HealthCatalyst

What's Next for the OPPS

A Look at the 2024 Final Rule

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HealthCatalyst

Updates Affecting OPPS Payment

"Ironically, if you have to pay through the nose for hospital care, your insurance will cover the cost of sinus treatments."

Updates Affecting OPPS Payment

- Final 2024 OPPS Conversion Factor of $87.382 – Up from $85.585 for 2023
- Predicted increase of 3.2% in OPPS payments to providers
- The 2% reduction will still apply to hospitals not meeting quality reporting requirements – CF of $85.687
- The 7.1% adjustment for rural sole community hospitals will continue
- Adjustment for cancer hospitals will continue (payment-to-cost ratio equal to 0.88)

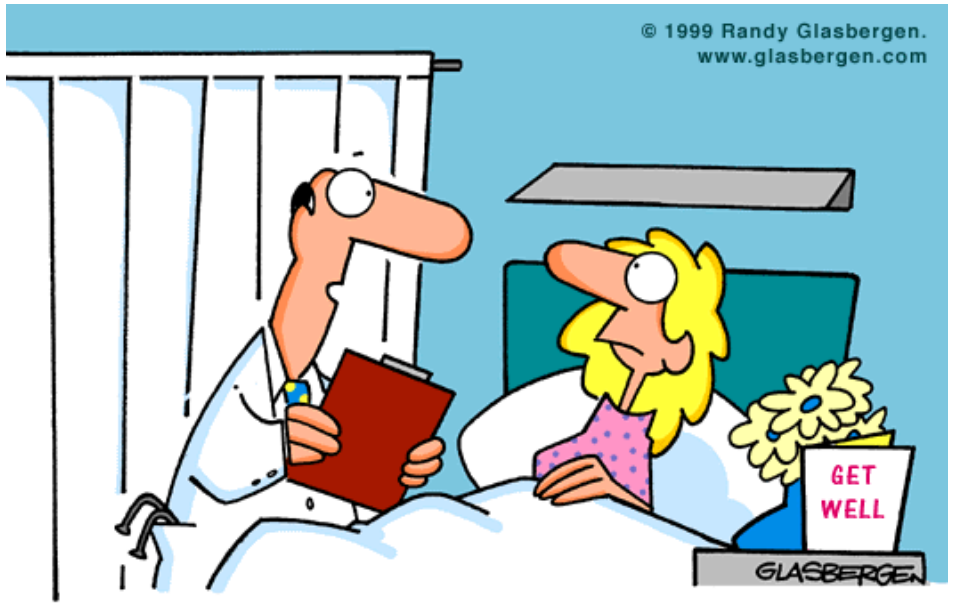
Updates Affecting OPPS Payment

- IPPS wage index adjustments will be used to calculate OPPS adjustments on 1/1/2024
- Continuing to use revised delineations per the OMB (built from 2010 census results)
- Wage index decreases will be capped at 5%; no cap on increases
- All changes are budget neutral
  - Decrease in conversion factor (.9691) will be implemented to offset the 340B drug changes

Updates Affecting OPPS Payment

- Hospital outlier payments will be triggered when a hospital's cost of furnishing a service exceeds 1.75x the APC payment amount AND exceeds the fixed dollar amount of $7,750 (down from $8,625 for CY 2023)
- Outlier payments continue to be calculated as 50% of the amount by which the cost of the service exceeds 1.75x the APC payment amount

Updates to Comprehensive APCs (C-APCs)



"You've got a song in your heart, a poem in your lungs, a limerick in your liver and a novella in your pancreas."

Final Changes to C-APCs

- Two New C-APCs are being added for CY 2024
  - C-APC 5342 – Level 2 Abdominal/Peritoneal/Biliary and Related Procedures
    - 44950 – Appendectomy
    - 47541 – Placement of new access through the biliary tree and into the small bowel to assist with an endoscopic procedure
    - 47552 – Diagnostic biliary endoscopy via T-tube or other tract
    - 47553 – Biliary endoscopy via T-tube or other tract with biopsy
    - 49500 – Repair of initial reducible inguinal hernia in patient 6 months up to 5 years
    - 49521 – Repair of recurrent incarcerated or strangulated inguinal hernia
    - 55535 – Excision of varicocele via abdominal approach

Final Changes to C-APCs

- C-APC 5496 – Level 6 Intraocular
  - 0308T – Insertion of ocular telescope prosthesis
  - 0616T – Insertion of iris prosthesis without removal or insertion of lens
  - 0617T – Insertion of iris prosthesis with removal and insertion of lens
  - 0618T – Insertion of iris prosthesis with secondary IOL placement or exchange
    - CustomFlex Artificial Iris (C1839) – Pass-through status will expire on 12/31/2023; cost of supply will now be bundled into procedure

Updates to OPPS APC-Specific Policies

"Heads, you get a quadruple bypass.
Tails, you take a baby aspirin."

Changes to New Technology APC Groups

HCPCS	Description	2024 APC	2024 $	2023 APC	2023 $
0662T	Scalp cooling, mechanical; initial measurement and calibration of cap	1514	$1,251	1520	$1,851
0686T	Histotripsy (i.e., non-thermal ablation via acoustic energy delivery) of malignant hepatocellular tissue, including image guidance	1576	$17,501	1575	$12,501
0810T	Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies	1563	$4,251	N/A	N/A
78431	Myocardial imaging, PET, perfusion study; multiple studies at rest and stress, with concurrently acquired CT transmission scan	1522	$2,251	1523	$2,751

Changes to New Technology APC Groups

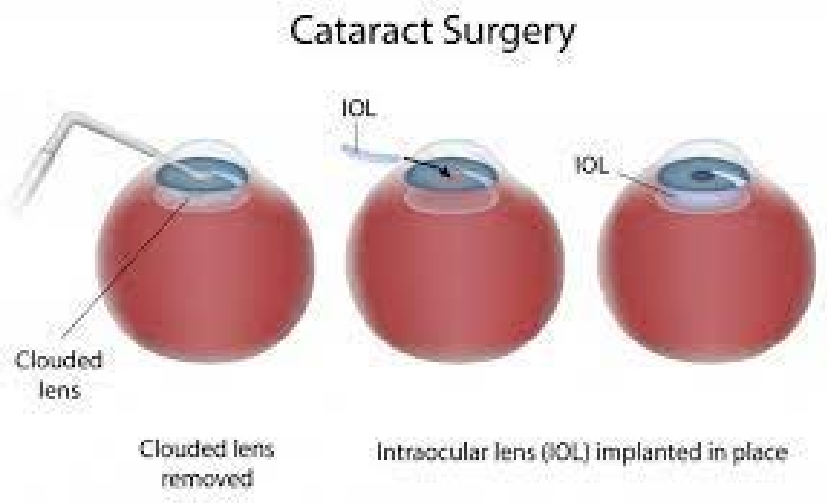
HCPCS	Description	2024 APC	2024 $	2023 APC	2023 $
G2082	Office or other outpatient visit for an established patient that requires the supervision of a physician or other QHP and provision of up to 56 mg of esketamine nasal self-administration	1513	$1,151	1512	$1,051
G2083	Office or other outpatient visit for an established patient that requires the supervision of a physician or other QHP and provision of greater than 56 mg of esketamine nasal self-administration	1520	$1,851	1516	$1,451
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	1580	$45,001	1581	$55,001

Minimally Invasive Glaucoma Surgery

66989 – Extracapsular cataract removal with insertion of IOL and anterior segment aqueous drainage device, complex

66991 – Extracapsular cataract removal with insertion of IOL and anterior segment aqueous drainage device

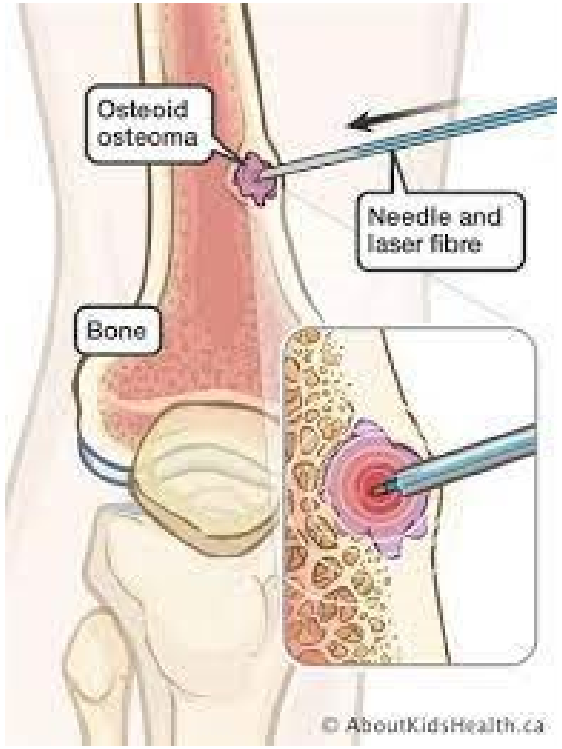
- Reassigned from APC 1563 (2023) to 5493 (2024)
- Status Indicator changing from T to J1
- Reimbursement change from $4,251 (2023) to $4,985 (2024)
- **0671T – Insertion of anterior segment aqueous drainage device without cataract removal** was also reviewed and is being reassigned from APC 5491 (2023) to 5493 (2024) with reimbursement change from $2,159 (2023) to $4,985



