CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13032	**Date: January 3, 2025**
	Change Request 13933

NOTE: This Transmittal is no longer sensitive and is being re-communicated January 10, 2025. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: January 2025 Update of the Hospital Outpatient Prospective Payment System (OPPS)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to describe changes to and billing instructions for various payment policies implemented in the January 2025 Outpatient Prospective Payment System (OPPS) update. The January 2025 Integrated Outpatient Code Editor (I/OCE) will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this Change Request (CR). This Recurring Update Notification applies to Chapter 4, section 50.8 (Annual Updates to the OPPS Pricer for Calendar Year (CY) 2007 and Later).

EFFECTIVE DATE: January 1, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 6, 2025

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	4/Table of Contents
R	4/10.2.3 - Comprehensive APCs
R	4/10.6.3/Payment Adjustment for Certain Cancer Hospitals
N	4/62/Billing and Payment for Medical Devices Classified as Non-Opioid Treatments for Pain Relief Under the OPPS and ASC Payment System
N	4/62.1/Qualifying Criteria for Payment for Medical Devices Classified as Non-Opioid Treatments for Pain Relief Under the OPPS and ASC Payment System
N	4/62.2/Payment amount for Medical Devices Classified as Non-Opioid Treatments for Pain Relief Under the OPPS and ASC Payment System
N	4/232/OPPS Payment for Drugs Covered as Additional Preventive Services (DCAPS)
N	4/232.1/OPPS Payment Amounts for Drugs Covered as Additional Preventive Services (DCAPS)
N	4/250.2/OPPS Payment for PrEP for HIV Drugs
R	4/260.1/Special Partial Hospitalization Billing Requirements for Hospitals, Community Mental Health Centers, and Critical Access Hospitals
R	4/261.1/Special Intensive Outpatient Program Billing Requirements for Hospitals, Community Mental Health Centers, and Critical Access Hospitals
R	4/261.1.1/Bill Review for Intensive Outpatient Program Services Provided in Community Mental Health Centers (CMHC)
R	17/Table of Contents
R	17/90.2/Drugs, Biologicals, and Radiopharmaceuticals
N	17/102/Payment for Drugs Classified as Non-Opioid Treatments for Pain Relief Under the OPPS and ASC Payment System
N	17/102.1/Qualifying Criteria for Payment for Drugs and Biologicals Classified as Non-Opioid Treatments for Pain Relief Under the OPPS and ASC Payment System
N	17/102.2/Payment amount for Drugs Classified as Non-Opioid Treatments for Pain Relief Under the OPPS and ASC Payment System

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding

continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification
Manual Instructions

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 13032	Date: January 3, 2025	Change Request: 13933

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SUBJECT: January 2025 Update of the Hospital Outpatient Prospective Payment System (OPPS)

EFFECTIVE DATE: January 1, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 6, 2025

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to describe changes to and billing instructions for various payment policies implemented in the January 2025 Outpatient Prospective Payment System (OPPS) update. The January 2025 Integrated Outpatient Code Editor (I/OCE) will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this Change Request (CR). This Recurring Update Notification applies to Chapter 4, section 50.8 (Annual Updates to the OPPS Pricer for Calendar Year (CY) 2007 and Later).

II. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to describe changes to and billing instructions for various payment policies implemented in the January 2025 Outpatient Prospective Payment System (OPPS) update.

This Recurring Update Notification (RUN) provides instructions on coding changes and policy updates that are effective January 1, 2025, for the Hospital OPPS. The updates include coding and policy changes for new PLA codes, new services, pass-through drug and devices, and other items and services. The January 2025 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming January 2025 I/OCE CR.

B. Policy: 1. CPT Proprietary Laboratory Analyses (PLA) Coding Changes Effective January 1, 2025

The AMA CPT Editorial Panel established 10 new PLA codes, specifically, CPT codes 0521U through 0530U, effective January 1, 2025.

Table 1, attachment A, lists the long descriptors and status indicators for the codes. The codes have been added to the January 2025 I/OCE with an effective date of January 1, 2025. In addition, the codes, along with their short descriptors and status indicators, are listed in the January 2025 OPPS Addendum B that is posted on the CMS website. For more information on OPPS status indicators, refer to OPPS Addendum D1 of the Calendar Year 2025 OPPS/ASC final rule for the latest definitions.

2. OPPS Device Pass-through

a. New Device Pass-Through Category Effective January 1, 2025

Section 1833(t)(6)(B) of the Social Security Act requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least two, but not more than three years. In addition, section 1833(t)(6)(B)(ii)(IV) of the Act requires that we create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

As discussed in section IV.A.2. New Device Pass-Through Applications for CY 2025 of the CY 2025 OPPS/ASC final rule with comment period, for the January 2025 update, we approved five new devices for pass-through status under the OPPS, specifically, HCPCS codes C1735, C1736, C1737, C1738, and C9610. For the full discussion on the criteria used to evaluate device pass-through applications, refer to the CY 2025 OPPS/ASC final rule with comment period, which was published in the **Federal Register** on November 27, 2024. In addition, we note that HCPCS code C1739 was preliminarily approved as part of the device pass-through quarterly review process with an effective date of January 1, 2025. The device application associated with HCPCS code C1739 will be included and discussed in the CY 2026 OPPS/ASC proposed and final rules. Refer to Table 2A, attachment A, for the long descriptor, status indicator, APC, and offset amount for these six HCPCS codes.

Furthermore, we are adding these six new device category codes and their pass-through expiration dates to Table 3, attachment A. Refer to Table 3 for the complete list of device category HCPCS codes and definitions used for present and previous transitional pass-through payment.

b. Device Offset from Payment for the Following HCPCS Codes

Section 1833(t)(6)(D)(ii) of the Act requires that we deduct from pass-through payments for devices an amount that reflects the device portion of the APC payment amount. This deduction is known as the device offset, or the portion(s) of the APC amount that is associated with the cost of the pass-through device. The device offset from payment represents a deduction from pass-through payments for the applicable pass-through device.

c. Transitional Pass-Through Payments and Offsets for Designated Devices

Certain designated new devices are assigned to APCs and identified by the I/OCE as eligible for payment based on the reasonable cost of the new device reduced by the amount included in the APC for the procedure that reflects the packaged payment for device(s) used in the procedure. The I/OCE will determine the proper payment amount for these APCs as well as the coinsurance and any applicable deductible. All related payment calculations will be returned on the same APC line and identified as a designated new device. Please refer to the most current publication of the OPPS HCPCS device offset amounts (Addendum P) associated with the CY 2025 OPPS payment system. OPPS rulemaking is accessible on the CMS website at: https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices. Addendum P has a separate device intensive tab that includes HCPCS with “device offset” amounts. For the device offset amounts of HCPCS codes that are not device-intensive, please refer to the tab in Addendum P for “HCPCS Offsets.”

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

For devices that have received FDA marketing authorization and a Breakthrough Device designation from the FDA, CMS provides an alternative pathway to qualify for device pass-through payment status, under which devices would not be evaluated in terms of the current substantial clinical improvement criterion for the purposes of determining device pass-through payment status. The devices would still need to meet the other criteria for pass-through status. This applies to devices that receive pass-through payment status effective on or after January 1, 2020. For information on the device criteria to qualify for pass-through status under the OPPS,

refer to this CMS website, specifically at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.

e. Expiring Pass-through Status for Two Device Category HCPCS Codes Effective January 1, 2025

As specified in section 1833(t)(6)(B) of the Social Security Act, under the OPPS, categories of devices are eligible for transitional pass-through payments for at least two, but not more than three years. For the January 2025 update, the pass-through status period for two device categories, specifically, HCPCS codes C1832 and C1833, will expire on December 31, 2024. We note these device category HCPCS codes will remain active; however, its payment will be included in the primary service. Refer to Table 2B, attachment A and Table 3 for the long descriptor associated with HCPCS codes C1832 and C1833.

As a reminder, for OPPS billing, because charges related to packaged services are used for outlier and future rate setting, hospitals are advised to report the device category HCPCS codes on the claim whenever they are provided in the HOPD setting. It is extremely important that hospitals report all HCPCS codes consistent with their descriptors, CPT and/or CMS instructions and correct coding principles, as well as all charges for all services they furnish, whether payment for the services is made separately or is packaged.

For the entire list of current and historical device category codes created since August 1, 2000, which is the implementation date of the hospital OPPS, refer to Table 3. We note this list can also be found in Chapter 4 of the Medicare Claims Processing Manual (Pub.100-04), specifically, Section 60.4.2 (Complete List of Device Pass-through Category Codes).

3. APC and Status Indicator Assignments for CPT Codes 0660T and 0661T, iDose TR (travoprost intracameral implant) for the Treatment of Glaucoma Retroactive to January 1, 2024

For the July 2021 Update, the CPT Editorial Panel established CPT codes 0660T and 0661T to describe the service associated with the implantation, removal, and reimplantation of the iDose TR, which is a prostaglandin analog used for the reduction of intraocular pressure (IOP) in patients with open-angle glaucoma (OAG) or ocular hypertension (OHT). On December 13, 2023, the iDose TR received FDA NDA approval. Based on the December 2023 FDA approval, these codes are separately payable under the OPPS effective retroactive to January 1, 2024.

Table 4, attachment A, lists the long descriptors and OPPS SI and APC assignments for CPT codes 0660T and 0661T. The codes, along with their short descriptors, status indicators, and payment rates are also listed in the January 2025 OPPS Addendum B that is posted on the CMS website. For information on the OPPS status indicators, refer to OPPS Addendum D1 of the CY 2025 Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center (ASC) final rule for the latest definitions.

4. New HCPCS Code Describing the 3D Anatomical Segmentation Imaging Software Service

CMS is establishing a new HCPCS code, C8001, to describe the 3D anatomical segmentation imaging intended as software for preoperative surgical planning, and as software for the intraoperative display of the aforementioned multi-dimensional digital images. Table 5, attachment A, lists the short descriptor, official long descriptor, status indicator, and APC assignment for HCPCS code C8001. For information on OPPS status indicators, please refer to OPPS Addendum D1 of the CY 2025 OPPS/ASC final rule for the latest definitions. This code, along with its short descriptor, status indicator, and payment rate, is also listed in the January 2025 Update of the OPPS Addendum B.

5. New HCPCS Code Describing the Automated Preparation of a Skin Cell Suspension Autograft

CMS is establishing a new HCPCS code, C8002, to describe the automated preparation of a skin cell suspension autograft. Table 6, attachment A, lists the short descriptor, official long descriptor, status indicator, and APC assignment for HCPCS code C8002. For information on OPPS status indicators, please refer to OPPS Addendum D1 of the CY 2025 OPPS/ASC final rule for the latest definitions. This code is also listed in the January 2025 Update of the OPPS Addendum B with the correct status indicator and APC assignment. We note that in the January 2025 I/OCE, we inadvertently assigned HCPCS code C8002 to an incorrect status indicator and APC assignment. The status indicator and APC assignment for HCPCS code C8002 will be corrected in the April 2025 I/OCE retroactive to January 1, 2025.

6. New HCPCS Code Describing the Implantation Procedure of a Medial Knee Shock Absorber

CMS is establishing a new HCPCS code, C8003, to describe the implantation procedure of a medial knee extraarticular shock absorber. Table 7, attachment A, lists the short descriptor, official long descriptor, status indicator, and APC assignment for the HCPCS code. For information on OPPS status indicators, please refer to OPPS Addendum D1 of the CY 2025 OPPS/ASC final rule for the latest definitions. This code, along with its short descriptor, status indicator, and payment rate, is also listed in the January 2025 Update of the OPPS Addendum B.

7. Changes to the Inpatient-Only list (IPO) for CY 2025

The Medicare Inpatient Only (IPO) list includes procedures that are typically only provided in the inpatient setting and therefore are not paid under the OPPS. For CY 2025, CMS is removing one procedure and adding three procedures to the IPO list. The changes to the IPO list for CY 2025 are included in Table 8, attachment A.

8. Inadvertent Deletion of HCPCS Code C9734 and Correct Status Indicator and APC Assignment

In the January 2025 I/OCE, we inadvertently deleted HCPCS code C9734 (U/s trtmt, not leiomyomata).

It will be reactivated in the April 2025 I/OCE retroactive to January 1, 2025. Table 9, attachment A, lists the correct status indicator and APC assignment for HCPCS code C9734. This code is also listed in the January 2025 Update of the OPPS Addendum B with the correct status indicator and APC assignment.

9. Correct Status Indicator and APC assignment for CPT code 15013

In the January 2025 I/OCE, we inadvertently assigned CPT code 15013 to an incorrect status indicator and APC assignment. The correct status indicator and APC assignment for this CPT code are listed in table 10, attachment A. The status indicator and APC assignment for CPT codes 15013 will be corrected in the April 2025 I/OCE retroactive to January 1, 2025. This code is also listed in the January 2025 Update of the OPPS Addendum B with the correct status indicator and APC assignment.

10. Comprehensive APC Changes

a. Additions to the Comprehensive APC Payment Policy Exclusions List

Cellular and gene therapies and non-opioid products qualifying under section 4135 of the Consolidated Appropriations Act (CAA), 2023 have been added to the list of services excluded from packaging when present with Comprehensive APC procedures as of January 1, 2025. Therefore, effective January 1, 2025, non-opioid

treatments for pain relief reported with new status indicators “H1” (Non-opioid Medical Devices for Post-Surgical Pain Relief) and “K1” (Non-Opioid Drugs and Biologicals for Post-Surgical Pain Relief) as well as services reported for cellular and gene therapy products will not be packaged when they appear on the same claim as Comprehensive APC procedures. The full list of C-APC payment policy exclusions is included in Addendum J of the CY 2025 OPPS/ASC Final Rule.

