ablation	1/1/2020	12/31/2023
C1052	Hemostatic agent, gastrointestinal, topical	1/1/2021	12/31/2023
C1062	Intravertebral body fracture augmentation with implant (e.g., metal, polymer)	1/1/2021	12/31/2023
C1825	Generator, neurostimulator (implantable), nonrechargeable with carotid sinus baroreceptor stimulation lead(s)	1/1/2021	12/31/2023
C1761	Catheter, transluminal intravascular lithotripsy, coronary	7/1/2021	6/30/2024
C1831	Personalized, anterior and lateral interbody cage (implantable)	10/1/2021	9/30/2024
C1832	Autograft suspension, including cell processing and application, and all system components	1/1/2022	12/31/2024
C1833	Monitor, cardiac, including intracardiac lead and all system components (implantable)	1/1/2022	12/31/2024
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
C1827	Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller	1/1/2023	12/31/2025
C1747	Endoscope, single-use (i.e. disposable), urinary tract, imaging/illumination device (insertable)	1/1/2023	12/31/2025

*Device for which pass-through status was extended for a 1-year period by section (a)(2) of the Consolidated Appropriations Act, 2023 (CAA, 2023) (Pub. L. 117-328), titled "Extension of Pass-Through Status Under the Medicare Program for Certain Devices Impacted by COVID-19."

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Of six pass-through device applications, CMS approved one early (through the quarterly review process), then it was determined to be approved in error and code C1834 was deleted on 3/31/23 (2Q23).

2024 OPPS Final Rule information

New Technology IOLs

- For 2024, OPPS Final Rule discuses New Technology Intraocular Lens (NTIOL) application cycle on page 100 of the Display Copy. CMS did not receive any requests for review of devices for classification as NTIOLs for 2024.
- The payment adjustment remains $50 per lens for a five-year period from when the new NTIOL class is created.

2023 OPPS Final Rule information (for reference)

- The 2023 OPPS Final Rule outlines Pass-Through Device payment in section IV. A. (page 390 of the display copy)

- CMS notes that it will continue existing policies of Device Edits without reviving "Device to Procedure" and "Procedure to Device" specific mapping tables. CMS's quote on this topic in the Final rule is:
  "…we continue to believe that the elimination of device-to-procedure edits and procedure-to-device edits is appropriate due to the experience hospitals now have in coding and reporting these claims fully. Under our current policy, hospitals are still expected to adhere to the guidelines of correct coding and append the correct device code to the claim when applicable. While we believe our current device edits policy, which requires that a device code be reported on a claim for procedures that have significant device costs, continues to accurately capture the device costs associated with device-intensive procedures and provides the necessary flexibility to hospitals to code claims accurately, we will continue to monitor the reporting of device costs on hospital outpatient claims to determine if any modifications to our existing policy are warranted in future rulemaking."

- CMS continues to utilize the CY 2019 revised description of C1889 of "Implantable/insertable device, not otherwise classified", and notes that it continues to be available to satisfy any device-intensive coding edit when devices are not described by a specific HCPCS Level II Category C code. CMS has observed incorrect use of this code in data and believes providers may have misunderstood that this code is now available for claims whether the associated procedure is labeled as "Device Intensive" or otherwise. The lack of reporting of this code is likely due to the failure to assign this code in CDM files and leaving the HCPCS field blank for device charges when a specific code is not available.

- CMS has noted that it updated the Medicare claims processing manual to support this definition and code use in the Final Rule quote below:

  "…Additionally, in our April 2022 update of the Hospital Outpatient Prospective Payment System, we revised Chapter 4, Section 61.1 of the Medicare Claims Processing Manual to clarify that hospitals should report HCPCS code C1889 for the use of devices that are not described by a specific HCPCS code."

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- CMS reiterates the 2019 definition for devices (for device-intensive policies) in the Final Rule on page 572 of the Display Copy. This language is useful for hospital policies when there is confusion about definitions or when negotiating contract terms with payers.

    - *The device offset amount must be significant, which is defined as exceeding 30 percent of the procedure's mean cost (83 FR 58945).*
    - *Has received FDA marketing authorization, has received an FDA investigational device exemption (IDE), and has been classified as a Category B device by FDA in accordance with §§ 405.203 through 405.207 and 405.211 through 405.215, or meets another appropriate FDA exemption from premarket review;*
    - *Is an integral part of the service furnished;*
    - *Is used for one patient only;*
    - *Comes in contact with human tissue;*
    - *Is surgically implanted or inserted (either permanently or temporarily); and*
    - *Is not either of the following:*
        - *Equipment, an instrument, apparatus, implement, or item of the type for which depreciation and financing expenses are recovered as depreciable assets as defined in Chapter 1 of the Medicare Provider Reimbursement Manual (CMS Pub. 15-1); or*
        - *A material or supply furnished incident to a service (for example, a suture, customized surgical kit, scalpel, or clip, other than a radiological site marker) (83 FR 58945).*

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CPT-4® / HCPCS LEVEL II CODE CHANGES

Code Section & Department-Specific 1Q24 Code Changes

Dental Codes

The American Dental Association (ADA) is the official and definitive source for Current Dental Terminology (CDT), and has copyright over the use and licensing of their codes.

New Codes:

D0396	3D printing of a 3D dental surface scan
D1301	immunization counseling
D2976	band stabilization per tooth
D2989	excavation of a tooth resulting in the determination of non-restorability
D2991	application of hydroxyapatite regeneration medicament per tooth
D6089	accessing and retorquing loose implant screw - per screw
D7284	excisional biopsy of minor salivary glands
D7939	indexing for osteotomy using dynamic robotic assisted or dynamic navigation
D9938	fabrication of a custom removable clear plastic temporary aesthetic appliance
D9939	placement of a custom removable clear plastic temporary aesthetic appliance
D9954	fabrication and delivery of oral appliance therapy (OAT) morning repositioning device
D9955	oral appliance therapy (OAT) titration visit
D9956	administration of home sleep apnea test
D9957	screening for sleep related breathing disorders

- 297 Dental codes have OPPS SI changes from 4q23 to 1Q24.
  - 40 now AI J1
  - 10 now SI N
  - 55 now SI Q1
  - 192 now SI T
  - 241 Codes were formerly SI B and 56 were formerly OPPS SI S in 3Q24

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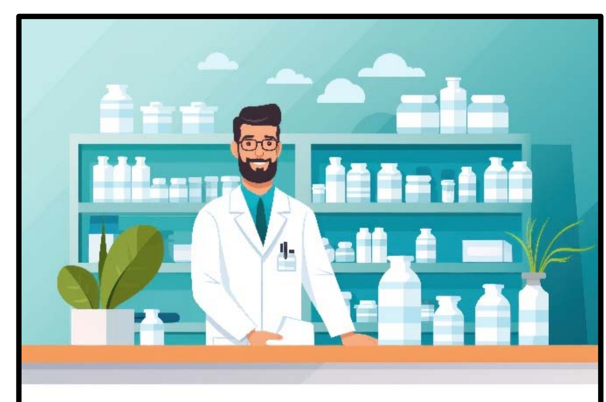
CPT-4® / HCPCS Level II Code Changes

Code Section & Department-Specific 1Q24 Code Changes

Pharmacy



- Other than vaccines, most pharmacy codes are represented as HCPCS Level II codes.
- Updates to regulations and payment systems are outlined in the OPPS/ASC Final Rule in accordance with the traditional CMS payment system language and sections.
- The typical migration of OPPS Status Indicators for drugs continues in 2024 and are summarized in this section.
- Code updates for drugs are easily identified in ChargeAssist® change modules.
    - Providers should review CPT websites or utilize software tools based on current coding and FDA approvals for the most current vaccine coding information and payment status.
    - Keep in mind that Vaccine codes change off schedule, and information displayed within CPT publication versions (CPT Manual and CPT Changes) is only updated by CPT description corrections documents from AMA.

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Drug Code updates – HCPCS Level II

New Codes:

7 new C range pharmacy codes:

	HCPCS Desc	SI	Payment Rate
C9159	Injection, prothrombin complex concentrate (human), balfaxar, per i.u. of factor ix activity	G	$3.25
C9160	Injection, daxibotulinumtoxina-lanm, 1 unit	G	$5.34
C9161	Injection, aflibercept hd, 1 mg	G	$337.97
C9162	Injection, avacincaptad pegol, 0.1 mg	G	$108.15
C9163	Injection, talquetamab-tgvs, 0.25 mg	G	$66.69
C9164	Cantharidin for topical administration, 0.7%, single unit dose applicator (3.2 mg)	G	$705.55
C9165	Injection, elranatamab-bcmm, 1 mg	G	$176.87

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19 new J range OPPS separately paid pharmacy codes (OPPS SI G and K):

J0184	Injection, amisulpride, 1 mg	G	$9.54
J0217	Injection, velmanase alfa-tycv, 1 mg	G	$424.00
J0391	Injection, artesunate, 1 mg	K	$47.31
J0402	Injection, aripiprazole (abilify asimtufii), 1 mg	G	$5.84
J0576	Injection, buprenorphine extended-release (brixadi), 1 mg	G	$12.84
J1105	Dexmedetomidine, oral, 1 mcg	K	$0.00
J1246	Injection, dinutuximab, 0.1 mg	K	$93.67
J1304	Injection, tofersen, 1 mg	G	$146.57
J1412	Injection, valoctocogene roxaparvovec-rvox, per ml, containing nominal 2 x 10^13 vector genomes	G	$12,007.81
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	G	$3,392,000.00
J2508	Injection, pegunigalsidase alfa-iwxj, 1 mg	G	$219.16
J2799	Injection, risperidone (uzedy), 1 mg	G	$25.38
J3401	Beremagene geperpavec-svdt for topical administration, containing nominal 5 x 10^9 pfu/ml vector genomes, per 0.1 ml	G	$2,570.50
J9052	Injection, carmustine (accord), not therapeutically equivalent to j9050, 100 mg	K	$594.08
J9072	Injection, cyclophosphamide, (dr. reddy's), 5 mg	G	$3.76
J9286	Injection, glofitamab-gxbm, 2.5 mg	G	$2,631.38
J9321	Injection, epcoritamab-bysp, 0.16 mg	G	$52.27
J9333	Injection, rozanolixizumab-noli, 1 mg	G	$22.90
J9334	Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc	K	$33.17