Ablation of Bone Tumors

20982 - Ablation therapy for reduction or eradication of 1 or more bone tumors (e.g., metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency

- Reassigned from APC 5114 (2023) to 5115 (2024)
- Status Indicator J1 not changing
- Reimbursement change from $6,615 (2023) to $12,553 (2024)



Autologous Adipose-Derived Regenerative Cell (ADRC) Therapy

0717T – Harvesting, isolation, and preparation of cells prior to ADRC therapy for partial-thickness rotator cuff tear

0718T – Injection into supraspinatus tendon of ADRC therapy for partial-thickness rotator cuff tear

- Placed in APC 5055 (2024)
- Status Indicator changing from E1 (2023) to T (2024)
- Reimbursement change from $0 (2023) to $3,422 (2024)

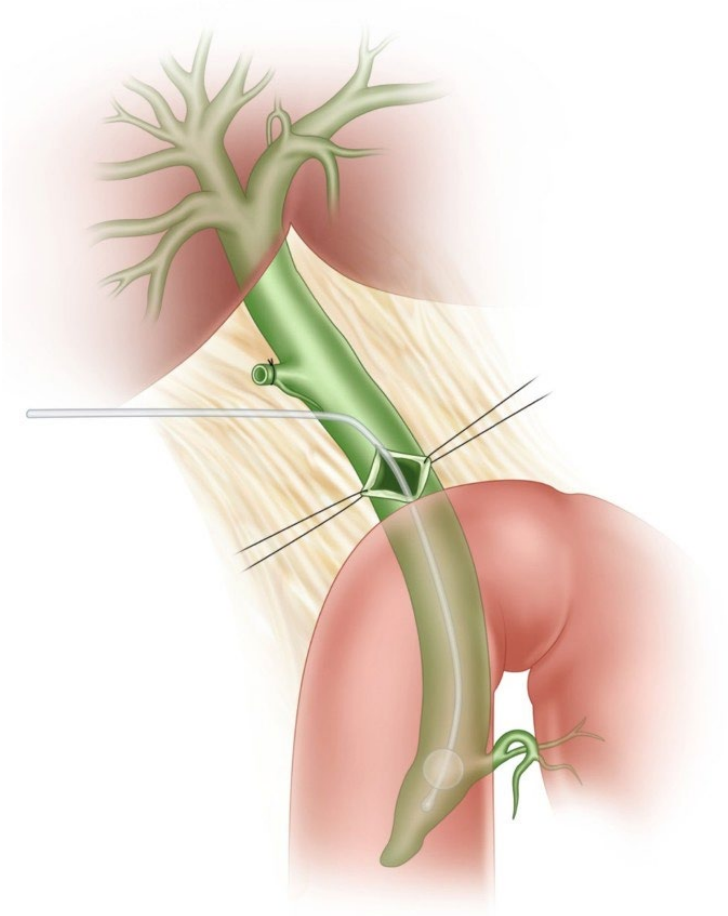
Barostim™ Heart Failure Device

0266T – Implantation or replacement of carotid sinus baroreflex activation device; total system

- Reassigned from APC 5465 (2023) to 1580 (2024)
- Status indicator changing from J1 (2023) to S (2024)
- Reimbursement change from $29,358 (2023) to $45,001 (2024)
  - Associated device (C1825) currently has pass-through status that is expiring as of 12/31/23; cost of device will now be bundled into procedure

Biliary Endoscopy

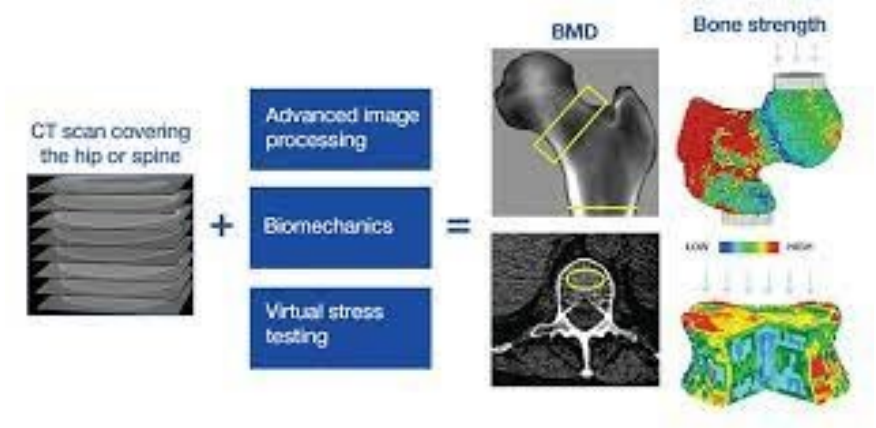
- 47564 – Laparoscopy, surgical; cholecystectomy with exploration of common duct



- Reassigned from APC 5361 (2023) to 5362 (2024)
- No change in Status Indicator (J1)
- Reimbursement change from $5,212 (2023) to $9,818 (2024)

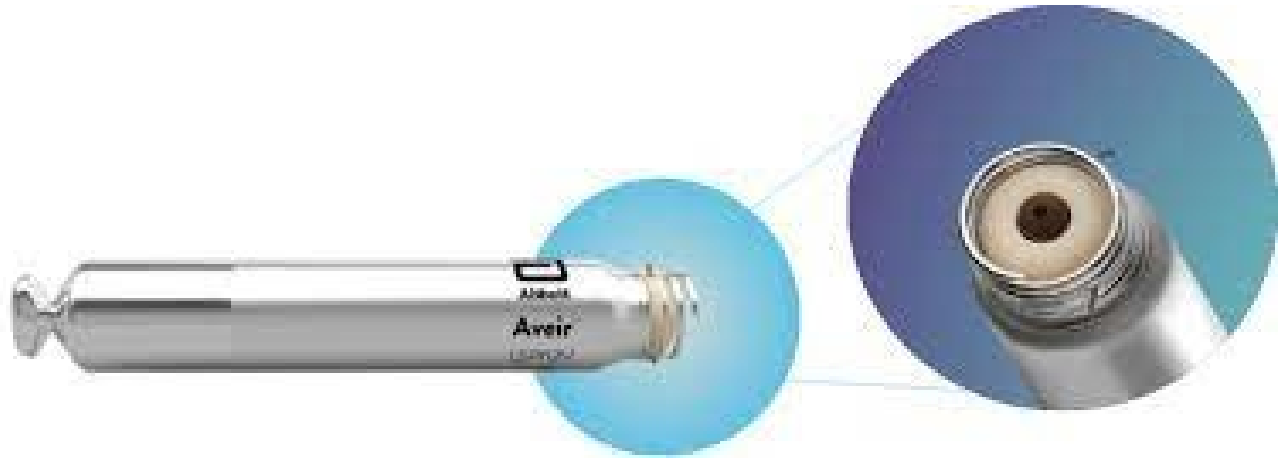
Bone Density Tests

- 0555T and 0558T have been reassigned from Status Indicator E1 to S
- 0554T, 0556T, 0557T, and 0743T have been reassigned from Status Indicator E1 to M
  - CMS received multiple comments stating that Biomechanical Computed Tomography (BCT) Analysis and Digital X-ray Radiogrammetry-Bone Mineral Density (DXR–BMD) do meet regulatory definition of bone mass measurement and should be considered for coverage
  - CMS notes that the change in status indicators does not guarantee coverage – MACs will be responsible for determining eligibility and coverage requirements



Leadless Pacemaker Procedures

- Aveir VR was approved by the FDA in March 2022 and was eligible for payment
- Aveir AR and Aveir DR received approval in June 2023
- CMS is restructuring status indicators and APC assignments for devices for consistency



Leadless Pacemaker Procedures

Code	Description	2023 SI/APC	2023 $$	2024 SI/APC	2024 $$
33274	Insertion of RV leadless pacemaker	J1/5194	$17,178	J1/5224	$18,585
0795T	Insertion of dual-chamber leadless pacemaker	E1	$0	J1/5224	$18,585
0796T	Insertion of RA leadless pacemaker	E1	$0	J1/5224	$18,585
0797T	Insertion of RV leadless pacemaker	J1/5194	$17,178	J1/5224	$18,585
0823T	Insertion of RA leadless pacemaker	E1	$0	J1/5224	$18,585