11. Updates to Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP) Code Lists Effective January 1, 2025

As finalized in the CY 2024 OPPS/ASC final rule with comment period, we add codes with descriptors similar to the PHP and IOP services described under §§ 410.43(a)(4) and 410.44(a)(4) to the list of HCPCS codes recognized for PHP and IOP payment through sub-regulatory guidance (88 FR 81822). We have identified codes G0539 and G0540 for caregiver training, a service that was added to the list of services applicable for PHP and IOP in the CY 2024 OPPS/ASC final rule with comment period (88 FR 81822) and have added them to the list of HCPCS codes recognized for PHP and IOP payment with an effective date of January 1, 2025. These codes, along with their short descriptors, are listed in the January 2025 OPPS Addendum B that is posted on the CMS website. As is true of the other codes for caregiver-focused services, when these codes are reported, they will not count toward payment for a 3-service or 4-service PHP or IOP day; however, we will include the costs associated with providing such services when calculating the PHP and IOP payment rates in future years.

12. Payment Adjustment for Certain Cancer Hospitals Beginning CY 2025

For certain cancer hospitals that receive interim monthly payments associated with the cancer hospital adjustment at 42 Code of Federal Regulation (CFR) 419.43(i), Section 16002(b) of the 21st Century Cures Act requires that, for CY 2018 and subsequent CYs, the target Payment-to-Cost Ratio (PCR) that should be used in the calculation of the interim monthly payments and at final cost report settlement is reduced by 0.01. For CY 2025, the target PCR, after including the reduction required by Section 16002(b), is 0.87.

We are updating Section 10.6.3 of Chapter 4 of the Medicare Claims Processing Manual (100-04), to more concisely describe the previous cancer hospital target PCRs as well as the CY 2025 target PCR.

13. Drugs, Biologicals, and Radiopharmaceuticals

a. New CY 2025 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals Receiving Pass-Through Status

Two (2) new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available starting on January 1, 2025. These drugs and biologicals will receive drug pass-through status starting January 1, 2025. These HCPCS codes are listed in Table 11, attachment A.

b. Existing HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals Starting Pass-Through Status as of January 1, 2025

There are five (5) existing HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals in the outpatient setting that will have their pass-through status start on January 1, 2025. These codes are listed in table 12, attachment A. Therefore, effective January 1, 2025, the status indicator for these codes is changing to status Indicator = “G”.

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

There are five (5) HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals in the outpatient setting that will have their pass-through status end on December 31, 2024. These codes are listed in Table 13, attachment A. Therefore, effective January 1, 2025, the status indicator for these codes is changing from "G" to either "K" or "N". For more information on OPPS status indicators, refer to OPPS Addendum D1 of the Calendar Year 2025 OPPS/ASC final rule for the latest definition. These codes, along with their short descriptors and status indicators are also listed in the January 2025 Update of the OPPS Addendum B.

d. Newly Established HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals as of January 1, 2025

Fifty (50) new drug, biological, and radiopharmaceutical HCPCS codes will be established on January 1, 2025. These HCPCS codes are listed in table 14, attachment A.

e. HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals Deleted as of December 31, 2024

Sixteen (16) drug, biological, and radiopharmaceutical HCPCS codes will be deleted on December 31, 2024. These HCPCS code are listed in table 15, attachment A.

We note that HCPCS code J9036 will replace both J9058 and J9059 for the reporting of these therapeutically equivalent bendamustine; J9058 and J9059 will be deleted on December 31, 2024.

f. HCPCS Code for Drug, Biological, and Radiopharmaceutical Changing Status Indicator as of January 1, 2025

One drug, biological and radiopharmaceutical HCPCS code will be changing payment status indicator on January 1, 2025. Therefore, effective January 1, 2025, the status indicator for this code is changing to status Indicator = "E1."as listed in table 16, attachment A.

g. HCPCS Code for Drug, Biological, and Radiopharmaceutical Changing Payment Status Retroactive to October 1, 2024

Four (4) drug, biological and radiopharmaceutical HCPCS codes will be changing payment status indicators retroactive to October 1, 2024. These HCPCS codes are listed in table 17, attachment A. We note that the status indicator for HCPCS code J9059 was previously changed to "E1" from "K" via TDL-250010. Subsequently, we are restoring the status indicator for HCPCS code J9059 to "K" for dates of services effective October 1, 2024, through December 31, 2024. The status indicator for HCPCS code J9329 was also incorrectly listed as "E2" in the January 2025 I/OCE for dates of service October 1, 2024, through December 31, 2024. The correct status indicator is "K". It was too late operationally to make retroactive changes to payable SIs for J9059 and J9329 effective 10/01/24 through 12/31/24 in the January 2025 I/OCE. Therefore, we will make these changes in the April 2025 I/OCE.

h. HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals with Descriptor Changes as of January 1, 2025

Four (4) drug, biological, and radiopharmaceutical HCPCS codes have had a substantial descriptor change as of January 1, 2025. These HCPCS codes are listed in table 18, attachment A.

i. Diagnostic Radiopharmaceuticals Previously in a Packaged Status (SI=N) changing to a Payable Status (SI=K) as of January 1, 2025

Twenty-three (23) diagnostic radiopharmaceuticals that previously been packaged (SI=N) will be separately payable (SI=K) as of January 1, 2025. In addition, one diagnostic radiopharmaceutical (HCPCS code A9595 - Piflufolastat f-18, diagnostic, 1 millicurie) which has its pass-through status ending on December 31, 2024, will be separately payable (SI=K) as of January 1, 2025. These HCPCS codes are listed in table 19, attachment A.

In the January 2025 I/OCE, we inadvertently assigned radiopharmaceutical APC offsets to the Nuclear Medicine and Related Services APCs associated with these 23 diagnostic radiopharmaceuticals. The radiopharmaceutical APC offsets for these 23 diagnostic radiopharmaceuticals will be removed in the April 2025 I/OCE retroactive to January 1, 2025.

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

For CY 2025, payment for the majority of nonpass-through drugs, biologicals, and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent (or ASP plus 6 or 8 percent of the reference product for biosimilars. In CY 2025, a single payment of ASP plus 6 percent for pass-through drugs, biologicals, and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items (or ASP plus 6 or 8 percent of the reference product for biosimilars). Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Effective January 1, 2025, payment rates for many drugs and biologicals have changed from the values published in the CY 2025 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from third quarter of CY 2024. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2025 Fiscal Intermediary Standard System (FISS) release. CMS is not publishing the updated payment rates in this Change Request implementing the January 2025 update of the OPPS. However, the updated payment rates effective January 1, 2025, can be found in the January 2025 update of the OPPS Addendum A and Addendum B on the CMS website at https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient

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

Some drugs and biologicals paid based on ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the CMS website on the first date of the quarter at https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/restated-drug-biological-payment-rates

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

l. Drug Billing Modifiers Deleted as of December 31, 2024

One (1) billing modifier will be deleted on December 31, 2024. This billing modifier is listed in table 20, attachment A.

m. Drug Billing Modifier Descriptor Revised as of January 1, 2025

One (1) billing modifier will have its descriptor revised effective January 1, 2025. This billing modifier is listed in table 21, attachment A.

n. Not otherwise classified FDA-approved prescription drugs for PrEP for HIV reported under HCPCS code J0799

For CY 2025, we are revising the definition of status indicator "A" to include not otherwise classified FDA-approved prescription drugs for HIV PrEP reported under HCPCS code J0799. Similar to HCPCS code C9399, when HCPCS code J0799 appears on a claim, the Outpatient Code Editor (OCE) suspends the claim for manual pricing by the Medicare Administrative Contractor (MAC). The MAC prices the claim at 95 percent of the drug or biological's average wholesale price (AWP) using the Red Book or an equivalent recognized compendium for payment processing of the claim.

o. HCPCS Codes for Pharmacy Dispensing / Supplying Fees Changing Payment Status Indicators starting January 1, 2025

Eleven (11) HCPCS codes describing pharmacy dispensing / supplying fees will have their payment status indicators change starting January 1, 2025. These HCPCS code are listed in table 22, attachment A.

14. Skin Substitutes

The payment for skin substitute products that do not qualify for pass-through status will be packaged into the payment for the associated skin substitute application procedure. For payment packaging purposes, the skin substitute products are divided into two groups: 1) high cost skin substitute products and 2) low cost skin substitute products. New skin substitute HCPCS codes are assigned into the low-cost skin substitute group unless CMS has pricing data that demonstrates that the cost of the product is above either the mean unit cost of $50 or the per day cost of $833 for CY 2025.

a. New Skin Substitute Products as of January 1, 2025

There are eight (8) new skin substitute HCPCS codes that will be active as of January 1, 2025. These codes are listed in table 23, attachment A.

b. Skin Substitute assignments to High Cost and Low Costs Groups for CY 2025

Table 24, attachment A, lists the skin substitute products and their assignment as either a high cost or a low cost skin substitute product, when applicable.

15. HCPCS Code for Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) Counseling Covered as Additional Preventative Services Changing APC Effective January 1, 2025

One (1) HCPCS codes describing PrEP for HIV counseling will have its APC updated starting January 1, 2025. This HCPCS code is listed in table 25, attachment A.

16. HCPCS Code for Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) Counseling Covered as Additional Preventative Services Changing SI Effective January 1, 2025

One (1) HCPCS codes describing PrEP for HIV counseling will have its status indicator updated starting January 1, 2025. This HCPCS code is listed in table 26, attachment A. The effective date of status indicator change was incorrectly listed in the January 2025 I/OCE as October 1, 2024. It will be corrected in the April 2025 I/OCE retroactive to January 1, 2025.

17. HCPCS Code for Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) Administration APC Assignment Change Retroactive to October 1, 2024

In the January 2025 I/OCE, we changed the APC assignment of HCPCS code G0012 (Injection of hiv prep drug) from APC 5691 (Level 1 Drug Administration) to APC 5692 (Level 2 Drug Administration) effective

01/01/2025 instead of 10/01/2024. Therefore, we will correct the effective date of the APC change in the April 2025 I/OCE, retroactive to 10/01/2024. Table 27, attachment A list the correct APC assignment for the HCPCS code G0012 effective 10/01/24.

18. HCPCS Codes, Status Indicator, APC Assignments and Payment Limitations for Qualifying Non-Opioid Treatments for Pain Relief Starting January 1, 2025.

Section 4135 of the Consolidated Appropriations Act (CAA), 2023 established the eligibility criteria for temporary additional payments for certain non-opioid treatments for pain relief, and was finalized in the CY 2025 OPPS/ASC final rule with comment period. CMS has fully evaluated applicable non-opioid treatments against the statutory eligibility criteria and determined that the products in table 28, attachment A, meet the statutory definition of a Non-opioid Treatment for Pain Relief and should be paid according to the finalized policy beginning January 2024. Section 1833(t)(16)(G)(iii) of the Act states that the separate payment amount specified in clause (ii), shall not exceed the estimated average of 18 percent of the OPD fee schedule amount for the OPD service (or group of services) with which the non-opioid treatment for pain relief is furnished, as determined by the Secretary. The finalized payment limitation amount for each product can be found in table 29, attachment A, and will be updated annually. Table 30, attachment A, provides an additional qualifying non-opioid treatment for pain relief effective April 1, 2025.

19. Changes to OPPS Pricer Logic

1.
   a. Rural Sole Community Hospitals (SCH) and Essential Access Community Hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in CY 2025. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with section 1833(t)(13)(B) of the Act, as added by section 411 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

1.
   b. New OPPS payment rates and copayment amounts will be effective January 1, 2025. All copayment amounts will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the CY 2025 inpatient deductible of $1,676. For most OPPS services, copayments are set at 20 percent of the APC payment rate.

1.
   c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2025. This threshold of 1.75 is multiplied by the total line-item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount. The payment formula is (cost-(APC payment x 1.75))/2.

1.
   d. The fixed-dollar threshold for OPPS outlier payments decreases in CY 2025 relative to CY 2024. The estimated cost of a service must be greater than the APC payment amount plus $7,175 in order to qualify for outlier payments.

1.
   e. For outliers for CMHCs (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2025. This threshold of 3.4 is multiplied by the total line-item APC payment for the assigned PHP or IOP APC (5851 through 5854) to determine eligibility for outlier payments. This multiple amount is also used to determine the outlier payment, which is 50

percent of estimated costs less 3.4 times the APC payment amount. The payment formula is (cost-(APC payment x 3.4))/2.

1.

f. Continuing our established policy for CY 2025, the OPPS Pricer will apply a reduced update ratio of 0.9806 to the payment and copayment for hospitals that fail to meet their hospital outpatient quality data reporting requirements or that fail to meet CMS validation edits. The reduced payment amount will be used to calculate outlier payments.

g. Effective January 1, 2025, CMS is adopting the Fiscal Year (FY) 2025 Inpatient Prospective Payment System (IPPS) post-reclassification wage index values, as published in the FY 2025 IPPS final rule (with subsequent correction notice), with application of the CY 2025 out-commuting adjustment authorized by Section 505 of the MMA to non- IPPS (non-Inpatient Prospective Payment System) hospitals as implemented through the Pricer logic.

1.

h. Effective January 1, 2025, New status indicators K1 and H1 for Non-Opioid Policy were implemented and the rates are capped accordingly (listed in Table 29, attachment A). We note that certain codes will have caps that apply effective April 1, 2025 (listed in Table 30, attachment A).

20. Update the Outpatient Provider Specific File (OPSF)

Effective January 1, 2025, contractors shall maintain the accuracy of the provider records in the Outpatient Provider Specific File (OPSF) as changes occur in data element values.