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11 new J range non-covered or packaged J range pharmacy codes (OPPS SI E2, N, or no SI (blank)):

J0688	Injection, cefazolin sodium (hikma), not therapeutically equivalent to j0690, 500 mg	N
J0873	Injection, daptomycin (xellia) not therapeutically equivalent to j0878, 1 mg	N
J1596	Injection, glycopyrrolate, 0.1 mg	N
J1939	Injection, bumetanide, 0.5 mg	N
J2404	Injection, nicardipine, 0.1 mg	N
J2679	Injection, fluphenazine hcl, 1.25 mg	N
J3425	Injection, hydroxocobalamin, 10 mcg	N
J9172	Injection, docetaxel (ingenus) not therapeutically equivalent to j9171, 1 mg	E2
J9255	Injection, methotrexate (accord) not therapeutically equivalent to j9250 and j9260, 50 mg	E2
J9258	Injection, paclitaxel protein-bound particles (teva) not therapeutically equivalent to j9264, 1 mg	N
J9324	Injection, pemetrexed (pemrydi rtu), 10 mg	E2

4 Q range drug codes new pharmacy codes (OPPS SI E2, N, or no SI (blank)):

Q5132	Injection, adalimumab-afzb (abrilada), biosimilar, 10 mg	E2
Q0516	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription drug, per 30-days	
Q0517	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription drug, per 60-days	
Q0518	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription drug, per 90-days	

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1 A range diagnostic radioisotope is available for 1Q24:

De...	HCPCS Desc		Payment Rate
A9608	Flotufolastat f 18, diagnostic, 1 millicurie	G	$614.78

Deleted Codes:

7 deleted C range pharmacy codes (one is a radioisotope):

Current ...	Deleted Code Desc	All Replacement Codes
C9152	Injection, aripiprazole, (abilify asimtufii), 1 mg	J0402
C9153	Injection, amisulpride, 1 mg	J0184
C9154	Injection, buprenorphine extended-release (brixadi), 1 mg	J0576
C9155	Injection, epcoritamab-bysp, 0.16 mg	J9321
C9156	Flotufolastat f 18, diagnostic, 1 millicurie	A9608
C9157	Injection, tofersen, 1 mg	J1304
C9158	Injection, risperidone, (uzedy), 1 mg	J2799

1 deleted J range pharmacy code:

Current ...	Deleted Code Desc	All Replacement Codes
J9160	Injection, denileukin diftitox, 300 micrograms	

- As noted in a pharmaceutical journal in 10/4/22, this product is labeled I/ONTAK and has a current biologic license application seeking approval of its reformulation as a therapeutic. The product was formerly marketed as Ontak from 1999 to 2014 in the US, but ultimately voluntarily withdrawn due to improvements in the manufacturing process. The new product exhibits better purity and bioactivity and possesses the same amino acid sequence.
    - CDM Teams will want to watch for the new code when approved and released.
    - Reference source: *https://www.onclive.com/view/fda-approval-sought-for-denileukin-diftitox-for-persistent-or-recurrent-cutaneous-t-cell-lymphoma*

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2 deleted S range pharmacy codes:

Current ...	Deleted Code Desc	All Replacement Codes
S0166	Injection, olanzapine, 2.5 mg	J2359
S0171	Injection, bumetanide, 0.5 mg	J1939

1 description change J range pharmacy code:

	New Description	Old Description	Auditor Notes
J0739	Injection, cabotegravir, 1mg, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment for hiv)	Injection, cabotegravir, 1 mg	Description clarified by adding 'fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment for hiv)'

Vaccine Updates (excluding Covid)

New codes 1Q24 *(these E1 SIs will change based on FDA and CPT updates)*

	HCPCS Desc	SI
90589	Chikungunya virus vaccine, live attenuated, for intramuscular use	E1
90623	Meningococcal pentavalent vaccine, conjugated Men A, C, W, Y- tetanus toxoid carrier, and Men B-FHbp, for intramuscular use	E1
90683	Respiratory syncytial virus vaccine, mRNA lipid nanoparticles, for intramuscular use	E1

90589 *Chikungunya virus vaccine, live attenuated, for intramuscular use* received FDA approval in November, 2023 with the announcement of it being added on January 1, 2024 via a CPT update on 12/1/23.

As a secondary resource to confirm vaccine code status, we have provided the January 1, 2024 effective date vaccines published in the CPT® Category I New Immunization* Vaccine Codes documents from the AMA CPT website:

The following vaccine codes were accepted at the February 2023 CPT Editorial Panel meeting for the 2024 CPT production cycle. Code 90679 was effective immediately on May 3, 2023. Codes 90589, 90623 are effective on January 1, 2024.

***Note that code 90589 will follow code 90586 and code 90623 will follow 90619.**

Codes	Short Descriptor	Released to AMA Website	Effective	Publication
#✗●90589	CHIKUNGUNYA VACCINE LIVE IM	June 30, 2023	January 1, 2024	CPT® 2024
#✗●90623	MENACWY-TT MENB-FHBP VACC IM	June 30, 2023	January 1, 2024	CPT® 2024

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#✗●90683	RSV VACC MRNA LIPID NANO IM	June 30, 2023	January 1, 2024	CPT® 2024

Earlier 2023 RSV Vaccine updates listed in CPT documents (excluding Covid vaccine updates) include the following. Use the ChargeAssist® HCPCS module for the full information on these codes.

CPT-4	CPT/HCPCS Long Desc	OPPS SI 4Q23	Code Effective Date	FR Add B Work RVU	FR Add B MPFS Status
96380	Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection, with counseling by physician or other qualified health care professional		10/6/23	0.24	A
96381	Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection		10/6/23	0.17	0.41
90380	Respiratory syncytial virus, monoclonal antibody, seasonal dose; 0.5 mL dosage, for intramuscular use	E1	7/17/23		
90381	Respiratory syncytial virus, monoclonal antibody, seasonal dose; 0.5 mL dosage, for intramuscular use, 1 mL dosage, for intramuscular use	E1	7/17/23		
90678	Respiratory syncytial virus vaccine, preF, subunit, bivalent, for intramuscular use	M	5/31/23		
90679	Respiratory syncytial virus vaccine, preF, recombinant, subunit, adjuvanted, for intramuscular use	M	5/3/23		

Reference:Content above is cut/pasted from the AMA Vaccine code Short descriptor CPT file from 12/1/23:
https://www.ama-assn.org/system/files/vaccine-short-descriptors.pdf

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Other Pharmacy updates

OPPS Payment for Drugs, Biologicals, and Radioisotopes

The following provides highlights of the impact of OPPS SI changes on this code family. Review these in the OPPS SI Changes within ChargeAssist® for the full list and/or the Audit module to see those within your own files.

- Four codes changed to OPPS SI G
  - Three J range HCPCS codes converted to OPPS SI G
    - 2 were OPPS SI K and 1 was OPPS SI E2 in 4Q23
  - One A range radioisotope HCPCS code converted to OPPS SI G

HCPCS Desc	Det...	New SI	Old SI
Flortaucipir f 18 injection, diagnostic, 1 millicurie	A9601	G	E2
Injection, lecanemab-irmb, 1mg	J0174	G	K
Injection, rezafungin, 1 mg	J0349	G	K
Injection, nadofaragene firadenovec-vncg, per therapeutic dose	J9029	G	E2

- Seventy-three codes changed to OPPS SI K
  - 10 were OPPS SI G in 4Q23
  - 63 were OPPS SI N in 4Q23
- Other notable drug code SI changes for the drugs, biologicals, and radioisotope code family:
  - Thirteen J range HCPCS codes changed to OPPS SI E2
    - All 13 were OPPS SI N in 4Q23
  - Two Q range HCPCS codes changed to OPPS SI E2
    - Both were OPPS SI N in 4Q23
  - Ten codes became packaged with OPPS SI N that were formerly SI K
    - 8 J range HCPCS
    - 1 A range therapeutic radioisotope, A9563
    - 1 C range drug code
  - One radioisotope code, A9295, changed from SI G to OPPS SI N
- Vaccine and Vaccine Administration 1Q24 OPPS SI changes:
  - Five codes became paid as OPPS SI L that were formerly blank OPPS SIs.
    - All of these are COVID vaccine codes shown in the table below this section.

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Det...	HCPCS Desc	New SI	Old SI
91318	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, 3 mcg/0.3 mL dosage, tris-sucro...	L	
91319	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, 10 mcg/0.3 mL dosage, tris-...	L	
91320	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, 30 mcg/0.3 mL dosage, tris-...	L	
91321	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, 25 mcg/0.25 mL dosage, for intramuscular use	L	
91322	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, 50 mcg/0.5 mL dosage, for intramuscular use	L	

- One COVID vaccine immunization administration code, 90480, changed to SI S and was formerly a blank OPPS SI.
- Two RSV Administration codes changed to SI M and were formerly blank OPPS SIs.

Pharmacy OPPS Regulatory Updates

- OPPS drug payment has not changed for many years and was outlined in detail in the CY 2016 OPPS Final Rule and summarized in annual Final Rules.
- The OPPS/ASC drug packaging threshold (based on estimated per-day costs) is finalized to be maintained at $135 despite being proposed at $140 ($135 in 2023).
- Payment for separately-paid drugs and biologicals is based on Average Sales Price (ASP) data.
  - ASP + 6% is the general payment methodology under OPPS for separately paid drugs and biologicals and also for drugs and biologicals acquired under the 340B program.
    - The 340B Remedy proposed rule has been published by CMS to unwind earlier cuts that were implemented for numerous years as required by Supreme Court decision.
  - For proposed rates, CMS used the second quarter 2023 ASP data. (This data is also used for physician office drugs/biological payment using the ASP methodology.) Rates under the CMS payment systems are updated in the January 2024 OPPS update based on more recent ASP data.