Leadless Pacemaker Procedures

Code	Description	2023 SI/APC	2023 $$	2024 SI/APC	2024 $$
0801T	Removal & Replacement of dual-chamber leadless pacemaker	E1	$0	J1/5224	$18,585
0802T	Removal & Replacement of RA leadless pacemaker	E1	$0	J1/5224	$18,585
0803T	Removal & Replacement of RV leadless pacemaker	J1/5194	$17,178	J1/5224	$18,585
0825T	Removal & Replacement of single-chamber leadless pacemaker	E1	$0	J1/5224	$18,585

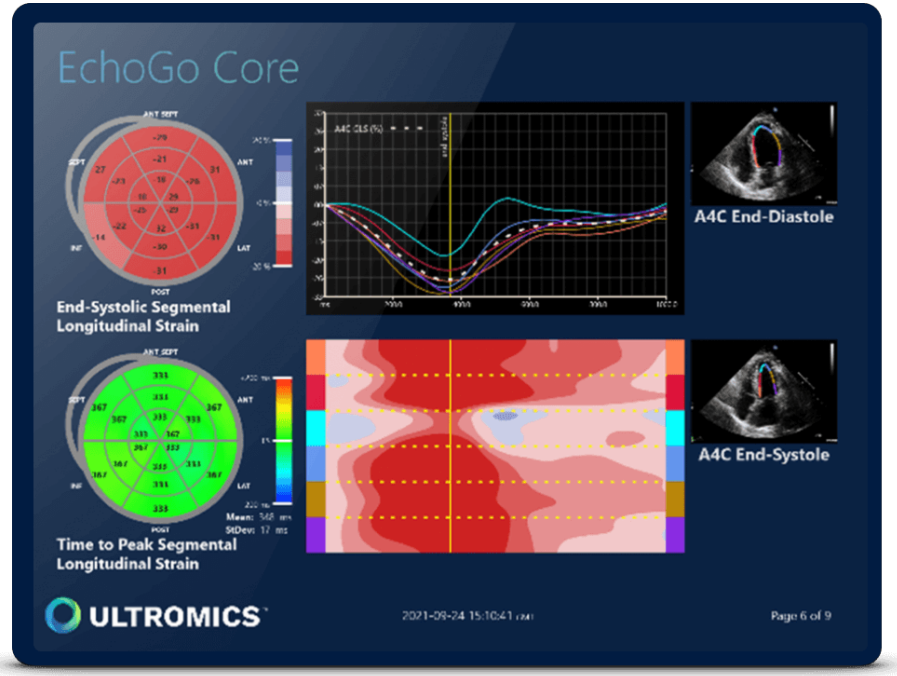
Leadless Pacemaker Procedures

Code	Description	2023 SI/APC	2023 $$	2024 SI/APC	2024 $$
0798T	Removal of dual-chamber leadless pacemaker	E1	$0	J1/5183	$3,040
0799T	Removal of RA leadless pacemaker	E1	$0	J1/5183	$3,040
0800T	Removal of RV leadless pacemaker	J1/5183	$2,979	J1/5183	$3,040
0824T	Removal of single-chamber leadless pacemaker	E1	$0	J1/5183	$3,040

EchoGo Image Processing

C9786 – Echocardiography image post processing for computer aided detection of heart failure with preserved ejection fraction, including interpretation and report

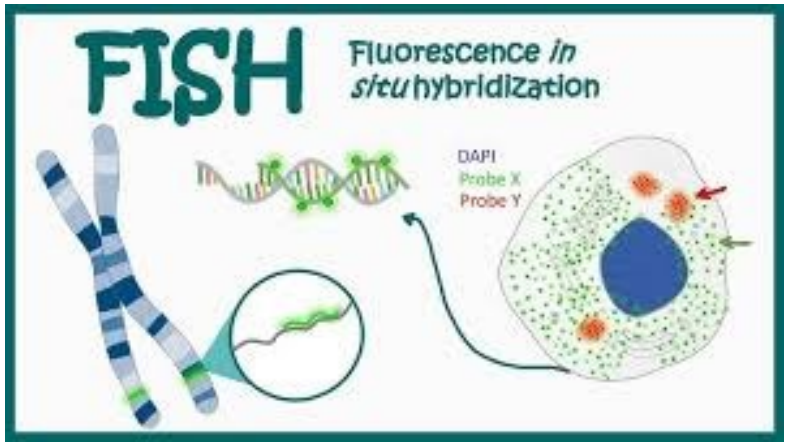
- Reassigned from APC 5742 (2023) to APC 5743 (2024)
- Status indicator of S remains unchanged
- Reimbursement change from $100 (2023) to $285 (2024)



Fluorescence In Situ Hybridization (FISH)

88366 – In situ hybridization (eg, FISH), per specimen; each multiplex probe stain procedure

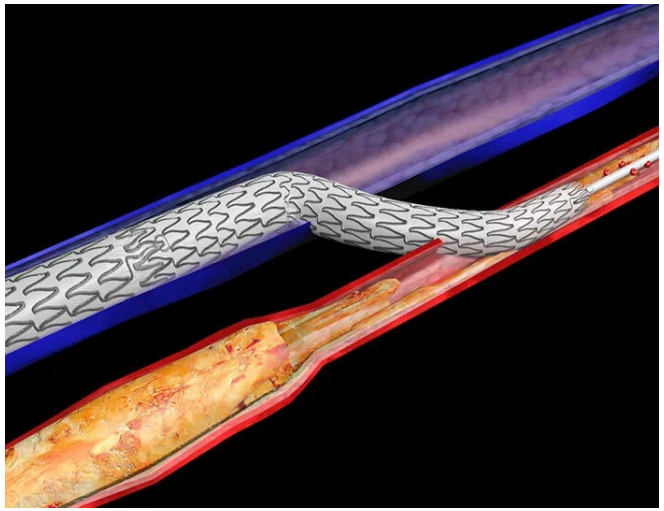
- Reassigned from APC 5673 (2023) to 5672 (2024)
- Status indicator remains Q1
- Reimbursement change from $324 (2023) to $163 (2024)



LimFlow TADV Procedure

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

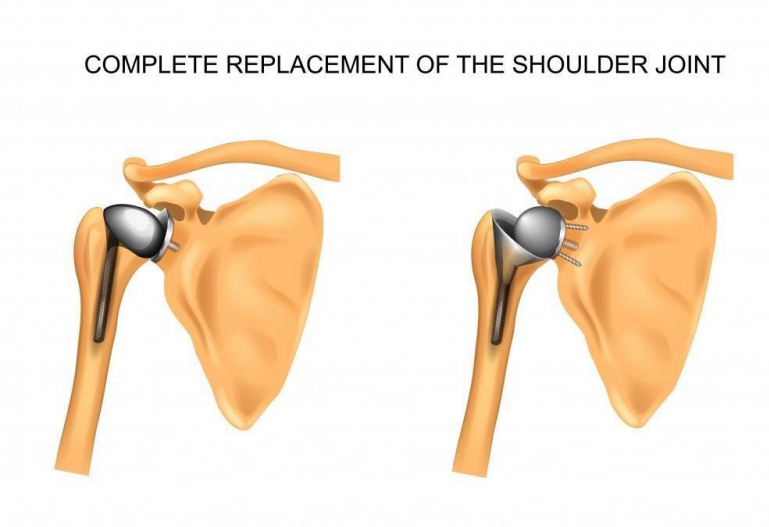
- Reassigned from APC 5194 (2023) to APC 1578 (2024)
- Status indicator change from J1 to S
- Reimbursement change from $17,178 (2023) to $27,501 (2024)



Total Shoulder Arthroplasty

23472 – Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (e.g., total shoulder))