As discussed in the CY 2025 OPPS/ASC final rule, the CY 2025 OPPS wage index will include the low wage index hospital policy. Therefore, the FY 2025 IPPS wage index and associated data referred to in this section will be to the FY 2025 IPPS final rule (and subsequent correction notice), which includes the policy described in section 4 and not the wages described in the IFC titled "Changes to the Fiscal Year 2025 Hospital Inpatient Prospective Payment System (IPPS) Rates Due to Court Decision".

a. **Updating the OPSF for the Supplemental Wage Index and Supplemental Wage Index Flag Fields**

In CY 2025, the Supplemental Wage Index and Supplemental Wage Index Flag fields will be used to implement the cap on wage index decrease policy. The Pricer requires the hospital's applicable CY 2024 OPPS wage index in the Supplemental Wage Index field in order to properly apply all wage index policies and determine the hospital's CY 2025 OPPS wage index. Therefore, for CY 2025, in order to accurately pay claims for providers paid through the OPPS for whom we expect the capped wage index policy to apply, the Supplemental Wage Index Flag must be "1" and have a wage index in the Supplemental Wage Index field.

MACs shall ensure that no OPPS providers have a "1" or "2" in the Special Payment Indicator field and no wage index value in the Special Wage Index field with an effective date of January 1, 2025. Unless otherwise instructed by CMS, MACs must seek approval from the CMS Central Office to use a "1" or "2" in the Special Payment Indicator field and a wage index value in the Special Wage Index field.

There generally are several types of assignments for the supplemental wage index that would apply under the OPPS. In all of the cases below, the Supplemental Wage Index field would be "1" and the effective date of such changes included for the steps outlined below would be January 1, 2025.

1. If the MAC receives approval from the CMS Central Office to assign an OPPS provider a special wage index in CY 2024 and the use of either "1" or "2" in the Special Payment Indicator field, MACs shall do the following:

    -
    - Enter the value from the Special Wage Index for CY 2024 into the Supplemental Wage index Field.
    - Enter a "1" in the Supplemental Wage Index Flag field.
    - Ensure that the Special Wage Index and Special Payment Indicator fields are blank.
    - Establish the record with an effective date of January 1, 2025.

2. If the MAC did not email CMS during CY 2024 for a provider's CY 2024 wage index:

i. **For IPPS hospitals that are also paid under the OPPS**

For these hospitals, as described in detail in the instructions in MAC Implementation File 5 at https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2025-ipps-final-rule-home-page the 2024 wage index should be obtained from the Table 2 associated with the FY 2025 IPPS final rule (or Correction Notice, if applicable). In other instances in which there is an IPPS value derived through the steps outlined in the "MAC Implementation File 5" instructions document, that same FY 2024 wage index value entered into the Supplemental Wage index for the IPSF shall also be entered into the Supplemental Wage Index Field and would apply into the OPPS on a calendar year basis.

In this case MACs shall do the following:

-
    - Enter the value from the Special Wage Index for CY 2024 (from Table 2 or through the steps outlined in MAC Implementation File 5) into the Supplemental Wage Index Field.
    - Enter a "1" in the Supplemental Wage Index Flag field.
    - Ensure that the Special Wage Index and Special Payment Indicator fields are blank.
    - Establish the record with an effective date of January 1, 2025.

ii. **For Non-IPPS hospitals, CMHCs, and other OPPS providers**

We have made the Supplemental Wage Index assignments (based on the CY 2024 OPPS wage index) for non-IPPS hospitals, CMHCs, and other OPPS providers available on the CMS website at https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/annual-policy-files under "*Annual Policy Files*."

In this case, MACs, shall do the following:

-
  - The CY 2024 Wage index from the Excel file available online shall be entered into the Supplemental Wage Index field.
  - Enter a "1" in the Supplemental Wage Index Flag field.
  - Ensure that the Special Wage Index and Special Payment Indicator fields are blank.
  - Establish the record with an effective date of January 1, 2025.

b. **Updating the OPSF for Expiration of Transitional Outpatient Payments (TOPs)**

Cancer and children's hospitals are held harmless under section 1833(t)(7)(D)(ii) of the Social Security Act and continue to receive hold harmless TOPs permanently. For CY 2025, cancer hospitals will continue to receive an additional payment adjustment.

c. **Updating the OPSF for the Hospital Outpatient Quality Reporting (HOQR) Program Requirements**

Effective for OPPS services furnished on or after January 1, 2009, subsection (d) hospitals that have failed to submit timely hospital outpatient quality data as required in Section 1833(t)(17)(A) of the Act will receive payment under the OPPS that reflects a 2 percentage point reduction from the annual OPPS update for failure to meet the HOQR program requirements. This reduction will not apply to hospitals not required to submit quality data or hospitals that are not paid under the OPPS.

For January 1, 2025, contractors shall maintain the accuracy of the provider records in the OPSF by updating the Hospital Quality Indicator field. CMS will release a Technical Direction Letter that lists Subsection (d) hospitals that are subject to and fail to meet the HOQR program requirements. Once this list is released, A/B Medicare Administrative Contractors (MACs) will update the OPSF by removing the '1', (that is, ensure that the Hospital Quality Indicator field is blank) for all hospitals identified on the list and will ensure that the OPSF Hospital Quality Indicator field contains '1' for all hospitals that are not on the list. CMS notes that if these hospitals are later determined to have met the HOQR program requirements, A/B MACs shall update the OPSF. For greater detail regarding updating the OPSF for the HOQR program requirements, see Transmittal 368, CR 6072, issued on August 15, 2008.

d. **Updating the OPSF for Cost to Charge Ratios (CCR)**

As stated in publication 100-04, Medicare Claims Processing Manual, chapter 4, section 50.1, contractors must maintain the accuracy of the data and update the OPSF as changes occur in data element values, including changes to provider cost–to-charge ratios and, when applicable, device department cost-to-charge ratios. The file of OPPS hospital upper limit CCRs and the file of Statewide CCRs are located on the CMS website at https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/annual-policy-files under "*Annual Policy Files*."

e. **Updating the "County Code" Field**

Prior to CY 2018, in order to include the outmigration in a hospital's wage index, we provided a separate table that assigned wage indexes for hospitals that received the outmigration adjustment. For the CY 2025 OPPS, the OPPS Pricer will continue to assign the outmigration adjustment using the "County Code" field in the OPSF. Therefore, MACs shall ensure that every hospital has listed in the "County Code" field the

Federal Information Processing Standards (FIPS) county code where the hospital is located to maintain the accuracy of the OPSF data fields.

f. **Updating the "Wage Index Location Core-Based Statistical Areas (CBSA)" Field**

We note that under historical and current OPPS wage index policy, hospitals that have wage index reclassifications for wage adjustment purposes under the IPPS would also have those wage index reclassifications applied under the OPPS on a calendar year basis. Therefore, MACs shall ensure that wage index reclassifications applied under the FY 2025 IPPS are also reflected in the OPSF on a CY 2025 OPPS basis.

g. **Updating the "Payment Core-Based Statistical Areas (CBSA)" Field**

In the prior layout of the OPSF, there were only two CBSA related fields: the "Actual Geographic Location CBSA" and the "Wage Index Location CBSA." These fields are used to wage adjust OPPS payment through the Pricer if there is not an assigned Special Wage Index (as has been used historically to assign the wage index for hospitals receiving the outmigration adjustment).

In Transmittal 3750, dated April 19, 2017, for Change Request 9926, we created an additional field for the "Payment CBSA," similar to the IPPS, to allow for consistency between the data in the two systems and identify when hospitals receive dual reclassifications. In the case of dual reclassifications, similar to the IPPS, the "Payment CBSA" field will be used to note the Urban to Rural Reclassification Under Section 1886(d)(8)(E) of the Act (§ 412.103). This "Payment CBSA" field is not used for wage adjustment purposes, but to identify when the 412.103 reclassification applies, because rural status is considered for rural sole community hospital adjustment eligibility. We further note that whereas the IPPS Pricer allows the Payment CBSA, even when applied as the sole CBSA field (without a Wage Index CBSA), to be used for wage adjusting payment, that field is not used for wage adjustment the OPPS.

3. **Wage Index Policies in the CY 2025 OPPS Final Rule**

In the FY 2025 IPPS and CY 2025 OPPS final rules, we finalized the following changes to the wage index: increased the wage index values for hospitals with a wage index value below the 25th percentile wage index value of 0.9009 across all hospitals and applied a 5 percent cap for CY 2025 on any wage index values that decreased relative to CY 2024. We note that the CY 2025 OPPS will include the low wage index hospital policy, even though the FY 2025 IPPS wage index will not.

21. Coverage Determinations

As a reminder, the fact that a drug, device, procedure, or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program but indicates only how the product, procedure, or service may be paid if covered by the program. Medicare Administrative Contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13933.1	Medicare contractors shall access the OPPS Pricer via the Cloud to pay 2025 payment rates on claims with statement from dates on or after January 1, 2025.	X		X						
13933.2	Medicare contractors shall adjust, as appropriate, claims brought to their attention with any retroactive changes that were received prior to implementation of the January 2025 OPPS PRICER.	X		X						
13933.3	Medicare contractors shall apply the following contractor bypass to lines with HCPCS C9734 and a date of service from 1/1/2025 – 3/31/25: Contractor bypass edits BP1 = 006 APC Flag = 05115 CB SI Flag = J1 CB PI Flag = 1 CB DF = 1 CB LID/RF = 0 CB PF = 0 CB PAF1 = 00 CB PMF = Z CB PAF2 = 00 **Note:** The April 2025 I/OCE and the January 2025 Update of the OPPS Addendum B will be updated with corrected	X								

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	information.									
13933.4	Medicare contractors shall apply the following contractor bypass to lines with HCPCS 15013 or C8002 and a date of service from 1/1/2025 – 3/31/25: Contractor bypass edits BP1 = 006 APC Flag = 01532 CB SI Flag = S CB PI Flag = 1 CB DF = 1 CB LID/RF = 0 CB PF = 0 CB PAF1 = 00 CB PMF = Z CB PAF2 = 00 **Note:** The April 2025 I/OCE and the January 2025 Update of the OPPS Addendum B will be updated with corrected information.	X								
13933.5	Medicare contractors shall apply IOCE Reason Code W7009 to lines with HCPCS J9198 and a date of service from 01/1/2025 – 03/31/25.	X								
13933.6	Medicare contractors shall apply the following contractor bypass to lines with HCPCS J9059 and a	X								

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	date of service from 10/1/2024 – 12/31/24: Contractor bypass edits BP1 = 009 APC Flag = 09153 CB SI Flag = _K CB PI Flag = 2 CB DF = 0 CB LID/RF = 0 CB PF = 0 CB PAF1 = 00 CB PMF = Z CB PAF2 = 00 • A/B MACs (A) shall reprocess any claims that were processed with the incorrect editing W7009 with DOS 10/01/24 – 12/31/24. • Adjustments shall be completed in 60 days from 1/1/2025. **Note:** The April 2025 I/OCE will be updated with corrected information.									
13933.7	Medicare contractors shall apply the following contractor bypass to lines with HCPCS J9329 and a date of service from 10/1/2024 – 12/31/24: Contractor bypass edits BP1 = 013 APC Flag = 0816	X								

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	CB SI Flag = _K CB PI Flag = 2 CB DF = 0 CB LID/RF = 0 CB PF = 0 CB PAF1 = 00 CB PMF = Z CB PAF2 = 00 • A/B MACs (A) shall reprocess any claims that were processed with the incorrect editing W7013 with DOS 10/01/24 – 12/31/24. • Adjustments shall be completed in 60 days from 1/1/2025. Note: The April 2025 I/OCE will be updated with corrected information.									
13933.8	Medicare contractors shall hook claims (driver 06) with one of the following 23 HCPCS on them (see HCPCS List below) and a LIDOS of 1/1/25 and after until the April 2025 IOCE is installed into production. • Apply the line level bypass on MAP103I Screen by entering a "2" in the OCE OVR field for the line with Revenue Code 0343. • Apply the claim level bypass on MAP1039 Screen by entering a "Y"	X								

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	in the MCE/OCE Bypass field. • Override Reason Code 31616. • Then PF9 the claim. HCPCS List: A9515, A9521, A9542, A9547, A9548, A9557, A9568, A9569, A9570, A9572, A9582, A9584, A9586, A9587, A9588, A9591, A9592, A9593, A9594, A9595, C9067, Q9982, Q9983									
13933.9	Medicare contractors shall populate PARM PRMNOPPL with the information found in table 29 for drugs which Non-Opioid Treatment for Pain Relief Payment Limits apply. • HCPCS • Start Date (20250101) • End Date (20251231) PYMT Limit Comments (This CR #)	X								
13933.10	As specified in chapter 4, section 50.1, of the Claims Processing Manual, Medicare contractors shall maintain the accuracy of the data and update the OPSF file as changes occur in data element values. For CY 2025, this includes all changes to the OPSF identified in Section 19 of this Change Request.	X								

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information:N/A

VI. CONTACTS

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

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 1

Attachment A − Tables for the Policy Section

Table 1. ─ PLA Coding Changes Effective January 1, 2025

CPT Code	Long Descriptor	OPPS SI
0521U	Rheumatoid factor IgA and IgM, cyclic citrullinated peptide (CCP) antibodies, and scavenger receptor A (SR-A) by immunoassay, blood	Q4
0522U	Carbonic anhydrase VI, parotid specific/secretory protein and salivary protein 1 (SP1), IgG, IgM, and IgA antibodies, chemiluminescence, semiqualitative, blood	Q4
0523U	Oncology (solid tumor), DNA, qualitative, next-generation sequencing (NGS) of single-nucleotide variants (SNV) and insertion/deletions in 22 genes utilizing formalin-fixed paraffin-embedded tissue, reported as presence or absence of mutation(s), location of mutation(s), nucleotide change, and amino acid change	A
0524U	Obstetrics (preeclampsia), sFlt1/PlGF ratio, immunoassay, utilizing serum or plasma, reported as a value	Q4
0525U	Oncology, spheroid cell culture, 11-drug panel (carboplatin, docetaxel, doxorubicin, etoposide, gemcitabine, niraparib, olaparib, paclitaxel, rucaparib, topotecan, veliparib) ovarian, fallopian, or peritoneal response prediction for each drug	Q4
0526U	Nephrology (renal transplant), quantification of CXCL10 chemokines, flow cytometry, urine, reported as pg/mL creatinine baseline and monitoring over time	Q4
0527U	Herpes simplex virus (HSV) types 1 and 2 and Varicella zoster virus (VZV), amplified probe technique, each pathogen reported as detected or not detected	Q4
0528U	Lower respiratory tract infectious agent detection, 18 bacteria, 8 viruses, and 7 antimicrobial-resistance genes, amplified probe technique, including reverse transcription for RNA targets, each analyte reported as detected or not detected with semiquantitative results for 15 bacteria	Q4