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- CMS packages some categories of drugs, biologicals, and radiopharmaceuticals regardless of their cost (called “policy-packaged”). Under this policy, CMS lists:
    - Anesthesia, certain drugs, biologicals, and other pharmaceuticals; medical and surgical supplies and equipment; surgical dressings; and devices used for external reduction of fractures and dislocations
    - Intraoperative items and services
    - Drugs, biologicals, and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure (including, but not limited to, diagnostic radiopharmaceuticals, contrast agents, and pharmacologic stress agents)
    - Drugs and biologicals that function as supplies when used in a surgical procedure (including, but not limited to, skin substitutes and similar products that aid wound healing and implantable biologicals).
        - CMS reiterates in the Final Rule that cost consideration is not a factor when determining whether an item is a surgical supply.
- As we emphasize each year, watch for updates to drug payments as 1Q24 OPPS payment corrections from CMS in December or January.
    - CMS clarifies in the OPPS Final Rule that payment rates for drugs and biologicals with ASP information for January 2024 will be determined through the standard quarterly process where ASP data submitted by manufacturers for the third quarter of CY 2023 (July 1, 2023, through September 30, 2023) which is used to set the payment rates that are released for the quarter beginning in January 2024.
- In the 2024 Final Rule, CMS finalized for January 1, 2025 changes for 340B modifiers.
    - CMS will require that all 340B covered entity hospitals paid under the OPPS report the “TB” modifier effective January 1, 2025, even if the hospital previously reported the “JG” modifier, for 340B-acquired drugs and biologicals. CMS states that it believes the transition to a single 340B modifier “TB” will allow for greater simplicity.
    - The “JG” modifier will remain effective through December 31, 2024.
    - CMS notes that hospitals that currently report the “JG” modifier may choose to continue to use it in CY 2024 or choose to transition to the use of the “TB” modifier sooner.
- Skin Substitutes are addressed in the OPPS Final Rule, and current policies will continue.
    - These graft application products are unconditionally packaged into surgical procedure costs under OPPS.
    - High-cost and low-cost groups are assigned by CMS and shown in I/OCE edits.
    - Skin substitutes assigned to the high-cost group are described by HCPCS codes 15271 through 15278, while those assigned to the low-cost group are described by HCPCS codes C5271 through C5278.
    - Table 95 of the OPPS Final Rule beginning on page 613 of the display copy lists all high and low classification for 2024 by HCPCS code.
        - This information will also be available when CMS releases the 2024 I/OCE.

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- Radioisotopes from non-highly enriched Uranium (non-HUE) sources are discussed in the OPPS Final rule (page 617).
    - As of 2013, CMS provides a $10 additional payment for the applicable radioisotopes.
    - HCPCS Q9969 *Tc-99m from non-highly enriched uranium source, full cost recovery add-on per study dose* is reported once per dose along with scan codes.
    - CMS notes that there is now a sufficient supply of non-HEU-sourced Mo-99 in the United States, and there is no available supply of HEU-sourced Mo-99 in the United States. As a result, states that they believe there is no longer a need for the additional $10 add-on payment for CY 2025 or future years.
        - CMS statement: "This policy was based on the Secretary of Energy's certification that the last HEU reactor that produces Mo-99 for medical providers in the United States would finish its conversion to a non-HEU reactor by December 31, 2022 and that all Tc-99m used for radiopharmaceuticals in 2023 would be produced from non-HEU sources. However, we understand that the conversion of the last HEU reactor that produces Tc-99m to a non-HEU reactor did not occur until March 2023, so it is possible that some claims for diagnostic radiopharmaceuticals in CY 2023 would report the cost of HEU-sourced Tc-99m."
        - CMS finalized that the additional $10 payment will end after December 31, 2025. They project that beginning with CY 2026 Medicare claims data will reflect the full cost of non-HEU-sourced Tc-99m.

- Additional guidelines on "Reporting Discarded Amounts of Certain Single-dose or Single-use Package Drugs" are found in the OPPS Final Rule (page 622 Display copy).
    - Current laws require manufacturers to provide a refund to CMS for certain discarded amounts from a refundable single-dose container or single-use package drug. CMS writes in the 2024 OPPS Final Rule that it wants to ensure interested parties are aware of proposals and refer to the Physician Fee Schedule proposed rule for a full description of the proposed policy.

2023 MPFS Final Rule - Drug Discard Refund

The "Drug Discard Refund Provision" requires manufacturers of certain single-dose container or single-use package drugs to provide refunds with respect to discarded amounts)

Note: A recap of current regulations and updated narrative on this regulatory area are in the 2024 MPFS Final Rule on the drug discard refund program (starting on page 680 Display Copy). Please review the 2024 Final Rule language if you are interested in the current details.

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- In the 2023 MPFS Final Rule, CMS finalized that refund amounts paid by manufacturers specified in the initial refund report for calendar quarters in CY 2023 must be paid no later than February 28, 2025, and for calendar quarters in each subsequent calendar year, no later than December 31 of the year in which the report is sent.
- In Section III of 2023 MPFS Final Rule, CMS provided a detailed new regulatory section titled: "Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts". CMS discussed the JW modifier requirements and drug company refund requirements associated with this rule.
  - CMS for 2023 finalized and codified its existing policy to require that billing providers report the JW modifier for all separately payable drugs with discarded drug amounts from single-use vials or single-use packages payable under Part B, beginning January 1, 2023.
  - In 2023, CMS finalized its proposal to require billing providers to report the JZ modifier for all such drugs with no discarded drug amounts beginning no later than October 1, 2023 (this was a delayed date from earlier-published timelines.)
    - To summarize, the JW modifier is required on claims for all single-dose containers or single-use drugs for which any amount is discarded (as reflected in our current policy and proposed above).
    - A separate modifier is required on claims for these drugs when there are no discarded amounts.
      - To align with the JW modifier policy, the JZ modifier would be required when there are no discarded amounts from single-use vials or single-use packages payable under Part B for which the JW modifier would be required if there were discarded amounts.
      - The rules on the drug discard refund program are specifically designed for occasions when a provider must discard the amount of drug that was unused (clarified by CMS as "the discarded amount") from a single-dose container of a drug after administering a dose to a Medicare beneficiary. CMS notes that it provides payment for the unused and discarded amount, as well as the dose administered, up to the amount of the drug indicated on the vial or package labeling.
      - CMS clarified in the 2023 MPFS Final Rule that the JW modifier policy has been in place since 2017. CMS noted that providers should currently be reporting the JW modifier on their claims, as well as documenting the discarded amounts in the beneficiary's medical records.

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- JZ modifier 9-month transition period Summary *(2023 MPFS Final Rule)*
  - The JZ modifier will be effective starting January 1, 2023, but will not be required until July 1, 2023.
  - The JZ modifier must be used on the claim line with the billing and payment code of the drug when no amounts were discarded.
  - For dates of service beginning July 1, 2023 or after, providers will be required to use the JZ modifier on claims for single-dose containers when there are no discarded amounts.
  - CMS will not perform claims processing edits on its use until October 1, 2023.
  - As stated in the Final Rule language, if a provider cannot report the JW or JZ modifiers as required by October 1, 2023, they should hold their claims until they are able to do so. Claims submitted without required modifier data will not be accepted. If the provider has any other technical issues with submitting the required modifier data, CMS expects the provider to work with their Medicare Administrative Contractor (MAC) on an acceptable approach to submitting claims.

Updates from MPFS Final Rule 2024

- In 2024, CMS clarified that for CY 2023 and 2024, it was finalizing that JW units of skin substitutes will not be used for the discarded drug refund calculations.
  - CMS also stated that it will not issue reports to manufacturers with respect to skin substitutes.
- CMS clarifies that contrast agents are excluded from the definition of refundable single-dose container or single-use package drug.
- CMS stated that since it does not believe it would be appropriate to collect data about discarded amounts from beneficiaries, the reporting requirement does not apply to drugs that are self-administered by a patient or caregiver in the patient's home.
- Suppliers who dispense but do not actually administer a separately payable drug are not expected to report the JW modifier.
- Medicare restates in the 2024 Final Rule that since Medicare pays for units of single-dose drugs that are administered to the patient as well as units that are discarded (and billed using the JW modifier), that it does not expect the refund to affect reimbursement to providers.

Note: *refer to "The JW Modifier and JZ Modifier Policy Frequently Asked Questions Document" on the CMS website for more guidance on this policy.*
https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/jw-modifier-faqs.pdf

Other reference sources: https://www.cms.gov/files/document/mm13056-new-jz-claims-modifier-certain-medicare-part-b-drugs.pdf

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Pharmacy File Maintenance suggestions:

- Confirm which systems, applications, and masterfiles house HCPCS Level II codes for claims processing, and work with revenue cycle /CDM staff to learn how to audit and maintain your files using ChargeAssist®.
- Learn how to interpret coding and OPPS changes to assess how they impact charge capture, masterfiles, work processes, or reimbursement.
  - Review the change modules of ChargeAssist® against your Charge Master or pharmacy masterfiles.
- Top priority data integrity auditing for pharmacy:
  - Verify which data elements are in which masterfiles that populate claims data and support charge capture.
  - Ensure that only active records are utilized for auditing.
  - Confirm your organization's coding philosophy for assigning pharmacy HCPCS and determine the source of HCPCS codes in current files.
    - Confirm the validity of assigned HCPCS.
    - Audit or outsource to consulting experts a review of the accuracy of HCPCS codes against pharmacy charge descriptors.
  - Ensure billing descriptors provide appropriate detail and follow hospital-authorized syntax and contents.
  - Ensure proper Revenue Codes are utilized as required by payers.
    - Know when 636, self-administrable Revenue Code 637, or the general 25X range codes should be assigned.
  - Verify whether units of service of the assigned HCPCS code and the charge item are synchronized.
  - Understand your hospital system's method for calculating billing multipliers against HCPCS coding (if applicable to the HIS system) and audit to ensure they are accurately adjusting how the HCPCS is reported on claims.
  - Confirm the quarterly HCPCS update process and timeline.
  - Confirm whether NDC and other pharmacy-specific data elements require maintenance or audit.
  - Evaluate methods for recording and reporting drug wastage and assigning modifiers.