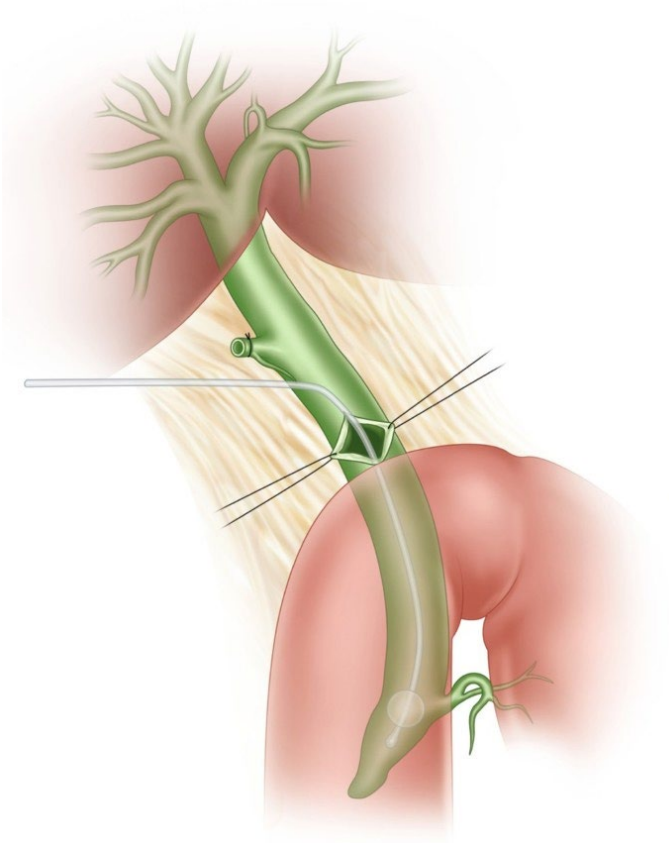
- APC changed from 5115 (2023) to 5116 (2024)
- Status indicator remains J1
- Reimbursement change from $13,048 (2023) to $17,775 (2024)



Peroral Endoscopic Myotomy (POEM)

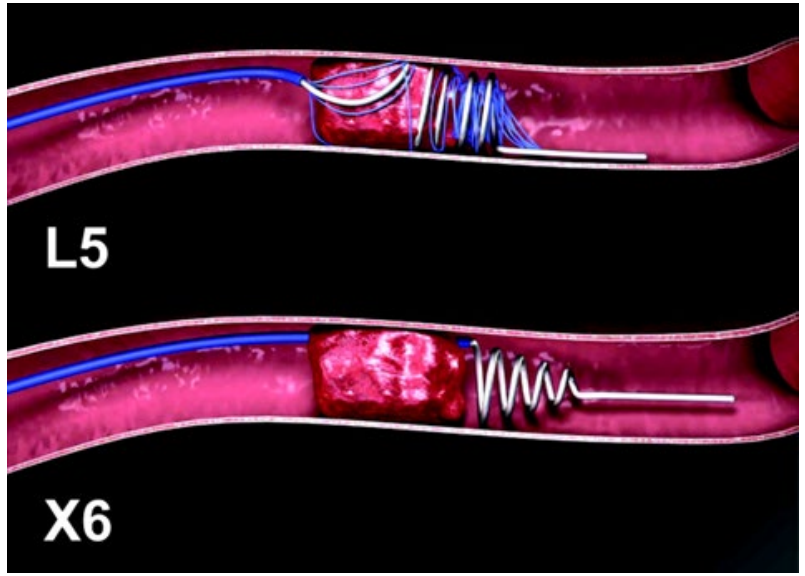
43497 – Lower esophageal myotomy, transoral (i.e., peroral endoscopic myotomy [POEM])

- Reassigned from APC 5303 (2023) to APC 5331 (2024)
- Status indicator remains J1
- Reimbursement change from $3,261 (2023) to $5,436 (2024)



Percutaneous Thrombectomy

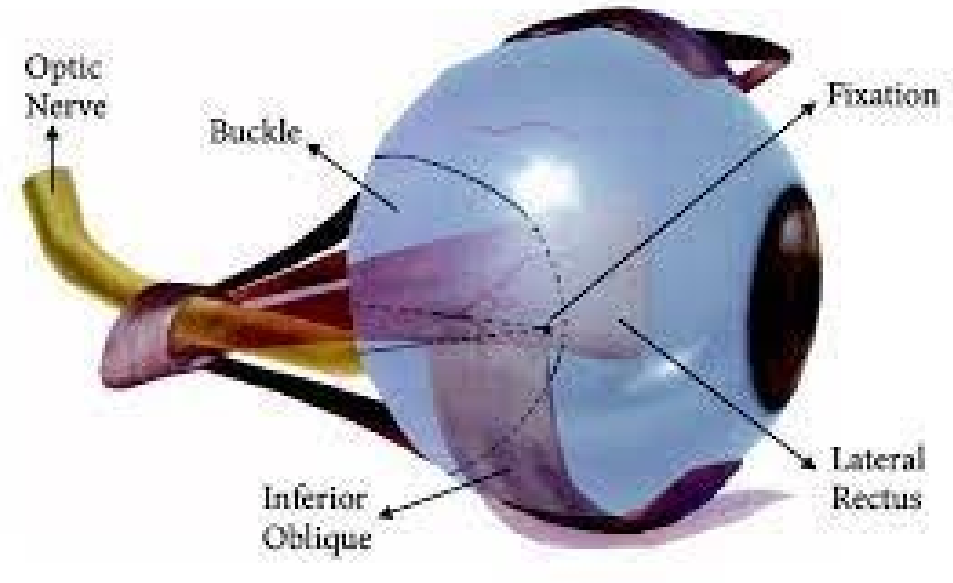
- **37184 – Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel**
  - Reassigned from APC 5193 (2023) to APC 5194 (2024)
  - Status indicator remains J1
  - Reimbursement change from $10,615 (2023) to $16,725 (2024)



Scleral Reinforcement

67255 – Scleral reinforcement (separate procedure); with graft

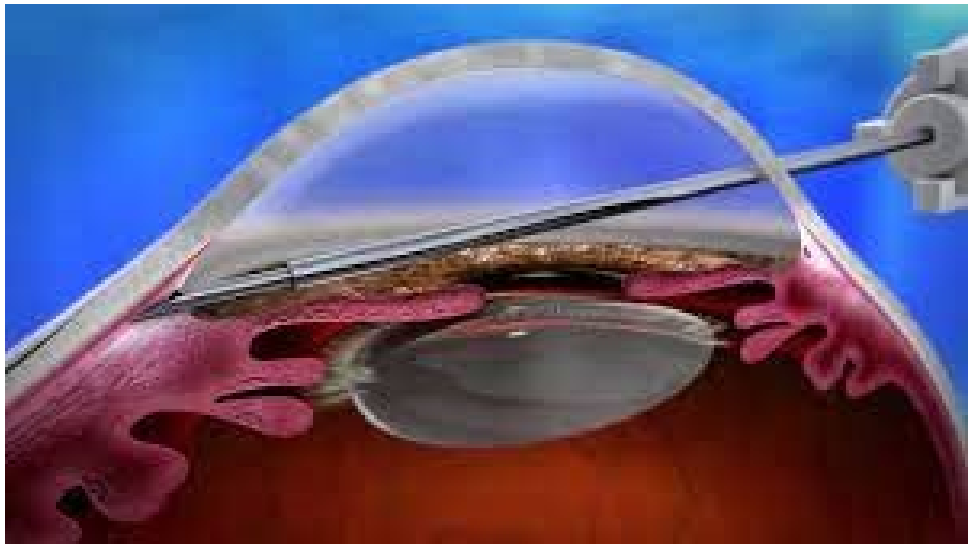
- Reassigned from APC 5491 (2023) to APC 5492 (2024)
- Status indicator remains J1
- Reimbursement change from $2,159 (2023) to $3,878 (2024)



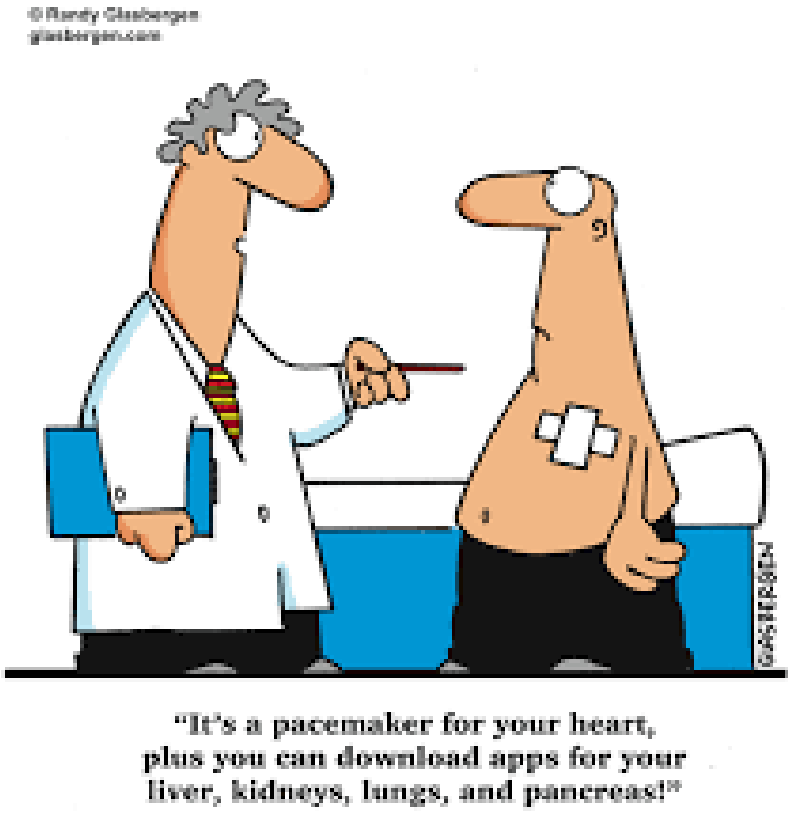
Xen Glaucoma Treatment

0449T – Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device

- Reassigned from APC 5492 (2023) to APC 5493 (2024)
- Status indicator remains J1
- Reimbursement change from $3,996 (2023) to $4,985 (2024)



OPPS Payment For Devices



Pass-Through Status for Devices

There are 8 devices whose pass-through status will expire in 2023.