0529U	Hematology (venous thromboembolism [VTE]), genome-wide single-nucleotide polymorphism variants, including F2 and F5 gene analysis, and Leiden variant, by microarray analysis, saliva, report as risk score for VTE	A
0530U	Oncology (pan-solid tumor), ctDNA, utilizing plasma, next-generation sequencing (NGS) of 77 genes, 8 fusions, microsatellite instability, and tumor mutation burden, interpretative report for single-nucleotide variants, copy-number alterations, with therapy association	A

Table 2A. — Device Pass-Through Category HCPCS Codes

HCPCS Code	Long Descriptor	SI	APC
C1735	Catheter(s), intravascular for renal denervation, radiofrequency, including all single use system components	H	2051
C1736	Catheter(s), intravascular for renal denervation, ultrasound, including all single use system components	H	2052
C1737	Joint fusion and fixation device(s), sacroiliac and pelvis, including all system components (implantable)	H	2053
C1738	Powered, single-use (i.e. disposable) endoscopic ultrasound-guided biopsy device	H	2054
C1739	Tissue marker, imaging and non-imaging device (implantable)	H	2055
C9610	Catheter, transluminal drug delivery with or without angioplasty, coronary, non-laser (insertable)	H	2050

(1) HCPCS Code C1735

Device category HCPCS code C1735 should always be billed with the following CPT codes:

HCPCS Code	Long Descriptor	SI	APC	CY 2025 Device Offset Amount
0338T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; unilateral	J1	5192	$1,443.62

0339T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; bilateral	J1	5192	$2,456.78

(2) HCPCS Code C1736

Device category HCPCS code C1736 should always be billed with the following CPT codes:

HCPCS Code	Long Descriptor	SI	APC	CY 2025 Device Offset Amount
0338T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; unilateral	J1	5192	$1,443.62
0339T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; bilateral	J1	5192	$2,456.78

(3) HCPCS Code C1737

Device category HCPCS code C1737 should always be billed with the following CPT codes:

HCPCS Code	Long Descriptor	SI	APC	CY 2025 Device Offset Amount
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device	J1	5116	$0.00
22612	Arthrodesis, posterior or posterolateral technique, single interspace; lumbar (with lateral transverse technique, when performed)	J1	5116	$0.00

22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace, lumbar;	J1	5116	$0.00
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace, lumbar;	J1	5116	$0.00

(4) HCPCS Code C1738

Device category HCPCS code C1738 should always be billed with the following CPT codes:

HCPCS Code	Long Descriptor	SI	APC	CY 2025 Device Offset Amount
43238	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), (includes endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures)	J1	5302	$25.80
43242	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)	J1	5302	$28.08
43232	Esophagoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)	J1	5302	$21.25

(5) HCPCS Code C1739

Device category HCPCS code C1739 should always be billed with the following CPT codes:

HCPCS Code	Long Descriptor	SI	APC	CY 2025 Device Offset Amount
19281	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance	Q1	5072	$826.48
19283	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance	Q1	5071	$371.85

19285	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance	Q1	5071	$379.02
19287	Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance	Q1	5071	$240.56
10035	Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; first lesion	T	5071	$322.81

(6) HCPCS Code C9610

Device category HCPCS code C9610 should always be billed with the following CPT codes:

HCPCS Code	Long Descriptor	SI	APC	CY 2025 Device Offset Amount
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	J1	5192	$0.00
92924	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch	J1	5193	$0.00
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	J1	5193	$0.00
92933	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	J1	5194	$0.00
92937	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel	J1	5193	$0.00
92943	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel	J1	5193	$0.00
C9600	Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	J1	5193	$0.00

C9602	Percutaneous transluminal coronary atherectomy, with drug eluting intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	J1	5194	$0.00
C9604	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel	J1	5193	$0.00
C9607	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; single vessel	J1	5194	$0.00
0913T	Percutaneous transcatheter therapeutic drug delivery by intracoronary drug delivery balloon (eg, drug-coated, drug-eluting), including mechanical dilation by nondrug-delivery balloon angioplasty, endoluminal imaging using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) when performed, imaging supervision, interpretation, and report, single major coronary artery or branch	J1	5192	$0.00

Table 2B. — Expiring Pass-through Status for Two Device Category HCPCS Codes Effective January 1, 2025

HCPCS Code	Long Descriptor	Device Pass-through Status Expiration Date
C1832	Autograft suspension, including cell processing and application, and all system components	12/31/2024
C1833	Monitor, cardiac, including intracardiac lead and all system components (implantable)	12/31/2024

Table 3. — List of Device Category HCPCS Codes and Definitions Used for Present and Previous Pass-Through Payment ***

	HCPCS Codes	Category Long Descriptor	Date First Populated	Pass-Through Expiration Date***
1.	C1883	Adaptor/extension, pacing lead or neurostimulator lead (implantable)	08/01/2000	12/31/2002

2.	C1765	Adhesion barrier	10/01/00 – 3/31/2001;07/ 01/2001	12/31/2003
3.	C1713	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)	08/01/2000	12/31/2002
4.	L8690	Auditory osseointegrated device, includes all internal and external components	01/01/2007	12/31/2008
5.	C1832	Autograft suspension, including cell processing and application, and all system components	01/01/2022	12/31/2024
6.	C1715	Brachytherapy needle	08/01/2000	12/31/2002
7.	C1716	Brachytherapy source, non-stranded, Gold-198, per source	10/01/2000	12/31/2002
8.	C1717	Brachytherapy source, non-stranded, high dose rate Iridium-192, per source	01/01/2001	12/31/2002
9.	C1718	Brachytherapy source, Iodine 125, per source	08/01/2000	12/31/2002
10.	C1719	Brachytherapy source, non-stranded, non-high dose rate Iridium-192, per source	10/01/2000	12/31/2002
11.	C1720	Brachytherapy source, Palladium 103, per source	08/01/2000	12/31/2002
12.	C2616	Brachytherapy source, non-stranded, Yttrium-90, per source	01/01/2001	12/31/2002
13.	C2632	Brachytherapy solution, iodine – 125, per mCi	01/01/2003	12/31/2004
14.	C1721	Cardioverter-defibrillator, dual chamber (implantable)	08/01/2000	12/31/2002
15.	C1882	Cardioverter-defibrillator, other than single or dual chamber (implantable)	08/01/2000	12/31/2002
16.	C1722	Cardioverter-defibrillator, single chamber (implantable)	08/01/2000	12/31/2002
17.	C1888	Catheter, ablation, non-cardiac, endovascular (implantable)	07/01/2002	12/31/2004
18.	C1726	Catheter, balloon dilatation, non-vascular	08/01/2000	12/31/2002
19.	C1727	Catheter, balloon tissue dissector, non-vascular (insertable)	08/01/2000	12/31/2002
20.	C1728	Catheter, brachytherapy seed administration	01/01/2001	12/31/2002
21.	C1729	Catheter, drainage	10/01/2000	12/31/2002
22.	C1730	Catheter, electrophysiology, diagnostic, other than 3D mapping (19 or fewer electrodes)	08/01/2000	12/31/2002
23.	C1731	Catheter, electrophysiology, diagnostic, other than 3d mapping (20 or more electrodes)	08/01/2000	12/31/2002
24.	C1732	Catheter, electrophysiology, diagnostic/ablation, 3D or vector mapping	08/01/2000	12/31/2002
25.	C1733	Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, other than cool-tip	08/01/2000	12/31/2002
26.	C2630	Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, cool-tip	10/01/2000	12/31/2002
27.	C1886	Catheter, extravascular tissue ablation, any modality (insertable)	01/01/2012	12/31/2013
28.	C1887	Catheter, guiding (may include infusion/perfusion capability)	08/01/2000	12/31/2002
29.	C1750	Catheter, hemodialysis/peritoneal, long-term	08/01/2000	12/31/2002
30.	C1752	Catheter, hemodialysis/peritonea l, short-term	08/01/2000	12/31/2002

31.	C1751	Catheter, infusion, inserted peripherally, centrally or midline (other than hemodialysis)	08/01/2000	12/31/2002
32.	C1759	Catheter, intracardiac echocardiography	08/01/2000	12/31/2002
33.	C1754	Catheter, intradiscal	10/01/2000	12/31/2002
34.	C1755	Catheter, intraspinal	08/01/2000	12/31/2002
35.	C1753	Catheter, intravascular ultrasound	08/01/2000	12/31/2002
36.	C2628	Catheter, occlusion	10/01/2000	12/31/2002
37.	C1756	Catheter, pacing, transesophageal	10/01/2000	12/31/2002
38.	C2627	Catheter, suprapubic/cystoscopic	10/01/2000	12/31/2002
39.	C1757	Catheter, thrombectomy/embolectomy	08/01/2000	12/31/2002
40.	C2623	Catheter, transluminal angioplasty, drug-coated, non-laser	04/01/2015	12/31/2017
41.	C1885	Catheter, transluminal angioplasty, laser	10/01/2000	12/31/2002
42.	C1725	Catheter, transluminal angioplasty, non-laser (may include guidance, infusion/perfusion capability)	08/01/2000	12/31/2002
43.	C1714	Catheter, transluminal atherectomy, directional	08/01/2000	12/31/2002
44.	C1724	Catheter, transluminal atherectomy, rotational	08/01/2000	12/31/2002
45.	C1761	Catheter, transluminal intravascular lithotripsy, coronary	07/01/2021	06/30/2024
46.	C1760	Closure device, vascular (implantable/insertable)	08/01/2000	12/31/2002
47.	L8614	Cochlear implant system	08/01/2000	12/31/2002
48.	C1762	Connective tissue, human (includes fascia lata)	08/01/2000	12/31/2002
49.	C1763	Connective tissue, non-human (includes synthetic)	10/01/2000	12/31/2002
50.	C1881	Dialysis access system (implantable)	08/01/2000	12/31/2002
51.	C1884	Embolization protective system	01/01/2003	12/31/2004
52.	C1749	Endoscope, retrograde imaging/illumination colonoscope device (implantable)	10/01/2010	12/31/2012
53.	C1748	Endoscope, single-use (i.e. disposable), Upper GI, imaging/illumination device (insertable)	07/01/2020	06/30/2023
54.	C1764	Event recorder, cardiac (implantable)	08/01/2000	12/31/2002
55.	C1822	Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system	01/01/2016	12/31/2017
56.	C1767*	Generator, neurostimulator (implantable), non-rechargeable	08/01/2000	12/31/2002
57.	C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system	01/01/2006	12/31/2007
58.	C1825	Generator, neurostimulator (implantable), non-rechargeable with carotid sinus baroreceptor stimulation lead(s)	01/01/2021	12/31/2023
59.	C1823	Generator, neurostimulator (implantable), nonrechargeable , with transvenous sensing and stimulation leads	01/01/2019	12/31/2022
60.	C1768	Graft, vascular	01/01/2001	12/31/2002
61.	C1769	Guide wire	08/01/2000	12/31/2002
62.	C1052	Hemostatic agent, gastrointestinal, topical	01/01/2021	12/31/2023
63.	C1770	Imaging coil, magnetic resonance (insertable)	01/01/2001	12/31/2002
64.	C2624	Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components	01/01/2015	12/31/2016

65.	C1891	Infusion pump, non-programmable, permanent (implantable)	08/01/2000	12/31/2002
66.	C2626	Infusion pump, non-programmable, temporary (implantable)	01/01/2001	12/31/2002
67.	C1772	Infusion pump, programmable (implantable)	10/01/2000	12/31/2002
68.	C1818	Integrated keratoprosthesis	07/01/2003	12/31/2005
69.	C1821	Interspinous process distraction device (implantable)	01/01/2007	12/31/2008
70.	C1062	Intravertebral body fracture augmentation with implant (e.g., metal, polymer)	01/01/2021	12/31/2023
71.	C1893	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, other than peel-away	10/01/2000	12/31/2002
72.	C1892	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, peel-away	01/01/2001	12/31/2002
73.	C1766	Introducer/sheath, guiding, intracardiac electrophysiologica l, steerable, other than peel-away	01/01/2001	12/31/2002
74.	C1894	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, non-laser	08/01/2000	12/31/2002
75.	C2629	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, laser	01/01/2001	12/31/2002
76.	C1776	Joint device (implantable)	10/01/2000	12/31/2002
77.	C1895	Lead, cardioverter-defibrillator, endocardial dual coil (implantable)	08/01/2000	12/31/2002
78.	C1777	Lead, cardioverter-defibrillator, endocardial single coil (implantable)	08/01/2000	12/31/2002
79.	C1896	Lead, cardioverter-defibrillator, other than endocardial single or dual coil (implantable)	08/01/2000	12/31/2002
80.	C1900	Lead, left ventricular coronary venous system	07/01/2002	12/31/2004
81.	C1778	Lead, neurostimulator (implantable)	08/01/2000	12/31/2002
82.	C1897	Lead, neurostimulator test kit (implantable)	08/01/2000	12/31/2002
83.	C1898	Lead, pacemaker, other than transvenous VDD single pass	08/01/2000	12/31/2002
84.	C1779	Lead, pacemaker, transvenous VDD single pass	08/01/2000	12/31/2002
85.	C1899	Lead, pacemaker/cardioverter-defibrillator combination (implantable)	01/01/2001	12/31/2002
86.	C1780	Lens, intraocular (new technology)	08/01/2000	12/31/2002
87.	C1840	Lens, intraocular (telescopic)	10/01/2011	12/31/2013
88.	C2613	Lung biopsy plug with delivery system	07/01/2015	12/31/2017
89.	C1878	Material for vocal cord medialization, synthetic (implantable)	10/01/2000	12/31/2002
90.	C1781	Mesh (implantable)	08/01/2000	12/31/2002
91.	C1833	Monitor, cardiac, including intracardiac lead and all system components (implantable)	01/01/2022	12/31/2024
92.	C1782	Morcellator	08/01/2000	12/31/2002
93.	C1784	Ocular device, intraoperative, detached retina	01/01/2001	12/31/2002
94.	C1783	Ocular implant, aqueous drainage assist device	07/01/2002	12/31/2004
95.	C2619	Pacemaker, dual chamber, non rate-responsive (implantable)	08/01/2000	12/31/2002
96.	C1785	Pacemaker, dual chamber, rate-responsive (implantable)	08/01/2000	12/31/2002