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CPT-4® / HCPCS Level II Code Changes

Code Section & Department-Specific 1Q24 Code Changes

COVID-19 Testing, Vaccines & Therapeutics

2024 Changes

Most CPT and HCPCS Level II code updates have already occurred in this code set prior to 1/1/24 updates, so 2024 updates are minimal.

- Deleted code C9803 *Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), any specimen source*

2023 changes

During 2023, CMS converted vaccine codes for COVID-19 to a more streamlined coding methodology. It made significant code changes that impacted code assignments for both the administration and the vaccines themselves. The AMA CPT blog update on these changes is copied below:

> ***COVID-19 CPT vaccine and immunization codes***
>
> *Beginning Aug. 14, 2023, new Current Procedural Terminology (CPT®) codes have been created that consolidate over 50 previous codes and greatly streamline the reporting of immunizations for the novel coronavirus (SARS-CoV-2, also known as COVID-19).*
>
> ***Unique CPT codes approved for COVID-19 immunizations***
>
> *Beginning on Aug. 14, 2023, the CPT Editorial Panel approved the addition of new product codes 91318-91322 (91318 , 91319 , 91320 , 91321 , 91322) to identify monovalent vaccine product for immunization against COVID-19 (Pfizer, Moderna); retained existing Novavax Product Code 91304 for currently authorized vaccine product available for use in the U.S. and the updated (XBB.1.5) vaccine; deletion and/or revision of all other existing COVID codes (product and administration with associated guidelines and parenthetical note deletions/revisions); and addition of a single administration code (90480) for administration of new (i.e., 91318-91322) and existing (i.e., 91304) COVID-19 vaccine product. All existing CPT codes that describe COVID-19 vaccine products and associated administration codes that end in "A" for products that are no longer covered under an existing Emergency Use Authorization (EUA) or Biologics License Application (BLA) from the US Food and Drug Administration (FDA) will be deleted effective Nov. 1, 2023.*

Source: https://www.ama-assn.org/practice-management/cpt/covid-19-cpt-vaccine-and-immunization-codes

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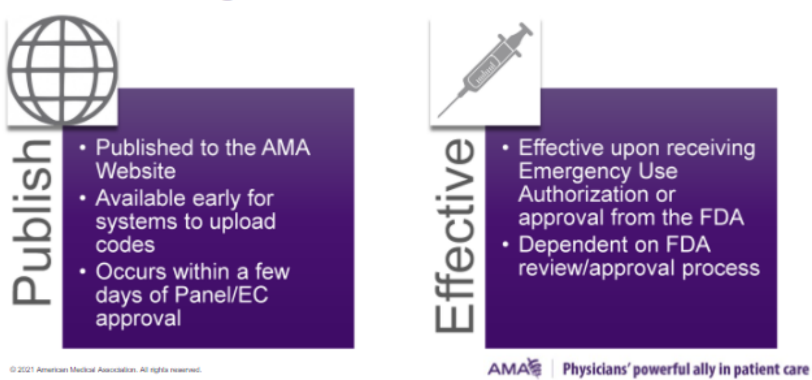
Regulatory updates on COVID vaccines and therapeutics:

- Past guidance for COVID Vaccine/administration coding was included in the long-running ChargeAssist® article updated monthly during the PHE, as well as within CPT reference sites noted below:



Helpful links for COVID vaccines and therapeutics:

https://www.ama-assn.org/practice-management/cpt/covid-19-cpt-coding-and-guidance
https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/covid-19-vaccines-and-monoclonal-antibodies
https://www.cms.gov/medicare/covid-19/monoclonal-antibody-covid-19-infusion
https://www.cdc.gov/vaccines/programs/iis/COVID-19-related-codes.html
https://www.cms.gov/monoclonal

Payment Updates:

- CMS makes Medicare Part B payment for preventive vaccine administration in hospital outpatient departments under the OPPS payment system (for OPPS-reimbursed hospitals) based on the APCs for the assigned codes.
- In the CY ***2023*** MPFS rulemaking, CMS addressed refinements to the payment amount for preventive vaccine administration. In order to effectuate these refinements, CMS implemented a national fee schedule. ***Effective January 1, 2023***, the Medicare Part B payment amount for preventive vaccine administration is updated on an annual basis by the annual increase to the Medicare Economic Index (MEI). The updated payment amount is then adjusted for geographic locality, based upon the PFS locality where the preventive vaccine is administered using the Geographic Adjustment Factor (GAF). These adjustments apply to HCPCS codes G0008, G0009, G0010, COVID-19 vaccine administration CPT codes*, and the in-home add-on payment (HCPCS code M0201)
- The 2024 MPFS Final Rule outlines "Medicare Part B Payment for Preventive Vaccine Administration Services" (§§ 410.10, 410.57, 410.152) in section H on page 1249 of the Display Copy.
- The 2024 Final Rule provides this CMS link to current Medicare "Vaccine Pricing" payment rates: https://www.cms.gov/medicare/payment/all-fee-service-providers/medicare-part-b-drug-average-sales-price/vaccine-pricing

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- We suggest review of the CMS and CPT websites as well as the 2024 MPFS and OPPS Final Rules for updates and current regulatory guidance for COVID-19 vaccines and administration if your team is not current on 2023 changes.

COVID-19 lab testing & vaccine CPT codes

Source: AMA website download as of 12/06/23

CPT Code	Long Descriptor	Published Date	Effective Date	Type of Change
86318	Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single-step method (eg, reagent strip);	10-Apr-20	10-Apr-20	REVISED
86328	Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single-step method (eg, reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])	10-Apr-20	10-Apr-20	NEW
86408	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); screen	10-Aug-20	10-Aug-20	NEW
86409	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); titer	10-Aug-20	10-Aug-20	NEW
86413	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) antibody, quantitative	8-Sep-20	8-Sep-20	NEW
86769	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])	10-Apr-20	10-Apr-20	NEW
87301	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; adenovirus enteric types 40/41	6-Oct-20	6-Oct-20	REVISED
87305	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Aspergillus	6-Oct-20	6-Oct-20	REVISED
87320	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Chlamydia trachomatis	6-Oct-20	6-Oct-20	REVISED

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87324	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Clostridium difficile toxin(s)	6-Oct-20	6-Oct-20	REVISED
87327	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Cryptococcus neoformans	6-Oct-20	6-Oct-20	REVISED
87328	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; cryptosporidium	6-Oct-20	6-Oct-20	REVISED
87329	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; giardia	6-Oct-20	6-Oct-20	REVISED
87332	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; cytomegalovirus	6-Oct-20	6-Oct-20	REVISED
87335	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Escherichia coli 0157	6-Oct-20	6-Oct-20	REVISED
87336	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Entamoeba histolytica dispar group	6-Oct-20	6-Oct-20	REVISED
87337	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Entamoeba histolytica group	6-Oct-20	6-Oct-20	REVISED

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87338	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Helicobacter pylori, stool	6-Oct-20	6-Oct-20	REVISED
87339	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Helicobacter pylori	6-Oct-20	6-Oct-20	REVISED
87340	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; hepatitis B surface antigen (HBsAg)	6-Oct-20	6-Oct-20	REVISED
87341	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; hepatitis B surface antigen (HBsAg) neutralization	6-Oct-20	6-Oct-20	REVISED
87350	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; hepatitis Be antigen (HBeAg)	6-Oct-20	6-Oct-20	REVISED
87380	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; hepatitis, delta agent	6-Oct-20	6-Oct-20	REVISED
87385	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Histoplasma capsulatum	6-Oct-20	6-Oct-20	REVISED

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87389	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result	6-Oct-20	6-Oct-20	REVISED
87390	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; HIV-1	6-Oct-20	6-Oct-20	REVISED
87391	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; HIV-2	6-Oct-20	6-Oct-20	REVISED
87400	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Influenza, A or B, each	6-Oct-20	6-Oct-20	REVISED
87420	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; respiratory syncytial virus	6-Oct-20	6-Oct-20	REVISED
87425	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; rotavirus	6-Oct-20	6-Oct-20	REVISED
87426	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; severe acute respiratory syndrome coronavirus (eg, SARS-CoV, SARS-CoV-2 [COVID-19])	25-Jun-20	25-Jun-20	REVISED

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87427	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Shiga-like toxin	6-Oct-20	6-Oct-20	REVISED
87428	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; severe acute respiratory syndrome coronavirus (eg, SARS-CoV, SARS-CoV-2 [COVID-19]) and influenza virus types A and B	10-Nov-20	10-Nov-20	NEW
87430	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; Streptococcus, group A	6-Oct-20	6-Oct-20	REVISED
87449	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; not otherwise specified, each organism	6-Oct-20	6-Oct-20	REVISED
87451	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; polyvalent for multiple organisms, each polyvalent antiserum	6-Oct-20	6-Oct-20	REVISED
87635	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique	13-Mar-20	13-Mar-20	NEW
87636	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) and influenza virus types A and B, multiplex amplified probe technique	6-Oct-20	6-Oct-20	NEW
87637	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), influenza virus types A and B, and respiratory syncytial virus, multiplex amplified probe technique	6-Oct-20	6-Oct-20	NEW
87802	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; Streptococcus, group B	6-Oct-20	6-Oct-20	REVISED