HCPCS Code	Long Descriptor	Product Name	Expiration Date
C1052	Hemostatic agent, gastrointestinal, topical	Hemospray®	12/31/23
C1062	Intravertebral body fracture augmentation with implant (e.g., metal, polymer)	SpineJack® System	12/31/23
C1734	Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue-to-bone (implantable)	AUGMENT® bone graft	12/31/23
C1824	Generator, cardiac contractility modulation (implantable)	Optimizer® Smart CCM	12/31/23
C1825	Generator, neurostimulator (implantable), non-rechargeable with carotid sinus baroreceptor stimulation lead(s)	BaroStim™ Neo Device	12/31/23
C1839	Iris prosthesis	ArtificialIris™	12/31/23
C1982	Catheter, pressure-generating, one-way valve, intermittently occlusive	Surefire® Spark™ Infusion System	12/31/23
C2596	Probe, image-guided, robotic, waterjet ablation	AquaBeam® System	12/31/23

Pass-Through Status for Devices

There are 7 devices whose pass-through status expires in 2024/2025.

HCPCS Code	Long Descriptor	Product Name	Expiration Date
C1761	Catheter, transluminal intravascular lithotripsy, coronary	Shockwave C^2 Intravascular Lithotripsy Catheter	6/30/24
C1831	Interbody cage, anterior, lateral, or posterior, personalized (implantable)	aprevo™	9/30/24
C1832	Autograft suspension, including cell processing and application, and all system components	RECELL® System	12/31/24
C1833	Monitor, cardiac, including intracardiac lead and all system components (implantable)	AngelMed Guardian™	12/31/24
C1826	Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system	Evoke® SCS System	12/31/25
C1827	Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller	ViviStim® System	12/31/25
C1747	Endoscope, single-use (i.e. disposable), urinary tract, imaging/illumination device (insertable)	Ureterol™	12/31/25

Pass-Through Status for Devices

There are 4 new devices with pass-through status on 1/1/2024.

HCPCS Code	Long Descriptor	Product Name
C1600	Catheter, transluminal intravascular lesion preparation device, bladed, sheathed (insertable)	FLEX VP™ System
C1601	Endoscope, single-use (i.e. disposable), pulmonary, imaging/illumination device (insertable)	Ambu® aScope™ 5 Broncho HD
C1602	Orthopedic/device/drug matrix/absorbable bone void filler, antimicrobial-eluting (implantable)	CERAMENT® G
C1603	Retrieval device, insertable, laser (used to retrieve intravascular inferior vena cava filter)	CavaClear IVC Filter Removal Laser Sheath

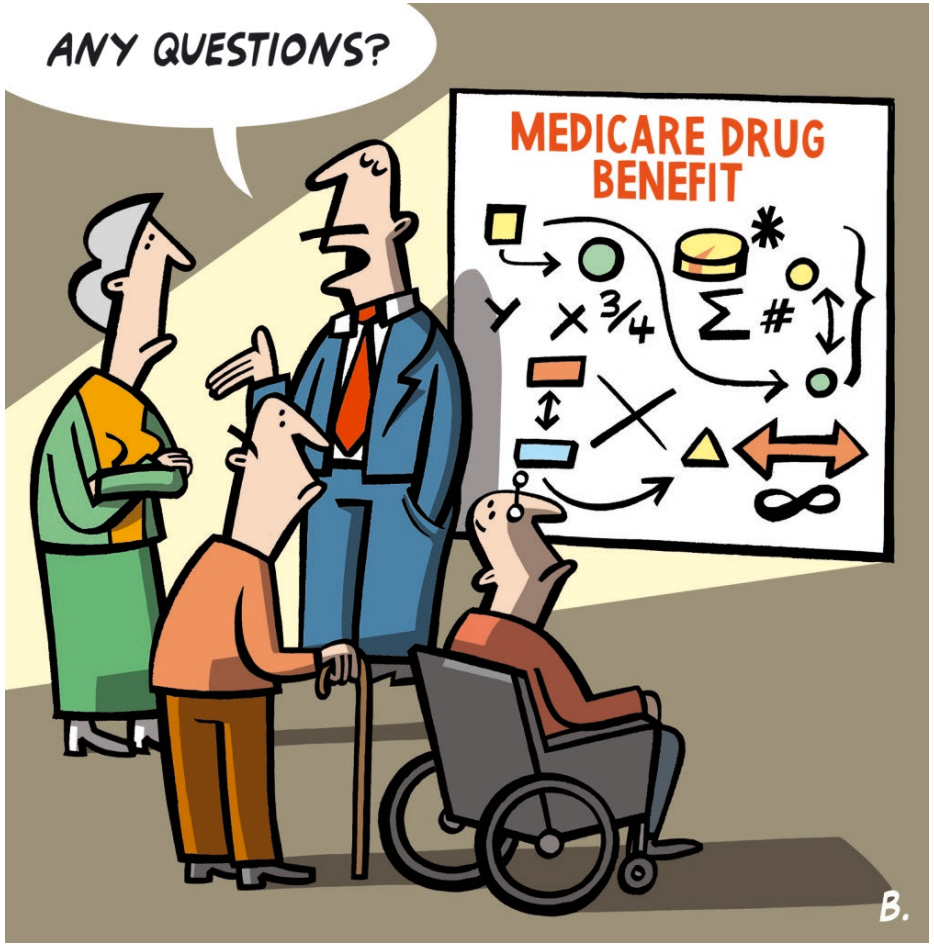
New Procedure-to-Device Edit

CMS is creating new procedure-to-device edits for procedures assigned to APC 5496 (Level 6 Intraocular Procedures)

- 0308T – C1840
- 0616T – C1839
- 0617T – C1839
- 0618T – C1839

CMS declines to reinstate any other procedure-to-device edits at the current time

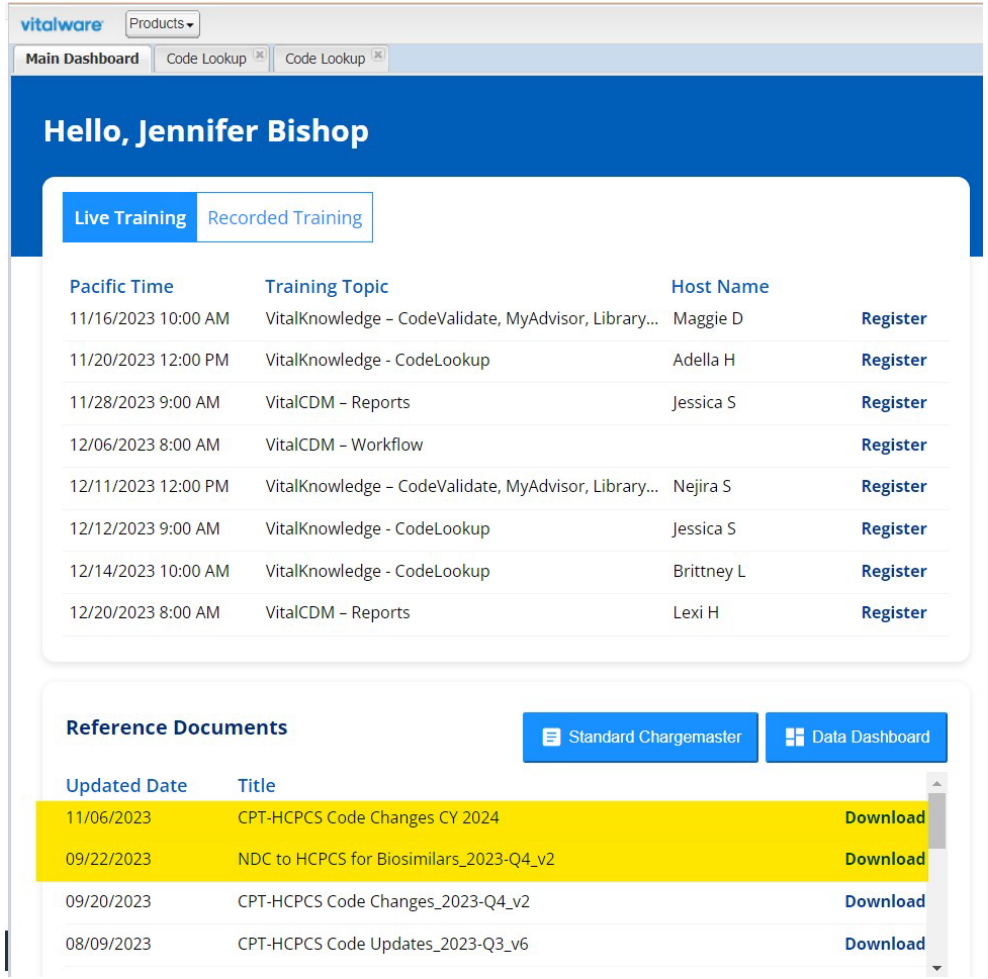
Drugs, Biologicals & Radiopharmaceuticals