97.	C2621	Pacemaker, other than single or dual chamber (implantable)	01/01/2001	12/31/2002
98.	C2620	Pacemaker, single chamber, non rate-responsive (implantable)	08/01/2000	12/31/2002
99.	C1786	Pacemaker, single chamber, rate-responsive (implantable)	08/01/2000	12/31/2002
100.	C1787	Patient programmer, neurostimulator	08/01/2000	12/31/2002
101.	C1831	Interbody cage, anterior, lateral or posterior, personalized (implantable)	10/01/2021	09/30/2024
102.	C1788	Port, indwelling (implantable)	08/01/2000	12/31/2002
103.	C1830	Powered bone marrow biopsy needle	10/01/2011	12/31/2013
104.	C2618	Probe, cryoablation	04/01/2001	12/31/2003
105.	C2614	Probe, percutaneous lumbar discectomy	01/01/2003	12/31/2004
106.	C1789	Prosthesis, breast (implantable)	10/01/2000	12/31/2002
107.	C1813	Prosthesis, penile, inflatable	08/01/2000	12/31/2002
108.	C2622	Prosthesis, penile, non-inflatable	10/01/2001	12/31/2002
109.	C1815	Prosthesis, urinary sphincter (implantable)	10/01/2000	12/31/2002
110.	C1816	Receiver and/or transmitter, neurostimulator (implantable)	08/01/2000	12/31/2002
111.	C1771	Repair device, urinary, incontinence, with sling graft	10/01/2000	12/31/2002
112.	C2631	Repair device, urinary, incontinence, without sling graft	08/01/2000	12/31/2002
113.	C1841	Retinal prosthesis, includes all internal and external components	10/01/2013	12/31/2015
114.	C1814	Retinal tamponade device, silicone oil	04/01/2003	12/31/2005
115.	C1773	Retrieval device, insertable	01/01/2001	12/31/2002
116.	C2615	Sealant, pulmonary, liquid (implantable)	01/01/2001	12/31/2002
117.	C1817	Septal defect implant system, intracardiac	08/01/2000	12/31/2002
118.	C1874	Stent, coated/covered, with delivery system	08/01/2000	12/31/2002
119.	C1875	Stent, coated/covered, without delivery system	08/01/2000	12/31/2002
120.	C1876	Stent, non-coated/non-covered, with delivery system	08/01/2000	12/31/2002
121.	C1877	Stent, non-coated/non-covered, without delivery system	08/01/2000	12/31/2002
122.	C2625	Stent, non-coronary, temporary, with delivery system	10/01/2000	12/31/2002
123.	C2617	Stent, non-coronary, temporary, without delivery system	10/01/2000	12/31/2002
124.	C1819	Tissue localization excision device	01/01/2004	12/31/2005
125.	C1879	Tissue marker (implantable)	08/01/2000	12/31/2002
126.	C1880	Vena cava filter	01/01/2001	12/31/2002
127.	**C1826**	**Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system**	**01/01/2023**	**12/31/2025**
128.	**C1827**	**Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller**	**01/01/2023**	**12/31/2025**
129.	**C1747**	**Endoscope, single-use (i.e. disposable), urinary tract, imaging/illumination device (insertable)**	**01/01/2023**	**12/31/2025**
130.	C1824^	Generator, cardiac contractility modulation (implantable)	01/01/2020	12/31/2023
131.	C1982^	Catheter, pressure-generating, one-way valve,	01/01/2020	12/31/2023

		intermittently occlusive		
132.	C1839^	Iris prosthesis	01/01/2020	12/31/2023
133.	C1734^	Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue-to bone (implantable)	01/01/2020	12/31/2023
134.	C2596^	Probe, image-guided, robotic, waterjet ablation	01/01/2020	12/31/2023
135.	**C1600**	**Catheter, transluminal intravascular lesion preparation device, bladed, sheathed (insertable)**	**01/01/2024**	**12/31/2026**
136.	**C1601**	**Endoscope, single-use (i.e. disposable), pulmonary, imaging/illumination device (insertable)**	**01/01/2024**	**12/31/2026**
137.	**C1602**	**Orthopedic/device/drug matrix/absorbable bone void filler, antimicrobial-eluting (implantable)**	**01/01/2024**	**12/31/2026**
138.	**C1603**	**Retrieval device, insertable, laser (used to retrieve intravascular inferior vena cava filter)**	**01/01/2024**	**12/31/2026**
139.	**C1604**	**Graft, transmural transvenous arterial bypass (implantable), with all delivery system components**	**01/01/2024**	**12/31/2026**
140.	**C1605**	**Pacemaker, leadless, dual chamber (right atrial and right ventricular implantable components), rate-responsive, including all necessary components for implantation**	**07/01/2024**	**06/30/2027**
141.	**C1606**	**Adapter, single-use (i.e. disposable), for attaching ultrasound system to upper gastrointestinal endoscope**	**07/01/2024**	**06/30/2027**
142.	**C8000**	**Support device, extravascular, for arteriovenous fistula (implantable)**	**10/01/2024**	**09/30/2027**
143,	**C1735**	**Catheter(s), intravascular for renal denervation, radiofrequency, including all single use system components**	**01/01/2025**	**12/31/2027**
144.	**C1736**	**Catheter(s), intravascular for renal denervation, ultrasound, including all single use system components**	**01/01/2025**	**12/31/2027**
145.	**C1737**	**Joint fusion and fixation device(s), sacroiliac and pelvis, including all system components (implantable)**	**01/01/2025**	**12/31/2027**
146.	**C1738**	**Powered, single-use (i.e. disposable) endoscopic ultrasound-guided biopsy device**	**01/01/2025**	**12/31/2027**
147.	**C1739**	**Tissue marker, imaging and non-imaging device (implantable)**	**01/01/2025**	**12/31/2027**
148.	**C9610**	**Catheter, transluminal drug delivery with or without angioplasty, coronary, non-laser (insertable)**	**01/01/2025**	**12/31/2027**

BOLD codes are still actively receiving pass-through payment.

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

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

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

Table 4. — APC and Status Indicator Assignments for CPT Codes 0660T and 0661T, iDose TR (travoprost intracameral implant) for the Treatment of Glaucoma Retroactive to January 1, 2024

CPT Code	Long Descriptor	SI	APC
0660T	Implantation of anterior segment intraocular nonbiodegradable drug-eluting system, internal approach	J1	5492
0661T	Removal and reimplantation of anterior segment intraocular nonbiodegradable drug-eluting implant	J1	5492

Table 5. — CY 2025 OPPS New Technology APC and Status Indicator Assignments for the 3D Anatomical Segmentation Imaging Software Service

HCPCS Code	Short Descriptor	Long Descriptor	SI	APC
C8001	3D anat seg imaging preop	3D anatomical segmentation imaging for preoperative planning, data preparation and transmission, obtained from previous diagnostic computed tomographic or magnetic resonance examination of the same anatomy	S	5521

Table 6. — CY 2025 OPPS New Technology APC and Status Indicator Assignments for the Automated Skin Cell Suspension Autograft Preparation Service

HCPCS Code	Short Descriptor	Long Descriptor	SI	APC
C8002	Prep skin cell susp, automtd	Preparation of skin cell suspension autograft, automated, including all enzymatic processing and device components (do not report with manual suspension preparation)	S	1532

Table 7. — CY 2025 OPPS New Technology APC and Status Indicator Assignments for the Knee Shock Absorber Implantation Service

HCPCS Code	Short Descriptor	Long Descriptor	SI	APC
C8003	Imp extra knee shck absrb	Implantation of medial knee extraarticular implantable shock absorber spanning the knee joint from distal femur to proximal tibia, open, includes	J1	5116

		measurements, positioning and adjustments, with imaging guidance (eg, fluoroscopy)		

Table 8. – Changes to the IPO List for CY 2025

CPT Code	Long Descriptor	Action	SI
0894T	Cannulation of the liver allograft in preparation for connection to the normothermic perfusion device and decannulation of the liver allograft following normothermic perfusion	Add to the IPO list	C
0895T	Connection of liver allograft to normothermic machine perfusion device, hemostasis control; initial 4 hours of monitoring time, including hourly physiological and laboratory assessments (eg, perfusate temperature, perfusate pH, hemodynamic parameters, bile production, bile pH, bile glucose, biliary)	Add to the IPO list	C
0896T	Connection of liver allograft to normothermic machine perfusion device, hemostasis control; each additional hour, including physiological and laboratory assessments (eg, perfusate temperature, perfusate pH, hemodynamic parameters, bile production, bile pH, bile glucose, biliary bicarbonate, lactate levels, macroscopic assessment) (List separately in addition to code for primary procedure)	Add to the IPO list	C
22848	Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum (List separately in addition to code for primary procedure)	Remove from the IPO list	N

Table 9. – Correct Status Indicator and APC Assignment for HCPCS Code C9734, Effective January 1, 2025

HCPCS Code	Long Descriptor	OPPS SI	OPPS APC
C9734	Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with magnetic resonance (mr) guidance	J1	5115

Table 10. – Correct Status Indicator and APC Assignment for CPT Codes 15013 Effective January 1, 2025

CPT Code	Long Descriptor	OPPS SI	OPPS APC
15013	Preparation of skin cell suspension autograft, requiring enzymatic processing, manual mechanical disaggregation of skin cells, and filtration; first 25 sq cm or less of harvested skin	S	1532

Table 11. ─ New CY 2025 HCPCS Codes Effective January 1, 2025, for Certain Drugs, Biologicals, and Radiopharmaceuticals Receiving Pass-Through Status

CY 2025 HCPCS Code	CY 2025 Long Descriptor	CY 2025 SI	CY 2025 APC
C9173	Injection, filgrastim-txid (nypozi), biosimilar, 1 microgram	G	0811
J0870	Injection, imetelstat, 1 mg	G	0813

Table 12. ─ Existing HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals Starting Pass-Through Status as of January 1, 2025

CY 2025 HCPCS Code	CY 2025 Long Descriptor	October 2024 SI	January 2025 SI	January 2025 APC
A9697	Injection, carboxydextran-coated superparamagnetic iron oxide, per study dose	N	G	0814
J0175	Injection, donanemab-azbt, 2 mg	K	G	0765
J2468	Injection, palonosetron hydrochloride (posfrea), 25 micrograms	E2	G	0815
J2601	Injection, vasopressin (baxter), 1 unit	K	G	0778
J9329	Injection, tislelizumab-jsgr, 1mg	E2	G	0816

Table 13. ─ HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals with Pass-Through Status Ending Effective December 31, 2024

CY 2025 HCPCS Code	CY 2025 Long Descriptor	October 2024 SI	January 2025 SI	January 2025 APC
A9595	Piflufolastat f-18, diagnostic, 1 millicurie	G	K	9430
J0219	Injection, avalglucosidase alfa-ngpt, 4 mg	G	K	9433
J0491	Injection, anifrolumab-fnia, 1 mg	G	K	9434
J9021	Injection, asparaginase, recombinant, (rylaze), 0.1 mg	G	K	9437
J9071	Injection, cyclophosphamide, (auromedics), 5 mg	G	K	9203

Table 14. – Newly Established HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals as of January 1, 2025

New HCPCS Code	Old HCPCS Code	Long Descriptor	SI	APC
90593		Chikungunya virus vaccine, recombinant, for intramuscular use	E1	N/A
90684		Pneumococcal conjugate vaccine, 21 valent (PCV21), for intramuscular use	L	N/A
A9615	C9171	Injection, pegulicianine, 1 mg	G	0772
C9173		Injection, filgrastim-txid (nypozi), biosimilar, 1 microgram	G	0811
J0139		Injection, adalimumab, 1 mg	K	0817
J0601		Sevelamer carbonate (renvela or therapeutically equivalent), oral, 20 mg (for ESRD on dialysis)	B	N/A
J0602		Sevelamer carbonate (renvela or therapeutically equivalent), oral, powder, 20 mg (for ESRD on dialysis)	B	N/A
J0603		Sevelamer hydrochloride (renagel or therapeutically equivalent), oral, 20 mg (for ESRD on dialysis)	B	N/A
J0605		Sucroferric oxyhydroxide, oral, 5 mg (for ESRD on dialysis)	B	N/A
J0607		Lanthanum carbonate, oral, 5 mg (for ESRD on dialysis)	B	N/A
J0608		Lanthanum carbonate, oral, powder, 5 mg, not therapeutically equivalent to J0607 (for ESRD on dialysis)	B	N/A
J0609		Ferric citrate, oral, 3 mg ferric iron, (for ESRD on dialysis)	B	N/A
J0615		Calcium acetate, oral, 23 mg (for ESRD on dialysis)	B	N/A
J0666	C9290	Injection, bupivacaine liposome, 1 mg	K1	0763
J0870		Injection, imetelstat, 1 mg	G	0813
J0901		Vadadustat, oral, 1 mg (for esrd on dialysis)	B	N/A
J1307		Injection, crovalimab-akkz, 10 mg	K	0818
J1414	C9172	Injection, fidanacogene elaparvovec-dzkt, per therapeutic dose	G	0773
J1552		Injection, immune globulin (alyglo), 500 mg	K	0819
J2290		Injection, nafcillin sodium, 20 mg	N	N/A
J2472		Injection, pantoprazole sodium in sodium chloride (baxter), 40 mg	N	N/A
J2802		Injection, romiplostim, 1 microgram	K	0822
J3392		Injection, exagamglogene autotemcel, per treatment	K	0824
J7514		Mycophenolate mofetil (myhibbin), oral suspension, 100 mg	N	N/A
J7601		Ensifentrine, inhalation suspension, fda approved final product, non-compounded, administered through dme, unit dose form, 3 mg	B	N/A