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87803	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; Clostridium difficile toxin A	6-Oct-20	6-Oct-20	REVISED
87806	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies	6-Oct-20	6-Oct-20	REVISED
87804	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; Influenza	6-Oct-20	6-Oct-20	REVISED
87807	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; respiratory syncytial virus	6-Oct-20	6-Oct-20	REVISED
87811	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])	6-Oct-20	6-Oct-20	NEW
87808	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; Trichomonas vaginalis	6-Oct-20	6-Oct-20	REVISED
87809	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; adenovirus	6-Oct-20	6-Oct-20	REVISED
87810	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; Chlamydia trachomatis	6-Oct-20	6-Oct-20	REVISED
87850	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; Neisseria gonorrhoeae	6-Oct-20	6-Oct-20	REVISED
87880	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; Streptococcus, group A	6-Oct-20	6-Oct-20	REVISED
87899	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; not otherwise specified	6-Oct-20	6-Oct-20	REVISED
87913	Infectious agent genotype analysis by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]), mutation identification in targeted region(s)	21-Feb-22	21-Feb-22	NEW
0202U	Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected	20-May-20	20-May-20	NEW

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0223U	Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected	25-Jun-20	25-Jun-20	NEW
0224U	Antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), includes titer(s), when performed	25-Jun-20	25-Jun-20	NEW
0225U	Infectious disease (bacterial or viral respiratory tract infection) pathogen-specific DNA and RNA, 21 targets, including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), amplified probe technique, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected	10-Aug-20	10-Aug-20	NEW
0226U	Surrogate viral neutralization test (sVNT), severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), ELISA, plasma, serum	10-Aug-20	10-Aug-20	NEW
0240U	Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 3 targets (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A, influenza B), upper respiratory specimen, each pathogen reported as detected or not detected	6-Oct-20	6-Oct-20	NEW
0241U	Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 4 targets (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A, influenza B, respiratory syncytial virus [RSV]), upper respiratory specimen, each pathogen reported as detected or not detected	6-Oct-20	6-Oct-20	NEW
99072	Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency, as defined by law, due to respiratory-transmitted infectious disease	8-Sep-20	8-Sep-20	NEW
90480	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, single dose	14-Aug-23	Upon EUA or FDA approval	
91304	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, 5 mcg/0.5 mL dosage, for intramuscular use	4-May-21	14-Aug-23	REVISED

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91318	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, 3 mcg/0.2 mL dosage, tris-sucrose formulation, for intramuscular use	14-Aug-23	Upon EUA or FDA approval	
91319	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, 10 mcg/0.2 mL dosage, tris-sucrose formulation, for intramuscular use	14-Aug-23	Upon EUA or FDA approval	
91320	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, 30 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use	14-Aug-23	Upon EUA or FDA approval	
91321	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, 25 mcg/0.25 mL dosage, for intramuscular use	14-Aug-23	Upon EUA or FDA approval	
91322	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, 50 mcg/0.5 mL dosage, for intramuscular use	14-Aug-23	Upon EUA or FDA approval	

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CPT-4® / HCPCS Level II Code Changes

Code Section & Department-Specific 1Q24 Code Changes

Category III Code Summary

Category III new codes are discussed in their applicable sections of this training manual and lectures. CPT publications are not typically reflective of the current Category III code changes because of updates during the year.

The ChargeAssist® grids can be utilized to review Category III code changes from quarter to quarter.

Updates of Category III codes for 1Q24 include:

- 63 new codes
- 31 deleted codes
- 13 revised codes
- 22 codes have SI changes from 3Q23 to 1Q24 (excluding deleted codes)

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CPT-4® / HCPCS Level II Code Changes

Code Section & Department-Specific 1Q24 Code Changes

G-Range HCPCS Codes

- 13 New Codes
- 32 Deleted Code
- 37 Description Changes

G-range HCPCS codes are created by the HCPCS workgroup and often serve to meet Medicare-specific payment policy or special billing or reporting requirements that are not accommodated by the AMA CPT code set. Codes in this range often migrate to other code ranges and should be monitored for validity quarterly. On occasion, some G codes are not accepted by Commercial insurances when CPT codes exist, so evaluation of correct coding continues to be a challenge. There are occasions of these codes being recycled (as noted this year), demonstrating the importance of monitoring the validity of codes against the service/item descriptors in masterfiles.

- Three of the New Codes (G0011-G0013) are for individual counseling pre-exposure prophylaxis (prep) or for injection of prep. OPPS SI is not available at the time of publication. MPFS Work RVUs are 0.45, 0.17 and 0.18, respectively. Please review the CMS decision memo for more information https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=Y&NCAId=310
    - The National Coverage Determination (NCD) was pending at the time of this publication.
- Two of the New Codes (G0017-G0018) are for Psychotherapy for Crisis, and are OPPS SI M, and MPFS Work RVU 4.70 for G0017 and 2.25 for G0018.
- Codes G0019 and G0022 are for Community health integration services. These codes have OPPS SI of S and N, respectively and MPFS Work RVU of 1.00 and 0.75, respectively.
- Codes G0023-G0024, G0140, and G0146 are for principal illness navigation services. G0023 and G0140 codes have OPPS SI of S and G0024 and G0146 have an SI of N. MPFS Work RVUs for G0023 and G0140 are 1.00 and for G0024 and G0146 are 0.75.
- G0136 is for administering standardized, evidence-based social determinants of health risk assessment. G0136 has an OPPS SI of S and MPFS Work RVU of 0.18.
- G0137 is for intensive outpatient services; weekly bundle, minimum of 9 services over a 7 contiguous day period. G0137 has an OPPS SI of A and MPFS RVU Status Indicator of X.

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New Codes:

Detail	HCPCS Desc
G0011	Individual counseling for pre-exposure prophylaxis (prep) by physician or qualified health care professional (qhp)to prevent human immunodeficiency virus (hiv), includes hiv risk assessment (initial or continued assessment of risk), hiv risk reduction and medication adherence, 15-30 minutes
G0012	Injection of pre-exposure prophylaxis (prep) drug for hiv prevention, under skin or into muscle
G0013	Individual counseling for pre-exposure prophylaxis (prep) by clinical staff to prevent human immunodeficiency virus (hiv), includes: hiv risk assessment (initial or continued assessment of risk), hiv risk reduction and medication adherence
G0017	Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting); first 60 minutes
G0018	Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting); each additional 30 minutes (list separately in addition to code for primary service)
G0019	Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (sdoh) need(s) that are significantly limiting the ability to diagnose or treat problem(s) addressed in an initiating visit: person-centere...
G0022	Community health integration services, each additional 30 minutes per calendar month (list separately in addition to g0019)
G0023	Principal illness navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator; 60 minutes per calendar month, in the following activities: person-centered assessment, performed to better understand the individual context of the serious, high-risk condition. ++ conducting a person-centered assessment to understand the patient's life story...
G0024	Principal illness navigation services, additional 30 minutes per calendar month (list separately in addition to g0023)
G0136	Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5-15 minutes
G0137	Intensive outpatient services; weekly bundle, minimum of 9 services over a 7 contiguous day period, which can include individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under state law); occupational therapy requiring the skills of a qualified occupational therapist; services of social workers, trained psychiatric nurses, and other staff trained to wor...
G0140	Principal illness navigation - peer support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month, in the following activities: person-centered interview, performed to better understand the individual context of the serious, high-risk condition. ++ conducting a person-centered interview to understand the patient's...
G0146	Principal illness navigation - peer support, additional 30 minutes per calendar month (list separately in addition to g0140)

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Deleted Codes:

Current...	Deleted Code Desc
G0056	Optimizing chronic disease management mips value pathways
G2066	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system, implantable loop recorder system, or subcutaneous cardiac rhythm monitor system, remote data acquisition(s), receipt of transmissions and technician...
G2108	Patient age 66 or older in institutional special needs plans (snp) or residing in long-term care with pos code 32, 33, 34, 54 or 56 for more than 90 consecutive days during the measurement period
G2109	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and a dispensed medication for dementia during the measurement period or the year prior to the measurement period
G2110	Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period and either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ed or nonacute inpatient encounters on different dat...
G8506	Patient receiving angiotensin converting enzyme (ace) inhibitor or angiotensin receptor blocker (arb) therapy
G8818	Patient discharge to home no later than post-operative day #7
G8825	Patient not discharged to home by post-operative day #7
G8852	Positive airway pressure therapy was prescribed
G8883	Biopsy results reviewed, communicated, tracked and documented
G8884	Clinician documented reason that patient's biopsy results were not reviewed
G8885	Biopsy results not reviewed, communicated, tracked or documented
G8941	Elder maltreatment screen documented as positive, follow-up plan not documented, documentation the patient is not eligible for follow-up plan at the time of the encounter
G8963	Cardiac stress imaging performed primarily for monitoring of asymptomatic patient who had pci within 2 years
G8964	Cardiac stress imaging test performed primarily for any other reason than monitoring of asymptomatic patient who had pci within 2 years (e.g., symptomatic patient, patient greater than 2 years since pci, initial evaluation, etc)

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Current...	Deleted Code Desc
G9192	Documentation of system reason(s) for not prescribing beta-blocker therapy (eg, other reasons attributable to the health care system)
G9229	Chlamydia, gonorrhea, and syphilis screening results not documented (patient refusal is the only allowed exception)
G9451	Patient received one-time screening for hcv infection
G9453	Documentation of patient reason(s) for not receiving one-time screening for hcv infection (e.g., patient declined, other patient reasons)
G9454	One-time screening for hcv infection not received within 12-month reporting period and no documentation of prior screening for hcv infection, reason not given
G9596	Pediatric patient had a head ct for trauma ordered by someone other than an emergency care provider or was ordered for a reason other than trauma
G9612	Photodocumentation of two or more cecal landmarks to establish a complete examination
G9613	Documentation of post-surgical anatomy (e.g., right hemicolectomy, ileocecal resection, etc.)
G9614	Photodocumentation of less than two cecal landmarks (i.e., no cecal landmarks or only one cecal landmark) to establish a complete examination
G9697	Documentation of patient reason(s) for not prescribing a long-acting inhaled bronchodilator
G9715	Patients who use hospice services any time during the measurement period
G9725	Patients who use hospice services any time during the measurement period
G9852	Patients who died from cancer
G9853	Patient admitted to the icu in the last 30 days of life
G9854	Patient was not admitted to the icu in the last 30 days of life
G9927	Documentation of system reason(s) for not prescribing an fda-approved anticoagulation due to patient being currently enrolled in a clinical trial related to af/atrial flutter treatment
G9995	Patients who use palliative care services any time during the measurement period

Note: Please review ChargeAssist® for the complete listing of Description Changes on G Codes.