Pass-Through Packaging Threshold

- Packaging threshold will remain at $135 for CY 2024
- Packaging determinations made once a year
  - Based on 2nd Quarter 2023 ASP data from manufacturers
  - Drugs without ASP information use mean unit cost derived from claims data
- There are 11 drugs and biologicals whose pass-through status will expire on 12/31/2023
  - Status indicator will change from G (Pass-through drugs) to either K (Non-pass-through drugs) or N (Packaged items/services)
  - Drugs with status indicator of K will continue to be reimbursed at a rate equal to ASP + 6% (updated on a quarterly basis)

Reports Available on Dashboard



APC Changes Information

CPT/HCPCS Code	Short Descriptor	2024 S	2024 AP	2024 Relative Weight	2024 Payment Rate	2024 Minimum Unadjusted Copayment	2023 SI	2023 AP	2023 Relative Weight	2023 Payment Rate	2023 Minimum Unadjusted Copaymer	$$ Change in Payment Rat	% of Change in Payment Rate
J0122	Inj., eravacycline, 1 mg	K	9325	0.0000	$1.13	$0.23	N	N/A	0.0000	$0.00	$0.00	$1.13	100.00%
J0134	Inj acetaminophen -fresenius	K	9143	0.0000	$0.05	$0.02	N	N/A	0.0000	$0.00	$0.00	$0.05	100.00%
J0136	Inj, acetaminophen (b braun)	K	9160	0.0000	$0.05	$0.02	N	N/A	0.0000	$0.00	$0.00	$0.05	100.00%
J0137	Inj, acetaminophen (hikma)	K	9282	0.0000	$0.07	$0.02	N	N/A	0.0000	$0.00	$0.00	$0.07	100.00%
J0173	Inj, epinephrine (belcher)	K	9283	0.0000	$1.71	$0.35	N	N/A	0.0000	$0.00	$0.00	$1.71	100.00%
J0174	Inj, lecanemab-irmb, 1 mg	G	9157	0.0000	$1.35	$0.27	K	9157	0.0000	$1.35	$0.27	$0.00	0.00%
J0206	Inj allopurinol sodium 1 mg	K	9285	0.0000	$5.63	$1.13	N	N/A	0.0000	$0.00	$0.00	$5.63	100.00%
J0207	Amifostine	E2	N/A	0.0000	$0.00	$0.00	N	N/A	0.0000	$0.00	$0.00	$0.00	0.00%
J0283	Inj, amiodarone (nexterone)	E2	N/A	0.0000	$0.00	$0.00	N	N/A	0.0000	$0.00	$0.00	$0.00	0.00%
J0349	Inj, rezafungin, 1 mg	G	9267	0.0000	$10.04	$2.01	K	9267	0.0000	$10.04	$2.01	$0.00	0.00%
J0390	Chloroquine injection	N	N/A	0.0000	$0.00	$0.00	K	9352	0.0000	$0.71	$0.15	($0.71)	-100.00%
J0400	Aripiprazole injection	N	N/A	0.0000	$0.00	$0.00	K	9037	0.0000	$5.25	$1.05	($5.25)	-100.00%
J0457	Injection, aztreonam, 100 mg	K	9288	0.0000	$2.52	$0.51	N	N/A	0.0000	$0.00	$0.00	$2.52	100.00%
J0606	Inj, etelcalcetide, 0.1 mg	K	9031	0.0000	$2.61	$0.53	N	N/A	0.0000	$0.00	$0.00	$2.61	100.00%
J0612	Calcium glucon (fresenius)	K	9226	0.0000	$0.05	$0.02	N	N/A	0.0000	$0.00	$0.00	$0.05	100.00%
J0613	Calcium glucon (wg critical)	K	9238	0.0000	$0.09	$0.02	N	N/A	0.0000	$0.00	$0.00	$0.09	100.00%
J0642	Injection, khapzory, 0.5 mg	K	9334	0.0000	$1.06	$0.22	N	N/A	0.0000	$0.00	$0.00	$1.06	100.00%
J0665	Inj, bupivacaine, nos, 0.5mg	K	9290	0.0000	$0.02	$0.01	N	N/A	0.0000	$0.00	$0.00	$0.02	100.00%
J0689	Inj cefazolin sodium, baxter	K	9161	0.0000	$1.21	$0.25	N	N/A	0.0000	$0.00	$0.00	$1.21	100.00%

Policy-Packaged Drugs, Biologicals, and Radiopharmaceuticals

- Anesthesia
- Diagnostic radiopharmaceuticals
- Contrast agents
- Pharmacologic stress agents
- Skin substitutes
- Implanted biologics
- Postsurgical pain management

Packaging Exception for Biosimilars

- Biosimilars will be excepted from the threshold packaging policies when their reference product is not packaged (paid separately)
  - Biosimilars will be reimbursed even if they fail to meet the per-day cost threshold of $135
- ASP add-on for biosimilars is equal to 8% of the reference product's ASP for 5 years

Reversal of Alternate Payment Methodology for 340B Drugs

CMS has finalized their remedy for 340B-acquired drug payment policy for CY 2018-2022

- CMS is providing lump-sum payments to affected 340B providers
  - Estimated that these providers received $10.6 billion less than they would have without the 340B policy
  - Providers have received $1.6 billion of that already through reprocessed claims
- CMS is implementing a budget neutrality adjustment of 0.9691 to the OPPS conversion factor for CY 2026 until an estimated $7.8 billion is offset (approximately 16 years)
  - Providers not enrolled in Medicare until after January 1, 2018 will not have offset applied

Modifier Use for 340B Drugs

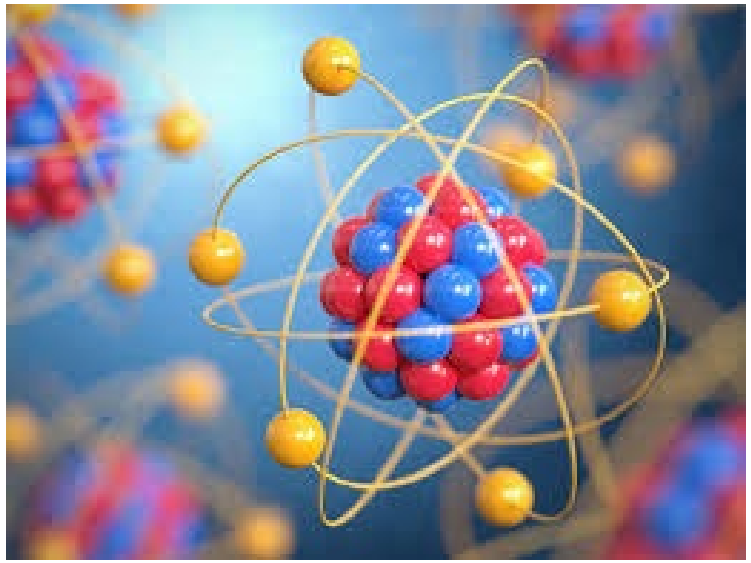
CMS continues to require modifier use for separately-payable drugs acquired through the 340B Program for tracking of Part B inflation rebate

- Modifier JG may continue to be assigned through December 31, 2024, but will be deleted at that time
- Modifier TB may be assigned by all providers as of January 1, 2024, but must be used as of January 1, 2025 to identify all separately-payable drugs acquired through the 340B Program
  - No payment reduction will result from modifier use