J9026	C9170	Injection, tarlatamab-dlle, 1 mg	G	0768
J9028	C9169	Injection, nogapendekin alfa inbakicept-pmln, for intravesical use, 1 microgram	G	0767
J9076		Injection, cyclophosphamide (baxter), 5 mg	E2	N/A
J9292		Injection, pemetrexed (avyxa), not therapeutically equivalent to j9305, 10 mg	E2	N/A
Q0155		Dronabinol (syndros), 0.1 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	N	N/A
Q0521		Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription	M	N/A
Q4346		Shelter dm matrix, per square centimeter	N	N/A
Q4347		Rampart dl matrix, per square centimeter	N	N/A
Q4348		Sentry sl matrix, per square centimeter	N	N/A
Q4349		Mantle dl matrix, per square centimeter	N	N/A
Q4350		Palisade dm matrix, per square centimeter	N	N/A
Q4351		Enclose tl matrix, per square centimeter	N	N/A
Q4352		Overlay sl matrix, per square centimeter	N	N/A
Q4353		Xceed tl matrix, per square centimeter	N	N/A
Q5139		Injection, eculizumab-aeeb (bkemv), biosimilar, 10 mg	E2	N/A
Q5140		Injection, adalimumab-fkjp, biosimilar, 1 mg	K	0826
Q5141		Injection, adalimumab-aaty, biosimilar, 1 mg	K	0828
Q5142		Injection, adalimumab-ryvk biosimilar, 1 mg	K	0829
Q5143		Injection, adalimumab-adbm, biosimilar, 1 mg	K	0830
Q5144		Injection, adalimumab-aacf (idacio), biosimilar, 1 mg	K	0833
Q5145		Injection, adalimumab-afzb (abrilada), biosimilar, 1 mg	K	0834
Q5146		Injection, trastuzumab-strf (hercessi), biosimilar, 10 mg	E2	N/A
Q9996		Injection, ustekinumab-ttwe (pyzchiva), subcutaneous, 1 mg	E2	N/A
Q9997		Injection, ustekinumab-ttwe (pyzchiva), intravenous, 1 mg	E2	N/A
Q9998		Injection, ustekinumab-aekn (selarsdi), 1 mg	E2	0772

Table 15. – HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals Deleted as of December 31, 2024

CY 2025 HCPCS Code	Long Descriptor	CY 2025 SI	APC
90654	Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use	D	N/A
90630	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use	D	N/A

CY 2025 HCPCS Code	Long Descriptor	CY 2025 SI	APC
J0135	injection, adalimumab, 20 mg	D	N/A
J0570	Buprenorphine implant, 74.2 mg	D	N/A
J2796	Injection,romiplostim, 10 micrograms	D	N/A
J2806	Injection, sincalide (maia), not therapeutically equivalent to j2805, 5 micrograms	D	N/A
J9058	Injection, bendamustine hydrochloride (apotex), 1 mg	D	N/A
J9059	Injection, bendamustine hydrochloride (baxter), 1 mg	D	N/A
J9259	Injection, paclitaxel protein-bound particles (american regent), not therapeutically equivalent to j9264, 1 mg	D	N/A
Q0516	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription oral drug, per 30-days	D	N/A
Q0517	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription oral drug, per 60-days	D	N/A
Q0518	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription oral drug, per 90-days	D	N/A
Q0519	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription injectable drug, per 30-days	D	N/A
Q0520	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription injectable drug, per 60-days	D	N/A
Q5131	Injection, adalimumab-aacf (idacio), biosimilar, 20 mg	D	N/A
Q5132	Injection, adalimumab-afzb (abrilada), biosimilar, 10 mg	D	N/A

Table 16. ─ Existing HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals Changing Payment Status Indicator as of January 1, 2025

CY 2025 HCPCS Code	CY 2025 Long Descriptor	October 2024 SI	January 2025 SI	January 2025 APC
J9198	Injection, gemcitabine hydrochloride, (infugem), 100 mg	K	E1	N/A

Table 17. ─ HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals Changing Payment Status Retroactive to October 1, 2024

CY 2024 HCPCS Code	CY 2024 Long Descriptor	October 2024 SI	October 2024 APC
J9059	Injection, bendamustine hydrochloride (baxter), 1 mg	K	9153
J9072	Injection, cyclophosphamide (dr. reddy's), 5 mg	E2	N/A
J9329	Injection, tislelizumab-jsgr, 1mg	K	0816
Q5131	Injection, adalimumab-aacf (idacio), biosimilar, 20 mg	K	0787

Table 18. – HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals with Substantial Descriptor Changes as of January 1, 2025

CY 2025 HCPCS Code	October 2024 Long Descriptor	January 2025 Long Descriptor
90661	Influenza virus vaccine, trivalent (ccIIV3), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use	Influenza virus vaccine, trivalent (ccIIV3), derived from cell cultures, subunit, antibiotic free, 0.5 mL dosage, for intramuscular use
J2468	Injection, palonosetron hydrochloride (avyxa), not therapeutically equivalent to J2469, 25 micrograms	Injection, palonosetron hydrochloride (posfrea), 25 micrograms
J9033	Injection, bendamustine hcl, not otherwise specified, 1 mg	Injection, bendamustine hydrochloride, 1 mg
J9072	Injection, cyclophosphamide, (dr. reddy's), 5 mg	Injection, cyclophosphamide (avyxa), 5 mg

Table 19. – Diagnostic Radiopharmaceuticals Previously in a Packaged Status (SI=N) changing to a Payable Status (SI=K) as of January 1, 2025

CY 2025 HCPCS Code	CY 2025 Long Descriptor	October 2024 SI	January 2025 SI	January 2025 APC
A9515	Choline C 11, diagnostic, per study dose	N	K	9461
A9521	technetium tc-99m exametazime, diagnostic, per study dose, up to 25 millicuries	N	K	0766
A9542	indium in-111 ibritumomab tiuxetan, diagnostic, per study dose, up to 5 millicuries	N	K	0769
A9547	indium in-111 oxyquinoline, diagnostic, per 0.5 millicurie	N	K	0770
A9548	indium in-111 pentetate, diagnostic, per 0.5 millicurie	N	K	0771
A9557	technetium tc-99m bicisate, diagnostic, per study dose, up to 25 millicuries	N	K	0774
A9568	technetium tc-99m arcitumomab, diagnostic, per study dose, up to 25 millicuries	N	K	0775

CY 2025 HCPCS Code	CY 2025 Long Descriptor	October 2024 SI	January 2025 SI	January 2025 APC
A9569	'Technetium TC-99M exametazime labeled autologous white blood cells, diagnostic, per study dose	N	K	0776
A9570	'Indium IN-111 labeled autologous white blood cells, diagnostic, per study dose	N	K	0777
A9572	Indium IN-111 pentetreotide, diagnostic, per study dose, up to 6 millicuries	N	K	0779
A9582	Iodine I-123 iobenguane, diagnostic, per study dose, up to 15 millicuries	N	K	0780
A9584	Iodine I-123 ioflupane, diagnostic, per study dose, up to 5 millicuries	N	K	0781
A9586	Florbetapir f18, diagnostic, per study dose, up to 10 millicuries	N	K	1664
A9587	Gallium ga-68, dotatate, diagnostic, 0.1 millicurie	N	K	9056
A9588	Fluciclovine f-18, diagnostic, 1 millicurie	N	K	9052
A9591	Fluoroestradiol F 18, diagnostic, 1 millicurie	N	K	9370
A9592	Copper cu-64, dotatate, diagnostic, 1 millicurie	N	K	9383
A9593	Gallium ga-68 psma-11, diagnostic, (ucsf), 1 millicurie	N	K	9409
A9594	Gallium ga-68 psma-11, diagnostic, (ucla), 1 millicurie	N	K	9419
A9595	Piflufolastat f-18, diagnostic, 1 millicurie	G	K	9430
C9067	Gallium ga-68, dotatoc, diagnostic, 0.01 mCi	N	K	9323
Q9982	Flutemetamol F18, diagnostic, per study dose, up to 5 millicuries	N	K	9459
Q9983	Florbetaben F18, diagnostic, per study dose, up to 8.1 millicuries	N	K	9458

One (1) billing modifier will be deleted on December 31, 2024. This billing modifier is listed in table 20, attachment A.

Table 20. ─ Billing Modifier Deleted as of December 31, 2024

CY 2025 Billing Modifier	Long Descriptor
JG	Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes

Table 21. ─ Billing Modifier with Revised Descriptor as of January 1, 2025

CY 2025 Billing Modifier	Long Descriptor
TB	Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes

Table 22. ─ HCPCS Codes for Pharmacy Dispensing / Supplying Fees Changing Payment Status Indicators starting January 1, 2025

CY 2025 HCPCS Code	CY 2025 Long Descriptor	October 2024 SI	January 2025 SI
Q0510	Pharmacy supply fee for initial immunosuppressive drug(s), first month following transplant	B	M
Q0511	Pharmacy supply fee for oral anti-cancer, oral anti-emetic or immunosuppressive drug(s); for the first prescription in a 30-day period	B	M
Q0512	Pharmacy supply fee for oral anti-cancer, oral anti-emetic or immunosuppressive drug(s); for a subsequent prescription in a 30-day period	B	M
Q0513	Pharmacy dispensing fee for inhalation drug(s); per 30 days	B	M
Q0514	Pharmacy dispensing fee for inhalation drug(s); per 90 days	B	M
Q0516	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription oral drug, per 30-days	B	D
Q0517	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription oral drug, per 60-days	B	D
Q0518	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription oral drug, per 90-days	B	D
Q0519	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription injectable drug, per 30-days	B	D
Q0520	Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription injectable drug, per 60-days	B	D
Q0521	1 Pharmacy supplying fee for hiv preexposure prophylaxis fda approved prescription	N/A	M

Table 23. ─ New Skin Substitute Products Low Cost Group/High Cost Group Assignment Effective January 1, 2025

CY 2025 HCPCS Code	Short Descriptor	CY 2025 SI	Low/High Cost Skin Substitute
Q4346	Shelter dm matrix per sq cm	N	Low

Q4347	Rampart dl matrix per sq cm	N	Low
Q4348	Sentry sl matrix per sq cm	N	Low
Q4349	Mantle dl matrix per sq cm	N	Low
Q4350	Palisade dm matrix per sq cm	N	Low
Q4351	Enclose tl matrix, per sq cm	N	Low
Q4352	Overlay sl matrix, per sq cm	N	Low
Q4353	Xceed tl matrix per sq cm	N	Low

Table 24. – Skin Substitute Assignments to High Cost and Low Cost Groups for CY 2025

CY 2025 HCPCS Code	CY 2025 Short Descriptor	CY 2024 High/Low Cost Assignment	CY 2025 High/Low Cost Assignment
A2001	Innovamatrix ac, per sq cm	High	High
A2002	Mirragen adv wnd mat per sq	High	High
A2005	Microlyte matrix, per sq cm	High	High
A2006	Novosorb synpath per sq cm	High	High
A2007	Restrata, per sq cm	High	High
A2008	Theragenesis, per sq cm	High	High
A2009	Symphony, per sq cm	High	High
A2010	Apis, per square centimeter	High	High
A2011	Supra sdrm, per sq cm	High	High
A2012	Suprathel, per sq cm	High	High
A2013	Innovamatrix fs, per sq cm	High	High
A2015	Phoenix wnd mtrx, per sq cm	High	High
A2016	Permeaderm b, per sq cm	High	High
A2017	Permeaderm glove, each	High	High
A2018	Permeaderm c, per sq cm	High	High
A2019	kerecis marigen shld sq cm	High	High
A2020	ac5 wound system	High	High
A2021	neomatrix per sq cm	High	High
A2022	Innovabrn/innovamatx xl sqcm	High	High
A2024	Resolve matrix per sq cm	High	High
A2025	Miro3d per cubic cm	High	High
A2027	Matriderm, per square centimeter	High	High
A2028	Micromatrix flex, per mg	High	High
A2029	Mirotract wound matrix sheet, per cubic centimeter	High	High
A4100	Skin sub fda clrd as dev nos	Low	Low
C9363	Integra meshed bil wound mat	High	High
Q4100	Skin substitute, nos	Low	Low
Q4101	Apligraf	High	High
Q4102	Oasis wound matrix	Low	Low
Q4103	Oasis burn matrix	High	High*
Q4104	Integra bmwd	High	High
Q4105	Integra drt or omnigraft	High	High
Q4106	Dermagraft	High	High
Q4107	Graftjacket	High	High
Q4108	Integra matrix	High	High