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CPT-4® / HCPCS Level II Code Changes

Code Section & Department-Specific 1Q24 Code Changes

Ambulatory Surgical Centers

ASC special payment policy for OPPS complexity-adjusted C-APCs

- Five new C range HCPCS codes C7556 – C7561 are outlined in the 2024 OPPS/ASC Final Rule addendum AA that are specifically for ASC claims for complexity adjusted C-APC payment method.
- The five new codes have a PI of G2.
- These codes are not reported on OPPS/MPFS claims. Please review the 2024 ASC CPX Supplemental File found in ChargeAssist® for the crosswalk to the appropriate CPT codes for OPPS and MPFS reporting.

Detail	HCPCS Desc	SI
C7556	Bronchoscopy, rigid or flexible, with bronchial alveolar lavage and transendoscopic endobronchial ultrasound (ebus) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s), including fluoroscopic guidance, when performed	E1
C7557	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed and intraprocedural coronary fractional flow reserve (ffr) with 3d functional...	E1
C7558	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, fre...	E1
C7560	Endoscopic retrograde cholangiopancreatography (ercp) with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s) and endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s)	E1
C7561	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less with manual preparation and insertion of drug-delivery device(s), deep (e.g., subfascial)	E1

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Annual CDM Update Processes

Priorities for CDM Update Implementation Planning

Details on operational process recommendations related to the CDM updates are provided in our training materials for Charge Management, as well as articles published within ChargeAssist®.

Our 10 Steps for Failsafe Charge Data Management legacy article from 9/24/11 is included in the ChargeAssist® Document Library and was republished on the Panacea Insights website below (registration required):

https://insights.panaceainc.com/10-steps-for-failsafe-charge-data-management/

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Annual CDM Update Processes (CONTINUED)

Create a Workplan for Success

Source: ChargeAssist® Update News November 1, 2023

Year-end CDM changes

Charge Master updates are an ongoing, high-priority process for hospitals and health systems of all sizes. Because updates are more extensive on a calendar-year basis, teams know that year-end masterfile changes are typically very time-intensive. Vigilant oversight and team-based CDM update workplans are essential to successful year-end CDM management.

This section highlights time-tested components of a successful annual CDM update project plan.

ChargeAssist® Product Use

Revenue Integrity and CDM teams integrate CDM software use with their broader annual update planning. Experienced customers realize that CDM tools add efficiency and introduce an integrated perspective of the year-end changes essential for correctly interpreting the necessary data updates.

Since September, we have published initial 2024 code change files, audit modules, and reference documents within the ChargeAssist® tool. Your team has access to not only 2024 Final Rule information but also current 1Q24 data, allowing a complete look at CDM changes required on January 1st.

We've seen hundreds of organizations (from Critical Access Hospitals to large multi-hospital systems) streamline and improve file update tasks using CDM software. Proactive CDM and Revenue Integrity leaders embrace a well-organized fourth-quarter plan integrating education, masterfile audits, and department working sessions.

Successful hospital teams revisit user access, confirm security and password features, evaluate user proficiency, conduct product refresher training, develop audit plans with grid view or file export standardization, and formalize masterfile update data entry and quality control. These and other Charge Management software plan activities are in the graphic that follows.

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Year-End Charge Management Software Plan

Plan for software use

- Identify CDM software users
- Confirm users know their passwords
- Confirm technology (web access, monitor sizes sufficient for daily tasks, display resolution, web meeting tools, etc.)
- Define software functions pivotal to each user/area
- Refine security settings per user
- Inventory reference resources & data needs
- Define expectations fo tool use

Plan for ensuring proficiency

- Conduct coaching sessions
- Evaluate users' proficiency
- Reference CDM tool help text & videos
- Provide training as needed
- Engage vendor assistance as needed
- Ensure users can interpret charge changes correctly (code info + OPPS SIs, MPFS status codes, I/OCE edits, tc.)

Plan for team education

- Identify regulatory & co educational resources
- Plan for ChargeAssist Streaming Webinars
- Plan for Panacea Price Transparency Webinar
- Plan for HIM coding education
- Plan for OPPS & MPFS Final Rule education
- Schedule meetings for CDM-related deployment of info learned from the above

Plan for data updates

- pload new CDM & R&U data
- Define audit & reference sources for year end work
- Adopt / refine grid views for standardized exports
- Outline how modules or grid exports should be used
- Schedule file update verification tasks
- Assign data entry tasks
- Develop QC & rollout plan

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CDM update workplan tips

A well-defined CDM update project plan will keep your team organized during the busy months of November and December. Year-end represents the most significant quantity of coding and payment system changes. Here are twelve basic steps for creating your plan:

1. **Define team participants**– Be sure your team has identified a project manager, selected key task owners, and obtained administrative support. Establish a core support team to represent key operational functions. Include representatives from Charge Management, Revenue Cycle, Hospital Information Systems, Patient Accounting, and Coding/HIM for the planning phase. Next, expand the year-end update participants with department representatives who can interpret the charge item changes. Define personnel who will bridge CDM updates with updates to other workflow processes, systems, applications, or charge capture tools in the applicable cost centers.
2. **Introduce the CDM update year-end plan** – Plan an initial kick-off web meeting to review expectations and general tasks. Announce your workplan and timeline for CDM and other masterfile updates. (Tip: Often, CDM leaders proactively request time on participants' calendars to ensure availability during the busy holiday weeks.)
3. **Plan task due dates & identify milestone activities** - Define your organization's file update timelines to ensure readiness on January 1st. The most successful workplans are based on collaborative schedules jointly developed by project teams, administrative representatives, and the executive leadership of impacted ancillary and clinical departments. Identify dates when essential data, references, and resources typically become available. Next, assign preliminary dates for file update tasks. (Aside from updating the CDM or EAP, other systems will also require updates (including pharmacy, materials, ancillary applications, charge capture applications, etc.)
4. **Know possible contingencies** - Proactive teams include workplan milestones into their annual update workplan. However, those milestone tasks may be derailed by unexpected issues or changes in organizational priorities. Since CDM updates can't be pushed into the new year without financial or compliance risk, it's vital to consider all possible contingencies and have an idea of alternative action plans. In the event of challenges, a proactive team can quickly adapt staffing and tasks to successfully complete year-end file updates.
5. **Define dates for reference materials orders** - There are numerous reference points to consider for complete annual updates. Don't underestimate the importance of integrated resource information linked to charge data elements. CDM tools like ChargeAssist® allow users to perform thorough and accurate CDM updates. Coding guidelines, auditor notes, payment system details, and code change rationale are essential for interpreting masterfile changes. Watch for updates from ChargeAssist® announcing coding, payment system, and regulatory releases as they become available.

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6. **Assign department tasks in phases** - When assigning workplan tasks, remind departments of your organization's specific phases of file update work. (Some hospitals delay file updates until all integrated information is available, while other health systems begin with initial data updates then fine-tune masterfile changes as more details are released.) Plan to revisit the applicable software functions and module with departments. Also, remember to have departments plan for educational programs.

7. **Plan meetings for coaching, training, and education** - Department meetings are typically needed to bring staff up to speed on the expectations for annual update data verification. For introductory department working sessions, provide beginner-level participants with orientation to applicable payment system and coding (including OPPS Status Indicators, MPFS Payment Indicators, CPT®/HCPCS orientation) as well as any internal protocols related to your organization's Charge Master management (charge description standards, billable supply policies, symbols, abbreviations, data retention requirements, charge description field length limitations, etc.). And finally, don't forget that educational materials for each department must reflect the applicable payment system.

8. **Vary the workplan by department** - Flexibility is essential when establishing CDM update task timelines for ancillary and clinical departments. The volume and methods used for masterfile updates will determine timelines. Administrative support (and sometimes their enforcement action) is essential for delegation and scheduling file verification tasks.

9. **Expand your workplan beyond CPT®** - CDM teams may have to remind departments that review of CPT® codes alone is insufficient for finalizing CDM changes. Clinical and technical department representatives often lack knowledge of CDM data beyond their specific CPT® code sections. Be sure to provide OPPS, MPFS, and other payment system indicator information, I/OCE edits, and pertinent regulatory updates as they become available. Attention to alternative codes (including Dental codes, Category III codes, HCPCS Level II codes, PLA codes, Medicare override coding, quality measurement codes, etc.) are all critical to a complete update process.

10. **Offer quantitative information** - Most departments appreciate a quantitative view of what they are facing with year-end changes. Upload a current CDM/EAP, pharmacy file, and materials file. Identify how many charges are affected by the new year's coding and payment system updates to determine the time needed for annual update activities. If possible, include revenue and utilization data to help prioritize high-use or high-revenue issues.

11. **Start now** – Most ChargeAssist® customers have already begun preliminary annual update activities. Users have been able to access AMA 2024 CPT® code details since September. Your team can begin its file update analysis with initial review of the 'level 1' (CPT® changes) identified in several ChargeAssist® modules. In addition to masterfile and charge capture changes, remember that year-end is the perfect time to have departments review their CDM masterfile section for validity and content.

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12. **Stay on task** – The Charge Management Team will need to monitor the annual update workplan progress carefully over the next eight weeks. Try to regroup weekly to ensure priority tasks are moving along. Monitor datafile update progress and plan for quality monitoring of changes to CDM, EAP, or other masterfiles.