Skin Substitute Products

- Skin substitute products that have been assigned A2xxx codes will be automatically assigned to high-cost skin substitute group until cost data can be obtained
- Five skin substitute products are being reassigned from low-cost to high-cost group for CY 2024
  - Q4135 - Mediskin
  - Q4218 – SurgiCORD per sq cm
  - Q4221 – Amnio Wrap 2 per sq cm
  - Q4250 – AmnioAMP-MP per sq cm
  - Q4253 – Zenith Amniotic Membrane per sq cm

Payment for Radioisotopes Derived from non-HEU Sources



- Radioisotopes that are at least 95% derived from non-HEU sources are paid an additional $10 when reported with Q9969 (TC-99m from non-highly enriched uranium source, full cost recovery add-on per study dose)
  - Payment will continue through December 31, 2025
  - CMS wants to ensure that costs are reflected in claims data before discontinuing this payment

JW and JZ Modifiers

- New JZ modifier (Zero drug amount discarded/not administered to any patient)
  - All claims with single-use vials will require a modifier
    - JW on a separate line to identify waste
    - JZ on the same claim line to identify no waste
    - Claim edits implemented on October 1, 2023

Outpatient Psychiatric Services

Revisions to PHP Physician Certification Requirements

- A physician must certify that each patient needs a minimum of 20 hours of PHP services per week
- Initial recertification must occur after 18 days with subsequent recertifications no less frequently than every 30 days
- No changes to requirement that physician must also certify that the patient would require inpatient psychiatric services if PHP was not offered
- Specific reference that treatment of substance use disorders is covered is being added to eligibility criteria

Intensive Outpatient Program (IOP)

- Definition – 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 the regulations
  - Individual and group therapy
  - Occupational therapy
  - Services of social workers, psychiatric nurses, and other staff trained to work with psychiatric patients
  - Drugs and biologicals
  - Individualized activity therapies that are not primarily recreational
  - Family counseling
  - Patient training and education
  - Diagnostic services

Intensive Outpatient Program (IOP)

- Patient eligibility criteria is mostly the same as that of the PHP program
  - A physician must certify that each patient needs a minimum of 9 hours of IOP services per week
  - No requirement that physician must also certify that the patient would require inpatient psychiatric services if IOP was not offered
- Physician certification should certify the need for either PHP or IOP; patients cannot participate in both at the same time
- Recertification must be done every 60 days
- CMHCs may enter into provider agreements to furnish care under an IOP and a PHP

Intensive Outpatient Program

Coding and Billing for IOP services

- Condition Code 92 must be used by hospitals and CMHCs when reporting intensive outpatient services
- Condition Code 41 will still be used by hospitals for PHP services; as of January 1, 2024, CMHCs must also report Condition Code 41 for PHP services
- Multiple codes added as services that can be provided under IOP or PHP
  - A primary service must be provided to qualify for IOP payment

CY 2024 Payment Rates for PHP/IOP

APC	APC Title	2024 $$
5851	Intensive Outpatient (3 services) for CMHCs	$87.66
5852	Intensive Outpatient (4 services) for CMHCs	$157.58
5853	Partial Hospitalization (3 services) for CMHCs	$87.66
5854	Partial Hospitalization (4 services) for CMHCs	$157.58
5861	Intensive Outpatient (3 services) for Hospital-based IOPs	$259.40
5862	Intensive Outpatient (4 services) for Hospital-based IOPs	$358.21
5863	Partial Hospitalization (3 services) for Hospital-based PHPs	$259.40
5864	Partial Hospitalization (4 services) for Hospital-based PHPs	$358.21

Intensive Outpatient Program (IOP)

- IOP is a permanent benefit for RHCs and FQHCs as of 1/1/2024 – Paid at a rate equal to APC 5861 ($259.40) for CY 2024
- “Opioid Treatment Program (OTP) intensive outpatient services” is a new covered Part B benefit incorporated into the opioid use disorder treatment services
  - OTPs will report a weekly add-on code (G0137) when at least 9 IOP services are provided in addition to Opioid Use Disorder (OUD) services with payment equal to $778.20 for CY 2024 (equal to APC 5863 x3)

Changes to Inpatient Only (IPO) List

"I would be a lot healthier if you'd stop finding things wrong with me!"

Codes Added to IPO for CY 2024

Code	Long Descriptor
0646T	Transcatheter tricuspid valve implantation (ttvi)/replacement with prosthetic valve, percutaneous approach, including right heart catheterization, temporary pacemaker insertion, and selective right ventricular or right atrial angiography, when performed
0790T	Revision (e.g., augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed
22836	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments
22837	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments
22838	Revision (e.g., augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed
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)
76984	Ultrasound, intraoperative thoracic aorta (e.g., epiaortic), diagnostic
76987	Intraoperative epicardial cardiac (e.g., echocardiography) ultrasound for congenital heart disease, diagnostic; including placement and manipulation of transducer, image acquisition, interpretation and report
76988	Intraoperative epicardial cardiac ultrasound (ie, echocardiography) for congenital heart disease, diagnostic; placement, manipulation of transducer, and image acquisition only
76989	Intraoperative epicardial cardiac ultrasound (ie, echocardiography) for congenital heart disease, diagnostic; interpretation and report only

Non-recurring Policy Changes

"Do my medical benefits cover being sick of rising medical costs?"

Remote Mental Health Services

Hospital staff may continue to provide remote mental health services

- Patient must be located at home – includes temporary shelters
- Provider must be appropriately licensed with the state
- ~~Patients must have an initial in-person visit within 6 months and subsequent visits every 12 months –~~ Requirement delayed until 1/1/25
  - Exception for patients with documentation that in-person visit would cause harm; hospitals must also document that patient has regular source of general medical care
- Audio-only communication is acceptable, but hospital must have capability to provide two-way, audio/video services

Remote Mental Health Services

HCPCS Code	Long Descriptor	2023 $
C7900	Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, initial 15-29 minutes, 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	$28
C7901	Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, initial 30-60 minutes, provided remotely by hospital staff who are licensed to provided mental health services under applicable state law(s), when the patient is in their home, and there is no associated professional service	$85
C7902	Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, each additional 15 minutes, 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	$0
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 associated professional service	$28

Remote Outpatient Therapies

Hospital staff may continue to provide remote services through the end of 2024

- Physical Therapy
- Occupational Therapy
- Speech-Language Pathology Services
- Diabetes Self-Management Training
- Medical Nutrition Therapy
  - Modifier 95 should be appended to services provided via telehealth
  - Patients' homes will no longer need to be registered as PBD of the hospital

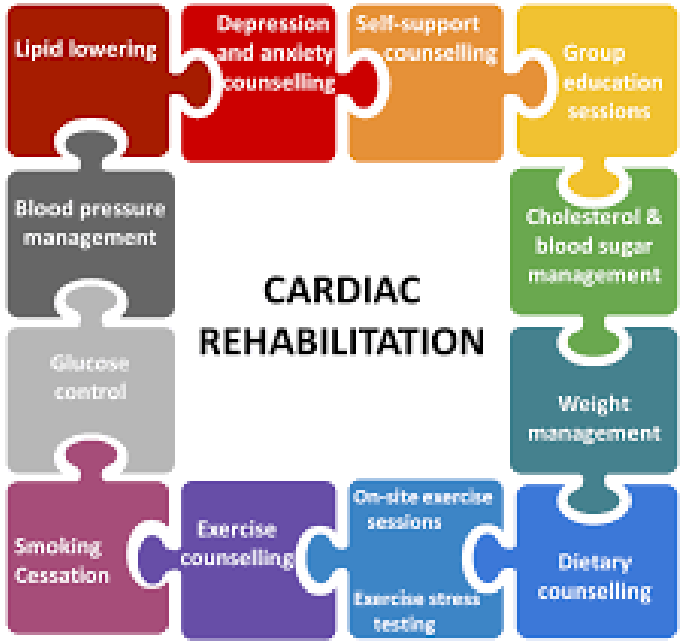
Supervision Requirements

- Cardiac Rehab (CR), Intensive Cardiac Rehab (ICR), and Pulmonary Rehab (PR) services may meet the direct supervision requirement through audio-video real-time communications technology through 12/31/2024
- Supervising practitioners for CR, ICR, and PR services have been expanded to include nurse practitioners, physician's assistants, and clinical nurse specialists
- The direct supervision of diagnostic services requirement will include the virtual presence of the physician or nonphysician practitioner through audio-video real-time communications technology through 12/31/2024

Intensive Cardiac Rehab in HOPD

To correct an inadvertent error, intensive cardiac rehab services (G0422 and G0423) will be reimbursed at 100% OPPS rate when provided in offsite hospital outpatient departments