CY 2025 HCPCS Code	CY 2025 Short Descriptor	CY 2024 High/Low Cost Assignment	CY 2025 High/Low Cost Assignment
Q4110	Primatrix	High	High
Q4111	Gammagraft	Low	Low
Q4115	Alloskin	Low	Low
Q4116	Alloderm	High	High
Q4117	Hyalomatrix	Low	Low
Q4121	Theraskin	High	High
Q4122	Dermacell, awm, porous sq cm	High	High
Q4123	Alloskin	High	High*
Q4124	Oasis tri-layer wound matrix	Low	Low
Q4126	Memoderm/derma/tranz/integup	High	High
Q4127	Talymed	High	High
Q4128	Flexhd/allopatchhd/matrixhd	High	High
Q4132	Grafix core, grafixpl core	High	High
Q4133	Grafix stravix prime pl sqcm	High	High
Q4134	Hmatrix	High	High
Q4135	Mediskin	High	High*
Q4136	Ezderm	Low	Low
Q4137	Amnioexcel biodexcel, 1 sq cm	High	High
Q4138	Biodfence dryflex, 1cm	High	High
Q4140	Biodfence 1cm	High	High
Q4141	Alloskin ac, 1cm	High	High*
Q4143	Repriza, 1cm	High	High*
Q4146	Tensix, 1cm	High	High*
Q4147	Architect ecm px fx 1 sq cm	High	High
Q4148	Neox rt or clarix cord	High	High
Q4150	Allowrap ds or dry 1 sq cm	High	High
Q4151	Amnioband, guardian 1 sq cm	High	High
Q4152	Dermapure 1 square cm	High	High
Q4153	Dermavest, plurivest sq cm	High	High
Q4154	Biovance 1 square cm	High	High
Q4156	Neox 100 or clarix 100	High	High
Q4157	Revitalon 1 square cm	High	High*
Q4158	Kerecis omega3, per sq cm	High	High*
Q4159	Affinity 1 square cm	High	High
Q4160	Nushield 1 square cm	High	High
Q4161	Bio-connekt per square cm	High	High*
Q4163	Woundex, bioskin, per sq cm	High	High
Q4164	Helicoll, per square cm	High	High*
Q4165	Keramatrix, per square cm	Low	Low
Q4166	Cytal, per square centimeter	Low	Low
Q4167	Truskin, per square centimeter	High	High
Q4169	Artacent wound, per sq cm	High	High
Q4170	Cygnus, per sq cm	High	High*
Q4173	Palingen or palingen xplus	High	High
Q4175	Miroderm, per square cm	High	High
Q4176	Neopatch, per sq centimeter	High	High

CY 2025 HCPCS Code	CY 2025 Short Descriptor	CY 2024 High/Low Cost Assignment	CY 2025 High/Low Cost Assignment
Q4178	Floweramniopatch, per sq cm	High	High
Q4179	Flowerderm, per sq cm	High	High*
Q4180	Revita, per sq cm	High	High
Q4181	Amnio wound, per square cm	High	High
Q4182	Transcyte, per sq centimeter	High	High
Q4183	Surgigraft, 1 sq cm	High	High
Q4184	Cellesta or duo per sq cm	High	High*
Q4186	Epifix 1 sq cm	High	High
Q4187	Epicord 1 sq cm	High	High
Q4188	Amnioarmor 1 sq cm	High	High*
Q4190	Artacent ac 1 sq cm	High	High*
Q4191	Restorigin 1 sq cm	High	High*
Q4193	Coll-e-derm 1 sq cm	High	High
Q4194	Novachor 1 sq cm	High	High*
Q4195	Puraply 1 sq cm	High	High
Q4196	Puraply am 1 sq cm	High	High
Q4197	Puraply xt 1 sq cm	High	High
Q4198	Genesis amnio membrane 1 sq cm	High	High
Q4199	Cygnus matrix, per sq cm	High	High
Q4200	Skin te 1 sq cm	High	High*
Q4201	Matrion 1 sq cm	High	High
Q4203	Derma-gide, 1 sq cm	High	High
Q4204	Xwrap 1 sq cm	Low	Low
Q4205	Membrane graft or wrap sq cm	High	High
Q4208	Novafix per sq cm	High	High
Q4209	Surgraft per sq cm	High	High*
Q4211	Amnion bio or axobio sq cm	High	High
Q4214	Cellesta cord per sq cm	Low	Low
Q4216	Artacent cord per sq cm	Low	High
Q4217	Woundfix biowound plus xplus	High	High*
Q4218	Surgicord per sq cm	High	High*
Q4219	Surgigraft dual per sq cm	High	High
Q4220	Bellacell HD, Surederm sq cm	Low	Low
Q4221	Amniowrap2 per sq cm	High	High
Q4222	Progenamatrix, per sq cm	High	High*
Q4224	Hhf10-p per sq cm	Low	Low
Q4225	Amniobind, per sq cm	Low	Low
Q4226	Myown harv prep proc sq cm	High	High
Q4227	Amniocore per sq cm	High	High
Q4229	Cogenex amnio memb per sq cm	High	High*
Q4232	Corplex, per sq cm	High	High
Q4234	Xcellerate, per sq cm	High	High
Q4235	Amniorepair or altiply sq cm	High	High
Q4236	Carepatch per sq cm	Low	Low
Q4237	cryo-cord, per sq cm	High	High*
Q4238	Derm-maxx, per sq cm	High	High

CY 2025 HCPCS Code	CY 2025 Short Descriptor	CY 2024 High/Low Cost Assignment	CY 2025 High/Low Cost Assignment
Q4239	Amnio-maxx or lite per sq cm	High	High*
Q4247	Amniotext patch, per sq cm	Low	Low
Q4248	Dermacyte Amn mem allo sq cm	High	High
Q4249	Amniply, per sq cm	High	High*
Q4250	AmnioAMP-MP per sq cm	High	High
Q4251	Vim, per square centimeter	Low	Low
Q4252	Vendaje, per square centimet	Low	High
Q4253	Zenith amniotic membrane psc	High	High*
Q4254	Novafix dl per sq cm	High	High*
Q4255	Reguard, topical use per sq	Low	Low
Q4256	Mlg complet, per sq cm	Low	Low
Q4257	Relese, per sq cm	Low	Low
Q4258	Enverse, per sq cm	High	High*
Q4259	Celera per sq cm	Low	Low
Q4260	Signature apatch, per sq cm	Low	Low
Q4261	Tag, per square centimeter	Low	Low
Q4262	Dual layer impax, per sq cm	Low	High
Q4263	Surgraft tl, per sq cm	Low	Low
Q4264	Cocoon membrane, per sq cm	Low	Low
Q4265	Neostim tl per sq cm	Low	Low
Q4266	Neostim per sq cm	Low	Low
Q4267	Neostim dl per sq cm	Low	Low
Q4268	Surgraft ft per sq cm	Low	High
Q4269	Surgraft xt per sq cm	Low	Low
Q4270	Complete sl per sq cm	Low	Low
Q4271	Complete ft per sq cm	Low	Low
Q4272	Esano a, per sq cm	Low	Low
Q4273	Esano aaa, per sq cm	Low	Low
Q4274	Esano ac, per sq cm	Low	Low
Q4275	Esano aca, per sq cm	Low	Low
Q4276	Orion, per sq cm	Low	Low
Q4278	Epieffect, per sq cm	High	High
Q4279	Vendaje ac, per sq cm	Low	Low
Q4280	Xcell amnio matrix per sq cm	Low	Low
Q4281	Barrera slor dl per sq cm	Low	Low
Q4282	Cygnus dual per sq cm	High	High
Q4283	Biovance tri or 3l, sq cm	Low	Low
Q4284	Dermabind sl, per sq cm	Low	Low
Q4285	Nudyn dl or dl mesh pr sq cm	High	High*
Q4286	Nudyn sl or slw, per sq cm	High	High*
Q4287	Dermabind dl, per sq cm	Low	Low
Q4288	Dermabind ch, per sq cm	Low	Low
Q4289	Revoshield+ amnio, per sq cm	Low	Low
Q4290	Membrane wrap hydr per sq cm	Low	Low
Q4291	Lamellas xt, per sq cm	Low	Low
Q4292	Lamellas, per sq cm	Low	Low

CY 2025 HCPCS Code	CY 2025 Short Descriptor	CY 2024 High/Low Cost Assignment	CY 2025 High/Low Cost Assignment
Q4293	Acesso dl, per sq cm	Low	Low
Q4294	Amnio quad-core, per sq cm	Low	Low
Q4295	Amnio tri-core, per sq cm	Low	Low
Q4296	Rebound matrix, per sq cm	Low	Low
Q4297	Emerge matrix, per sq cm	Low	Low
Q4298	Amnicore pro, per sq cm	Low	Low
Q4299	Amnicore pro+, per sq cm	Low	Low
Q4300	Acesso tl, per sq cm	Low	Low
Q4301	Activate matrix, per sq cm	Low	Low
Q4302	Complete aca, per sq cm	Low	Low
Q4303	Complete aa, per sq cm	Low	Low
Q4304	Grafix plus, per sq cm	Low	Low
Q4305	Amer am ac tri-lay per sq cm	Low	Low
Q4306	Americ amnion ac per sq cm	Low	Low
Q4307	American amnion, per sq cm	Low	Low
Q4308	Sanopellis, per sq cm	Low	Low
Q4309	Via matrix, per sq cm	Low	Low
Q4311	Acesso, per sq cm	Low	Low
Q4312	Acesso ac, per sq cm	Low	Low
Q4313	Dermabind fm, per sq cm	Low	Low
Q4314	Reeva, per sq cm	Low	Low
Q4315	Regenelink amniotic mem allo	Low	Low
Q4316	Amchoplast, per sq cm	Low	Low
Q4317	Vitograft, per sq cm	Low	Low
Q4318	E-graft, per sq cm	Low	Low
Q4319	Sanograft, per sq cm	High	High*
Q4320	Pellograft, per sq cm	High	High*
Q4321	Renograft, per sq cm	Low	Low
Q4322	Caregraft, per sq cm	Low	Low
Q4323	Alloply, per sq cm	Low	Low
Q4324	Amniotx, per sq cm	Low	Low
Q4325	Acapatch, per sq cm	Low	Low
Q4326	Woundplus, per sq cm	Low	Low
Q4327	Duoamnion, per sq cm	Low	Low
Q4328	Most, per sq cm	Low	Low
Q4329	Singlay, per sq cm	Low	Low
Q4330	Total, per sq cm	Low	Low
Q4331	Axolotl graft, per sq cm	High	High*
Q4332	Axolotl dualgraft, per sq cm	High	High*
Q4333	Ardeograft, per sq cm	Low	Low
Q4334	Amnioplast 1, per sq cm	Low	Low
Q4335	Amnioplast 2, per sq cm	Low	Low
Q4336	Artecent c, per sq cm	Low	Low
Q4337	Artecent trident, per sq cm	Low	Low
Q4338	Artacent velos, per sq cm	Low	Low
Q4339	Artacent vericlen, per sq cm	Low	Low

CY 2025 HCPCS Code	CY 2025 Short Descriptor	CY 2024 High/Low Cost Assignment	CY 2025 High/Low Cost Assignment
Q4340	Simpligraft, per sq cm	Low	Low
Q4341	Simplimax, per sq cm	Low	Low
Q4342	Theramend, per sq cm	Low	Low
Q4343	Dermacyte ac matrx per sq cm	Low	Low
Q4344	Tri membrane wrap, per sq cm	Low	Low
Q4345	Matrix hd allogrft per sq cm	Low	Low

* These products do not exceed either the MUC or PDC threshold for CY 2025 but are assigned to the high cost group because they were assigned to the high cost group in CY 2024.

Table 25. – HCPCS Code for Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) Counseling Covered as Additional Preventative Services Changing APC Effective January 1, 2025

CY 2025 HCPCS Code	CY 2025 Long Descriptor	October 2024 APC	January 2025 APC
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	5822	5821

Table 26. – HCPCS Code for Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) Counseling Covered as Additional Preventative Services Changing SI Effective January 1, 2025

CY 2025 HCPCS Code	CY 2025 Long Descriptor	October 2024 SI	January 2025 SI
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	B	M

Table 27. – HCPCS Code for Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) Administration APC Assignment Change Retroactive to October 1, 2024

HCPCS Code	Long Descriptor	October 2024 APC	January 2025 APC
G0012	Injection of pre-exposure prophylaxis (prep) drug for hiv prevention, under skin or into muscle	5691	5692

Table 28. – HCPCS Codes, Status Indicator and APC Assignments for Qualifying Non-Opioid Treatments for Pain Relief Effective January 1, 2025.

HCPCS Code	Long Descriptor	SI Oct 2024	SI Jan 2025	CY 2025 APC
C9290	Injection, bupivacaine liposome, 1mg	N	D	N/A
J0666	Injection, bupivacaine liposome, 1mg	N/A	K1	0763
J1097	Phenylephrine 10.16 mg/ml and ketorolac 2.88 mg/ml ophthalmic irrigation solution, 1 ml	N	K1	9324
J1096	Dexamethasone, lacrimal ophthalmic insert, 0.1 mg	N	K1	9308
C9089	Bupivacaine, collagen-matrix implant, 1 mg	N	K1	0762
J1885	Injection, ketorolac tromethamine, per 15 mg	N	K1	0764
C9804	Elastomeric infusion pump (e.g., ON-Q* Pump with Bolus), including catheter and all disposable system components, non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with Section 4135 of the CAA, 2023)	N/A	H1	2048
C9807	Nerve stimulator, percutaneous, peripheral (e.g., SPRINT Peripheral Nerve Stimulation System), including electrode and all disposable system components, non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with Section 4135 of the CAA, 2023)	N/A	H1	2057
C9808	Nerve cryoablation probe (e.g., cryoICE, cryoSPHERE, cryoSPHERE MAX, cryoICE cryoSPHERE, cryoICE Cryo2), including probe and all disposable system components, non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical	N/A	H1	2058

HCPCS Code	Long Descriptor	SI Oct 2024	SI Jan 2025	CY 2025 APC
	pain relief in accordance with Section 4135 of the CAA, 2023)			
C9806	Rotary peristaltic infusion pump (e.g., ambIT Pump), including catheter and all disposable system components, non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with Section 4135 of the CAA, 2023)	N/A	H1	2056
C9809	Cryoablation needle (e.g., iovera System), including needle/tip and all disposable system components, non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with Section 4135 of the CAA, 2023)	N/A	H1	2059

Table 29. ─ HCPCS Codes and Payment Limitations for Qualifying Non-Opioid Treatments for Pain Relief Effective January 1, 2025.