Summary

Teams following a structured annual CDM update workplan are typically more organized and coordinated with their year-end masterfile update tasks. There is no disputing that a proactive CDM update process reduces the risk of claims errors, lost payments, or misrepresented charges. Likewise, well-organized plans keep your team on track and reduce holiday stress.

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PROGRAM CONCLUSION

Thank you for participating in this year's annual 2024 CDM update program. Expanded education, coaching, or strategic help on the 2024 changes can be arranged for your team by contacting Rosemary Holliday rholliday@panaceainc.com or Peggi Ann Amstutz paamstutz@panaceainc.com.

A primary internal ChargeAssist® contact at your organization can point you to user access questions, product on-line help modules, and details on how the product is used in your facility.

For software questions, contact the ChargeAssist® support team at: (530) 550-0765 ext. 4 or by e-mail at: support@chargeassist.com

For Price Transparency 2024 education, register and view the Panacea Healthcare Solutions free webinar: "2024 Final Rule Price Transparency Changes".

Registration link for Price Transparency webinar recording: *Mastering the CMS 2024 Final Transparency Rule Regulations*
Link for e-book: *https://www.panaceainc.com/cms-2024-opps-final-rule-ebook/*
Link for service details: *https://www.panaceainc.com/cms-price-transparency-overview/*

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EXHIBITS

Exhibit A – CPT codebook information

The Symbols

This book uses the same coding conventions as those used in the CPT nomenclature.

- ● Indicates a new procedure number was added to the CPT nomenclature
- ▲ Indicates a code revision has resulted in a substantially altered procedure descriptor
- ✚ Indicates a CPT add-on code
- ⊘ Indicates a code that is exempt from the use of modifier 51 but is not designated as a CPT add-on procedure or service
- ►◄ Indicates revised guidelines, cross-references, and/or explanatory text
- ⚡ Indicates a code for a vaccine that is pending FDA approval
- # Indicates a resequenced code. Note that rather than deleting and renumbering, resequencing allows existing codes to be relocated to an appropriate location for the code concept, regardless of the numeric sequence. Numerically placed references (ie, Code is out of numerical sequence. See...) are used as navigational alerts in the CPT codebook to direct the user to the location of an out-of-sequence code. Therefore, remember to refer to the CPT codebook for these references.
- ★ Indicates a telemedicine code
- ⲯ Indicates a duplicate PLA test
- ⇅ Indicates a Category I PLA
- ◀ Indicates Audio-only Telemedicine Services

Whenever possible, complete segments of text from the CPT codebook are provided; however, in some instances, only pertinent text is included.

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Exhibit B - OPPS Status Indicators (note: see ChargeAssist® for complete and current OPPS SI Descriptions)

A Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, PAYMENT STATUS - Not paid under OPPS. Paid by MACs under a fee schedule or payment system other than OPPS. Services are subject to deductible or coinsurance unless indicated otherwise: Ambulance Services, Clinical Diagnostic Laboratory Services, Non-Implantable Prosthetic and Orthotic Devices, EPO for ESRD patients, Physical, Occupational, and Speech Therapy, Diagnostic Mammography, Screening Mammography, *(Note: as of 2023 this SI also now includes unclassified drugs and biologicals reportable under C9399)*

B Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x). OPPS PAYMENT STATUS: Not paid under OPPS. May be paid by fiscal intermediaries/MACs when submitted on a different bill type, for example, 75x (CORF), but not paid under OPPS. An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available.

C Inpatient Procedures; OPPS PAYMENT STATUS: Not paid under OPPS. Admit patient. Bill as inpatient.

E1 Items and Services not covered by any Medicare outpatient benefit category; Statutorily excluded by Medicare; Not reasonable and necessary; OPPS PAYMENT STATUS: Not paid by Medicare when submitted on outpatient claims (any outpatient bill type).

E2 Items and Services for which pricing information and claims data are not available; OPPS PAYMENT STATUS: Not paid by Medicare when submitted on outpatient claims (any outpatient bill type).

F Corneal tissue acquisition; certain CRNA services; OPPS PAYMENT STATUS: Not paid under OPPS. Paid at reasonable cost. *(Note: as of 2023 Hepatitis B vaccines were removed from this SI and moved to SI L)*

G Pass-Through Drugs, and Biologicals; OPPS PAYMENT STATUS: Paid under OPPS; separate APC payment.

H Pass-Through Device Categories. OPPS PAYMENT STATUS: Separate cost-based Pass-Through payment; not subject to copayment.

J1 Hospital Part B services paid through a comprehensive APC - OPPS PAYMENT STATUS: Paid under OPPS; all covered Part B services on the claim are packaged with the primary J1 service for the claim, except services with OPPS SI=F, G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.

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J2 Hospital Part B services paid through a comprehensive APC; OPPS PAYMENT STATUS: Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Comprehensive APC payment based on OPPS comprehensive-specific payment criteria. Payment for all covered Part B services on the claim is packaged into a single payment for specific combinations of services, except services with OPPS SI=F, G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services. (2) Packaged APC payment if billed on the same claim as a HCPCS code assigned Status Indicator J1. (3) In other circumstances, payment is made through a separate APC payment or packaged into payment for other services.

K Non Pass-Through Drugs and Non-implantable Biologicals, Including Therapeutic Radiopharmaceuticals - OPPS PAYMENT STATUS: Paid under OPPS; Separate APC payment.

L Influenza Vaccine; Pneumococcal Pneumonia Vaccine; Hepatitis B vaccines; OPPS PAYMENT STATUS: Not paid under OPPS. Paid at reasonable cost; Not subject to deductible or coinsurance. *(Note: as of 2023 hepatitis B vaccines were added to this SI and removed from SI F to make them not subject to deductible and coinsurance)*

M Items and Services Not Billable to the Fiscal Intermediary/MAC; OPPS PAYMENT STATUS: Not paid under OPPS.

N Items and Services packaged into APC Rates; OPPS PAYMENT STATUS: Paid under OPPS; Payment is packaged into payment for other services. Therefore, there is no separate APC payment.

P Partial Hospitalization OPPS PAYMENT STATUS: Paid under OPPS; Per diem APC payment.; this SI Description for 2024 will be "Partial Hospitalization or Intensive Outpatient Program".

Q1 STV-Packaged Codes -OPPS PAYMENT STATUS: Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned Status Indicator S, T, or V, (2) In other circumstances, payment is made through a separate APC payment.

Q2 T-Packaged Codes - OPPS PAYMENT STATUS: Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned Status Indicator T. (2) In other circumstances, payment is made through a separate APC payment.

Q3 Codes That May Be Paid through a Composite APC - OPPS PAYMENT STATUS: Paid under OPPS; Addendum B displays APC assignments when services are

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separately payable. Addendum M displays composite APC assignments when codes are paid through a composite APC. (1) Composite APC payment based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services. (2) In other circumstances, payment is made through a separate APC payment or packaged into payment for other services.

Q4 Conditionally packaged laboratory tests; OPPS PAYMENT STATUS: Paid under OPPS or CLFS. (1) Packaged APC payment if billed on the same claim as a HCPCS code assigned published Status Indicator J1, J2, S, T, V, Q1, Q2, or Q3. (2) In other circumstances, laboratory tests should have an SI=A and payment is made under the CLFS.

R Blood and Blood Products - OPPS PAYMENT STATUS: Paid under OPPS; separate APC payment.

S Procedure or Service, Not Discounted When Multiple - OPPS PAYMENT STATUS: Paid under OPPS; Separate APC payment.

T Procedure or Service, Multiple Reduction Applies - OPPS PAYMENT STATUS: Paid under OPPS; Separate APC payment.

U Brachytherapy Sources - OPPS PAYMENT STATUS: Paid under OPPS; separate APC payment.

V Clinic or Emergency Department Visit; OPPS PAYMENT STATUS: Paid under OPPS; Separate APC payment.

Y Non-Implantable Durable Medical Equipment; OPPS PAYMENT STATUS: Not paid under OPPS. All institutional providers other than Home Health Agencies bill to DMERC.

-----Not Displayed in ChargeAssist® Active HCPCS-----

D Discontinued Code - OPPS PAYMENT STATUS: Not paid under OPPS or any other Medicare payment system. (This does not appear in ChargeAssist® because we do not list discontinued codes in the active HCPCS modules. Deleted Codes are in the Quarterly Change modules.)

Source: Addendum D1.— OPPS Payment Status Indicators for CY 2023 *https://www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatientppshospital-outpatient-regulations-and-notices/cms-1772-fc*

Exhibit C - MPFS Status Code Reference

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This table has been removed due to duplication with similar status codes in another CMS masterfile. See Exhibit E "MPFS RVU Status Indicators"

Exhibit D - MPFS PC/TC Indicators

0 = Physician Service Codes Identifies codes that describe physician services. (Examples include visits, consultations, and surgical procedures.) For codes assigned '0', the concept of PC/TC does not apply since physician services cannot be split into professional and technical components. *Modifier rules:* Modifiers 26 and TC cannot be used with these codes. The RVUs include values for physician work, practice expense and malpractice expense. Note that there are some codes with no Work RVUs.

1 = Diagnostic Tests for Radiology Services Identifies codes that describe diagnostic tests. (Examples are pulmonary function tests and radiation therapy.) These codes have both a professional and technical component. ***Modifier rules:*** Modifiers 26 and TC can be used with these codes. The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense. The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier include values for physician work, practice expense, and malpractice expense.

2 = Professional Component Only Codes This indicator identifies stand-alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test. An example of a professional component only code is CPT code 93010--Electrocardiogram; Interpretation and Report. *Modifier rules:* Modifiers 26 and TC cannot be used with these codes. The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense.

3 = Technical Component Only Codes This indicator identifies stand- alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic test only. An example of a technical component only code is CPT code 93005--Electrocardiogram; Tracing Only, without interpretation and report. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code.
Modifier rules: Modifiers 26 and TC cannot be used with these codes. The total RVUs for technical component only codes include values for practice expense and malpractice expense only.