- Reported using PN modifier



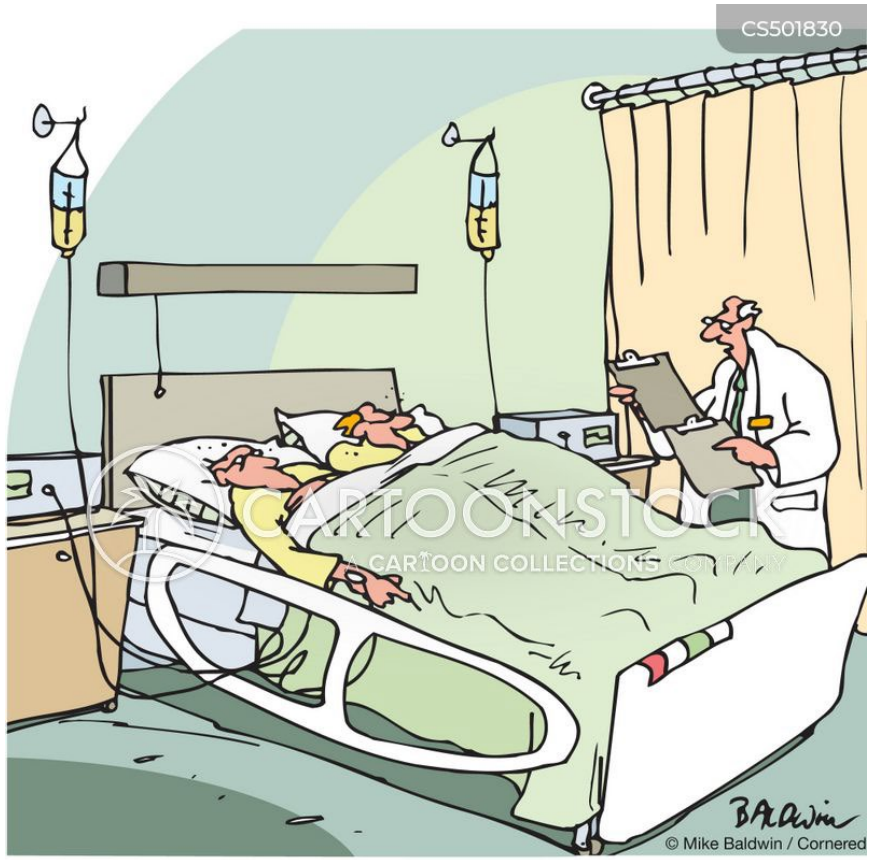
OPPS Payment for Dental Services

- Dental procedures that are inextricably linked to other covered services will be paid when payment and coverage requirements are met
  - Other covered services include organ transplant, cardiac valve replacement, valvuloplasty, treatment of head and neck cancer
  - Other services deemed to meet requirements may be submitted for consideration
  - MACs will make final coverage determinations
- Hospitals should report specific CDT code when the service meets these requirements and is assigned to an APC
  - 241 CDT codes have been assigned to an APC for CY 2024

OPPS Payment for Dental Services

- HCPCS code G0330 (Facility services for dental rehab) should only be assigned when no specific code exists to describe the service provide
  - MAY ONLY BE ASSIGNED WHEN THE SERVICE MEETS COVERAGE AND BILLING REQUIREMENTS
  - For CY 2024, APC for G0330 is being reassigned from 5871 to 5164 with an associated increase in reimbursement from $1,722 to $3,071
  - Status Indicator is also being reassigned from S to J1
    - Other services will now be bundled when code is reported
    - Use should be rare and decline with time

Hospital Outpatient Quality Reporting Program



"Sorry – there's a shortage of beds. On the bright side, you're way more infectious than the guy next to you."

Measures Added for Reporting

- Risk-Standardized Patient-Reported Outcome-Based Performance Measure (PRO–PM) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) in the HOPD Setting (THA/TKA PRO–PM)
  - Voluntary Reporting for CY 2025 – Mandatory for CY 2028
- Excessive Radiation eCQM (Previously referred to as Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults eCQM)
  - Voluntary Reporting for CY 2025 – Mandatory for CY 2027

Measures Modified for CY 2024 Reporting

- COVID-19 Vaccination Coverage Among Health Care Personnel (HCP)
  - Hospitals must report the number of HCP who are “up to date” with vaccinations; HCP with contraindications to the vaccine are still not included
- Cataracts: Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery
  - CMS is limiting the allowable survey instruments
    - The National Eye Institute Visual Function Questionnaire –25 (NEI VFQ-25)
    - The Visual Functioning Patient Questionnaire (VF-14)
    - The Visual Functioning Index Patient Questionnaire (VF-8R)

Measures Modified for CY 2024 Reporting

- Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
  - Patients tracked will now include all patients between the ages of 45 and 75
- Median Time for Discharged ED Patients – Transfer Patients and Median Time for Discharged ED Patients – Overall Rate
  - Data will be made publicly available in CY 2024

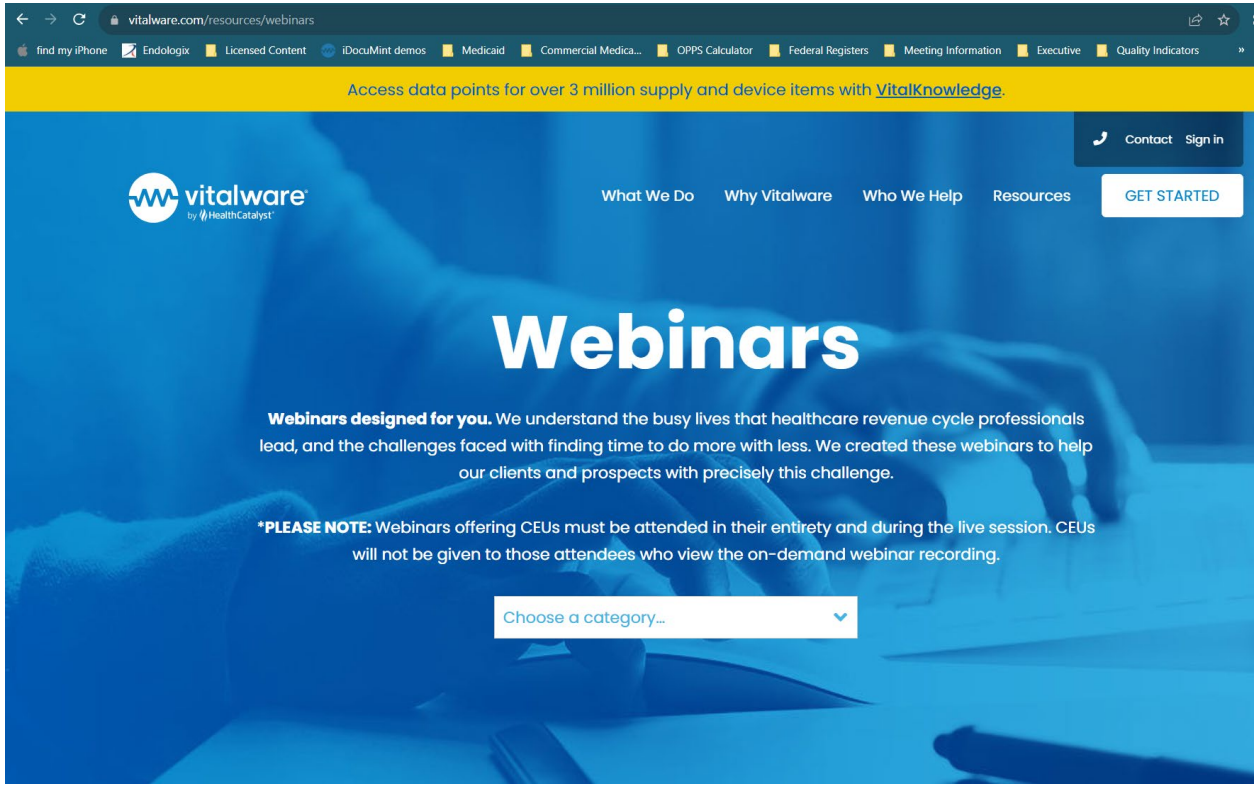
Hospital Price Transparency

New Requirements for January 1, 2024

- The public website must include a .txt file in the root folder with a standardized set of fields
  - Hospital location name(s) that correspond to the Machine-Readable File (MRF)
  - Source page URL that hosts the MRF
  - A direct link to the MRF URL
  - Hospital Point of Contact information
- The public website must include a footer that is labeled “Price Transparency
  - Footer must link directly to the publicly available webpage that hosts the link to the MRF
  - Must be on the hospital’s homepage

More Information on Hospital Price Transparency Requirements

- Webinar on 12/6/23 at 12:00 CST
- More information will be available soon



Questions?

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