4 = Global Test Only Codes This indicator identifies stand-alone codes that describe selected diagnostic tests for which there are associated codes that describe (a) the professional component of the test only, and (b) the technical component of the test only. *Modifier rules:* Modifiers 26 and TC cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice

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expense, and malpractice expense. The total RVUs for global procedure only codes equal the sum of the total RVUs for the professional and technical components only codes combined.

5 = Incident To Codes This indicator identifies codes that describe services covered incident to a physician's service when they are provided by auxiliary personnel employed by the physician and working under his or her direct personal supervision. Payment may not be made by carriers for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. *Modifier rules:* Modifiers 26 and TC cannot be used with these codes.

6 = Laboratory Physician Interpretation Codes This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. *Modifier rules:* Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense, and malpractice expense.

7 = Physical therapy service, for which payment may not be made Payment may not be made if the service is provided to either a patient in a hospital outpatient department or to an inpatient of the hospital by an independently practicing physical or occupational therapist.

8 = Physician interpretation codes This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient. This applies to CPT codes 88141, 85060 and HCPCS code P3001-26. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the PPS rate. No payment is recognized for CPT codes 88141, 85060 or HCPCS code P3001-26 furnished to hospital outpatients or non-hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test.

9 = Not Applicable Concept of a professional/technical component does not apply

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Exhibit E - MPFS RVU Status Indicators

A = Active Code These codes are paid separately under the physician fee schedule, if covered. There will be RVUs for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service; carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Bundled Code Payment for covered services are always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient).

C = Carriers price the code Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.

D = Deleted Codes These codes are deleted effective with the beginning of the applicable year. These codes will not appear on the new file as the grace period for deleted codes is no longer applicable.

E = Excluded from Physician Fee Schedule by regulation These codes are for items and/or services that CMS chose to exclude from the fee schedule payment by regulation. No RVUs are shown, and no payment may be made under the fee schedule for these codes. Payment for them, when covered, generally continues under reasonable charge procedures.

F = Deleted/Discontinued Codes (Code not subject to a 90 day grace period). These codes will not appear on the CMS file as the grace period for deleted codes is no longer applicable.

G = Not valid for Medicare purposes Medicare uses another code for reporting of, and payment for, these services. (Code subject to a 90 day grace period.) These codes will not appear on the CMS files as the grace period for deleted codes is no longer applicable.

H = Deleted Modifier This code had an associated TC and/or 26 modifier in the previous year. For the current year, the TC or 26 component shown for the code has been deleted, and the deleted component is shown with a status code of "H". These codes will not appear on the CMS file as the grace period for deleted codes is no longer applicable.

I = Not valid for Medicare purposes Medicare uses another code for reporting of, and payment for, these services. (Code NOT subject to a 90 day grace period.)

J = Anesthesia Services There are no RVUs and no payment amounts for these codes. The intent of this value is to facilitate the identification of anesthesia services.

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M = Measurement codes Used for reporting purposes only.

N = Non-covered Services These services are not covered by Medicare.

P = Bundled/Excluded Codes There are no RVUs and no payment amounts for these services. No separate payment should be made for them under the fee schedule.

--If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident. (An example is an elastic bandage furnished by a physician incident to physician service.)

--If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (i.e., colostomy supplies) and should be paid under the other payment provision of the Act.

Q = Therapy functional information code (used for required reporting purposes only).

R = Restricted Coverage Special coverage instructions apply. If covered, the service is carrier priced. (NOTE: The majority of codes to which this indicator will be assigned are the alpha-numeric dental codes, which begin with "D". CMS is assigning the indicator to a limited number of CPT codes which represent services that are covered only in unusual circumstances.)

T = Injections There are RVUS and payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made. (NOTE: This is a change from the previous definition, which states that injection services are bundled into any other services billed on the same date.)

X = Statutory Exclusion These codes represent an item or service that is not in the statutory definition of "physician services" for fee schedule payment purposes. No RVUS or payment amounts are shown for these codes, and no payment may be made under the physician fee schedule. (Examples are ambulance services and clinical diagnostic laboratory services.)

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Exhibit F - HCPCS Pricing Indicators

00 = Service not separately priced by part B (e.g., services not covered, bundled, used by Part A only, etc.)

Physician Fee Schedule and Non-Physician Practitioners

Linked to The Physician Fee Schedule

11 = Price established using national RVUs

12 = Price established using national anesthesia base units

13 = Price established by carriers (e.g., not otherwise classified, individual determination, carrier discretion)

Clinical Lab Fee Schedule

21 = Price subject to national limitation amount

22 = Price established by carriers (e.g., gap-fills, carrier established panels)

Durable Medical Equipment, Prosthetics, Orthotics, Supplies and Surgical Dressings

31 = Frequently serviced DME (price subject to floors and ceilings)

32 = Inexpensive & routinely purchased DME (price subject to floors and ceilings)

33 = Oxygen and oxygen equipment (price subject to floors and ceilings)

34 = DME supplies (price subject to floors and ceilings)

35 = Surgical dressings (price subject to floors and ceilings)

36 = Capped rental DME (price subject to floors and ceilings)

37 = Ostomy, tracheostomy and urological supplies (price subject to floors and ceilings)

38 = Orthotics, prosthetics, prosthetic devices & vision services (price subject to floors and ceilings)

39 = Parenteral and Enteral Nutrition

40 = Lymphedema Compression Treatment Items (eff 1/1/2024)

45 = Customized DME items

46 = Carrier priced (e.g., not otherwise classified, individual determination, carrier discretion, gap-FILLED AMOUNTS)

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Other

51 = Drugs
52 = Reasonable charge
53 = Statute
54 = Vaccinations
55 = Splints and Casts (effect 10/1/2014)
56 = IOL's inserted in a physician's office (eff 10/1/2014)
57 = Other carrier priced
99 = Value not established

Exhibit G - HCPCS Coverage Codes

HCPCS Coverage Code

C = Carrier judgment

D = Special coverage instructions apply

I = Not payable by Medicare

M = Non-covered by Medicare

S = Non-covered by Medicare statute

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Exhibit H. HCPCS Level II Code Ranges (not current; pending hard copy publication release)

A0021-A0999	Ambulance and Other Transport Services and Supplies
A4201-A8004	Medical and Surgical Supplies
A9150-A9999	Administrative, Miscellaneous and Investigational
B4034-B9999	Enteral and Parenteral Therapy
C1062-C9899	Outpatient PPS
E0100-E8002	Durable Medical Equipment
G0008-G9685	Procedures / Professional Services
H0001-H2037	Alcohol and Drug Abuse Treatment
J0120-J8999	Drugs Administered Other than Oral Method
J9000-J9999	Chemotherapy Drugs
K0001-K0127	DME Medicare administrative contractors
L0112-L4631	Orthotic Procedures and services
L5000-L9900	Prosthetic Procedures
M0075-M0301	Miscellaneous Medical Services
P2028-P9615	Pathology and Laboratory Services
Q0035-Q9992	Temporary Codes
R0070-R0076	Diagnostic Radiology Services
S0012-S9999	Temporary National Codes (Non-Medicare)
T1000-T5999	National Codes Established for State Medicaid Agencies
V2020-V2799	Vision Services
V5008-V5364	Hearing Services

***NOTE: CODES LISTED IN THE ABOVE RANGES MAY HAVE UPDATES FOR THE YEAR. REVIEW HCPCS LEVEL II CODS AND CODE FAMILY UTILIZING CURRENT CODING SOURCES SUCH AS THE CHARGEASSIST® HCPCS MODULE.**

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Exhibit I. HCPCS Type of Service Indicators

Code	Description
0	Whole Blood
1	Medical Care
2	Surgery
3	Consultation
4	Diagnostic Radiology
5	Diagnostic Laboratory
6	Therapeutic Radiology
7	Anesthesia
8	Assistant at Surgery
9	Other Medical Items or Services
A	Used DME
D	Ambulance
E	Enteral/Parenteral Nutrients/Supplies
F	Ambulatory Surgical Center (Facility Usage for Surgical Services)
G	Immunosuppressive Drugs
H	Hospice
J	Diabetic Shoes
K	Hearing Items and Services
L	ESRD Supplies
M	Monthly Capitation Payment for Dialysis
N	Kidney Donor
P	Lump Sum Purchase of DME, Prosthetics, Orthotics
Q	Vision Items or Services
R	Rental of DME
S	Surgical Dressings or Other Medical Supplies
T	Outpatient Mental Health Treatment Limitation
U	Occupational Therapy
V	Pneumococcal/Flu Vaccine
W	Physical Therapy

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Exhibit J. OPPS Final Rule Table of Addenda

2024 Final Rule

OPPS Addenda Table of Contents

1. Addendum A.— OPPS APCs for CY 2024
2. Addendum B.— OPPS Payment by HCPCS Codes for CY 2024
3. Addendum C. —HCPCS Codes Payable Under the 2024 OPPS by APC
4. Addendum D1.— OPPS Payment Status Indicators for CY 2024
5. Addendum D2.— OPPS Comment Indicators for CY 2024
6. Addendum E. —HCPCS Codes that Would Be Paid Only as Inpatient Procedure for CY 2024
7. Addendum J. — Comprehensive APCs
8. Addendum L. —Out-Migration Adjustment for CY 2024
9. Addendum M.— HCPCS Codes for Assignment to OPPS Composite APCs for CY 2024
10. Addendum N.— ByPass List for CY 2024
11. Addendum O.— New and Revised CY 2024 CPT Codes
12. Addendum P.— Device-Intensive Procedures for CY 2024
13. Data Addendum B.—Data Status Indicators, Data APC Assignments, and Data Comment Indicators Used in the Development of the Geometric Mean Costs for HCPCS codes and APCs for CY 2024

https://www.cms.gov/files/document/2024-nfrm-opps-addenda-table-contents.pdf

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