HCPCS Code	CY 2025 Payment Limit
C9089	$700.48
J0666	$2,368.14
J1096	$427.57
J1097	$425.89
J1885	$1,214.30
C9804	$2,284.98
C9806	$2,284.98
C9808	$985.94
C9809	$255.85
C9807	$2,483.16

Table 30. ─ HCPCS Codes and Payment Limitations for Qualifying Non-Opioid Treatments for Pain Relief Effective April 1, 2025

HCPCS Code	CY 2025 Payment Limit Effective April 1, 2025
C9088	$2,267.26

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

Table of Contents
(Rev.13032, Issued: 01-03-25)

Transmittals for Chapter 4

10.2.3 - Comprehensive APCs

(Rev. 13032; Issued: 01-03-25; Effective: 01-01-25; Implementation: 01-06-25)

The following services are excluded from comprehensive APC packaging:
• ambulance services
• brachytherapy sources (status indicator U)
• diagnostic and mammography screenings
• physical therapy, speech-language pathology and occupational therapy services reported on a separate facility claim for recurring services
• pass-through drugs, biologicals, and devices (status indicators G or H)
• preventive services defined in 42 CFR 410.2
• self-administered drugs (SADs) - drugs that are usually self-administered and do not function as supplies in the provision of the comprehensive service
• services assigned to OPPS status indicator F (including certain CRNA services, Hepatitis B vaccines and corneal tissue acquisition)
• services assigned to OPPS status indicator L (including influenza, pneumococcal pneumonia, and COVID-19 vaccines)
• certain Part B inpatient services – Ancillary Part B inpatient services payable under Part B when the primary J1 service for the claim is not a payable Medicare Part B inpatient service (for example, exhausted Medicare Part A benefits, beneficiaries with Part B only)
• services assigned to a New Technology APC
• Any drug or biological described by HCPCS code C9399 (Unclassified drugs or biologicals)
• Non-opioid treatments for pain relief qualifying under section 4135 of the Consolidated Appropriations Act (CAA), 2023
• cellular and gene therapies

10.6.3 - Payment Adjustment for Certain Cancer Hospitals

(Rev. 13032; Issued: 01-03-25; Effective: 01-01-25; Implementation: 01-06-25)

Section 3138 of the Affordable Care Act requires CMS to conduct a study to determine if, under the OPPS, outpatient costs incurred by 11 specified cancer hospitals exceed the costs incurred by other hospitals furnishing services under the OPPS. In addition, Section 3138 of the Affordable Care Act provides that if the specified cancer hospitals' costs are determined to be greater than the costs of other hospitals furnishing services under the OPPS, CMS shall provide a payment adjustment to the 11 specified cancer hospitals that will appropriately reflect these higher outpatient costs. We determined that outpatient costs incurred by the 11 specified cancer hospitals were greater than the costs incurred by other OPPS hospitals. Therefore, consistent with Section 3138 of the Affordable Care Act, we adopted a policy to provide additional payments to each of the 11 cancer hospitals so that each cancer hospital's final payment to cost ratio (PCR) for services provided in a given calendar year is equal to the weighted average PCR (which we refer to as the "target PCR") for other hospitals paid under the OPPS. The target PCR is set in advance of the calendar year and is calculated using the most recent submitted or settled cost report data that are available at the time of final rulemaking for the calendar year.

The cancer hospital payment adjustment will be made through interim monthly payments with the final payment adjustment amount calculated based on the provider's settled cost report. The calculation for the monthly cancer hospital payment adjustment amount is described as follows:

Step 1 - Compute the cancer hospital target payment amount for each month by first multiplying the total charges for covered services for all OPPS services on claims paid during the month and adjust the total charges to cost by multiplying them by the outpatient cost-to-charge ratio and then multiplying this amount by the target PCR for the calendar year.

Step 2 - Add together the total Medicare program payments, unreduced coinsurance and deductible applied for all APCs, as well as all outlier payments (including reconciled outlier payments and the time value of money) and transitional pass-through payments for drugs, biological and/or devices for those same claims paid during the month as those used in Step 1. If the result is greater than the result of Step 1, go to Step 4. No additional payment is due this month.

Step 3 - Subtract the result of Step 2 from the result of Step 1 and pay .85 times this amount.

Step 4 - When the result of step 2 is greater than the result of Step 1 for the final month of a provider's cost report period, do nothing more. When the result of Step 2 is greater than the result of Step 1 for any other month, store all Step 1 and Step 2 totals and include these totals with the totals for the next month's additional payment calculation.

The target PCR that should be used in the calculation of the interim monthly payments associated with the cancer hospital adjustment, as described above, and at final cost report settlement for hospital outpatient services furnished in the applicable calendar year is provided in the table below. Section 16002(b) of the 21st Century Cures Act requires that, for CY 2018 and subsequent calendar years, the target PCR that should be used in the calculation of the interim monthly payments associated with the cancer hospital adjustment, as described above in section 10.6.3, and at final cost report settlement is reduced by 0.01. The target PCR displayed in the table below is inclusive of the required .01 reduction.

Calendar Year	*Target PCR*
2012	*0.91*
2013	*0.91*
2014	*0.90*
2015	*0.90*
2016	*0.92*
2017	*0.91*
2018	*0.88*
2019	*0.88*
2020	*0.89*
2021	*0.89*
2022	*0.89*
2023	*0.89*
2024	*0.88*
2025	*0.87*

62 - Billing and *Payment for Medical Devices Classified as Non-Opioid Treatments for Pain Relief Under the OPPS and ASC Payment System*

(Rev. 13032; Issued: 01-03-25; Effective: 01-01-25; Implementation: 01-06-25)

The Consolidated Appropriations Act (CAA), 2023 (Pub. L. 117-328), was signed into law on December 29, 2022. Section 4135(a) and (b) of the CAA, 2023, titled Access to Non-Opioid Treatments for Pain Relief, amended section 1833(t)(16) and section 1833(i) of the Social Security Act, respectively, to provide for temporary additional payments for non-opioid treatments for pain relief (as that term is defined in section 1833(t)(16)(G)(i) of the Act).

62.1 - Qualifying Criteria for Payment for Medical Devices Classified as Non-Opioid Treatments for Pain Relief Under the OPPS and ASC Payment System

(Rev. 13032; Issued: 01-03-25; Effective: 01-01-25; Implementation: 01-06-25)

Eligibility for separate payment for non-opioid medical devices. From January 1, 2025, through December 31, 2027, a medical device is eligible for separate payment for an applicable calendar year if CMS determines it meets all of the following requirements through that year's rulemaking:

(1) The medical device is used to deliver a therapy to reduce postoperative pain, or produce postsurgical or regional analgesia, and has an application under section 515 of the FDCA that has been approved with respect to the device, has been cleared for market under section 510(k) of the FDCA, or is exempt from the requirements of section 510(k) of the FDCA pursuant to section 510(l) or (m) or 520(g) of the FDCA.

(2) The medical device has demonstrated the ability to replace, reduce, or avoid intraoperative or postoperative opioid use or the quantity of opioids prescribed in a clinical trial or through data published in a peer-reviewed journal.

(3) The medical device does not have transitional pass-through payment status under 42 CFR § 419.66. In the case where a medical device otherwise meets the requirements under this section and has transitional pass-through payment status that expires during the calendar year, the medical device will qualify for separate payment during such calendar year on the first day of the next calendar year quarter following the expiration of its pass-through status.

(4) The medical device has payment that is packaged into a payment for a covered OPD service (or group of services).

62.2 - Payment amount for Medical Devices Classified as Non-Opioid Treatments for Pain Relief Under the OPPS and ASC Payment System

(Rev. 13032; Issued: 01-03-25; Effective: 01-01-25; Implementation: 01-06-25)

From January 1, 2025, through December 31, 2027, the amount of payment for a qualifying non-opioid treatment for pain relief is as follows:

(1) For a qualifying medical device as defined in section 62.1 of this chapter, the amount of payment is the amount of the hospital's charges for the device, adjusted to cost, that exceeds the portion of the otherwise applicable Medicare OPD fee schedule amount subject to the payment limitation in which payment for qualifying medical devices shall not exceed the estimated average of 18 percent of the OPD fee schedule amount of the volume weighted average of the most frequent five OPD primary procedures into which a non-opioid treatment for pain relief would be packaged. These payment limitations are including in annual OPPS/ASC rulemaking.

232 - OPPS Payment for Drugs Covered as Additional Preventive Services (DCAPS)

(Rev. 13032; Issued: 01-03-25; Effective: 01-01-25; Implementation: 01-06-25)

Under § 1861(ddd)(1) of the Social Security Act (the Act), CMS has the authority to add coverage of "additional preventive services" through the Medicare national coverage determination (NCD) process if certain statutory requirements are met: (1) reasonable and necessary for the prevention or early detection of illness or disability, (2) recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF), and (3) appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

Effective for OPPS claims with dates of service on or after January 1, 2025, CMS has established an OPPS payment methodology for Drugs Covered as Additional Preventive Services (DCAPS drugs).

Medicare Part B coinsurance and deductible are waived for these preventive services.

232.1 - OPPS Payment Amounts for Drugs Covered as Additional Preventive Services (DCAPS)

(Rev. 13032; Issued: 01-03-25; Effective: 01-01-25; Implementation: 01-06-25)

Beginning January 1, 2025, CMS will pay OPPS DCAPS drugs as follows:

1. *If ASP data is available for the DCAPS drug, the payment limit will be determined based on the methodology under section 1847A(b) of the Act (usually 106 percent of ASP).*

    - *See Chapter 17 of this manual for more information on ASP payment methodology.*

2. *If ASP data is not available, the payment limit will be calculated using National Average Drug Acquisition Cost (NADAC) prices for the drug.*

    - *Medicaid's NADAC survey (OMB control number 0938-1041) is publicly available at* https://data.medicaid.gov/nadac.
    - *When calculating the price for multiple-source DCAPS drugs using NADAC pricing, CMS will use the lesser price of:*
        - *The median of all generic forms of the drug; or*
        - *The lowest brand name product.*

3. *If ASP data and NADAC prices are not available, the payment amount will be calculated using the Federal Supply Schedule (FSS) prices for the drug.*

    - *Drug pricing information from the Veterans Affairs' (VA's) FSS pharmaceutical pricing database is publicly available at* https://www.va.gov/opal/nac/fss/pharmPrices.asp.
    - *For the purposes of this policy, the FSS price is the "other government agencies" (OGA) price.*
    - *When calculating the price for multiple-source DCAPS drugs using FSS OGA pricing, CMS will use the lesser price of:*
        - *The median of all generic forms of the drug; or*
        - *The lowest brand name product.*

4. *If ASP data, NADAC prices, and FSS prices are not available, then, for the period beginning January 1, 2025, through December 31, 2025, the payment amount is WAC plus 6 percent, or 3 percent if in an initial sales period consistent with 1847A(c)(4) of the Act, and beginning January 1, 2026, the payment amount is the invoice price determined by the Medicare Administrative Contractor (MAC).*

250.2 *- OPPS Payment for PrEP for HIV Drugs*

(Rev. 13032; Issued: 01-03-25; Effective: 01-01-25; Implementation: 01-06-25)

On September 30, 2024, CMS determined that Pre-Exposure Prophylaxis (PrEP) using antiretroviral drugs to prevent Human Immunodeficiency Virus (HIV) is covered as an additional preventive service under §1861(ddd)(1) of the Act. Specifically, CMS has determined that PrEP using antiretroviral drugs to prevent HIV is reasonable and necessary for the prevention of an illness or disability; is recommended with a grade of A by the United States Preventive Services Task Force (USPSTF); and is appropriate for individuals entitled to Medicare benefits under Part A or enrolled under Part B.

Please see the Medicare National Coverage Determinations (NCD) Manual, Pub 100-03, Section 210.14 for complete coverage requirements for Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) Prevention.

Effective for claims with dates of service on or after September 30, 2024, CMS covers PrEP using antiretroviral drugs approved by the U.S. Food and Drug Administration (FDA) to prevent HIV in individuals at increased risk of HIV acquisition. The determination of whether an individual is at increased risk for HIV is made by the physician or health care practitioner who assesses the individual's history. CMS also covers furnishing HIV PrEP using antiretroviral drugs, including the supplying or dispensing of these drugs and the administration of injectable PrEP.

Medicare Part B coinsurance and deductible are waived for these preventive services.

For claims with dates of service September 30, 2024-December 31, 2024, OPPS payment rates for PrEP for HIV drugs can be found in the October 2024 OPPS Addendum B available: https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/addendum-a-b-updates

For claims with dates of services on or after January 1, 2025, CMS will pay for OPPS PrEP for HIV drugs according to the methodology in section 250.1 of this chapter.

260.1 - Special Partial Hospitalization Billing Requirements for Hospitals, Community Mental Health Centers, and Critical Access Hospitals

(Rev. 13032; Issued: 01-03-25; Effective: 01-01-25; Implementation: 01-06-25)

Medicare Part B coverage is available for hospital outpatient partial hospitalization services.

A. Billing Requirement

Section 1861 (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act defines the services under the partial hospitalization benefit in a hospital.

> Section 1866(e)(2) of the Act (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm)recognizes CMHCs as "providers of services" but only for furnishing partial hospitalization or intensive outpatient services. See §261.1.1 of this chapter for CMHC partial hospitalization bill review directions.

Hospitals and CAHs report condition code 41 in FLs 18-28 (or electronic equivalent) to indicate the claim is for partial hospitalization services. They must also report a revenue code and the charge for each individual covered service furnished. In addition, hospital outpatient departments are required to report HCPCS codes. CAHs are not required to report HCPCS code for this benefit.

Under component billing, hospitals are required to report a revenue code and the charge for each individual covered service furnished under a partial hospitalization program. In addition, hospital outpatient departments are required to report HCPCS codes. Component billing assures that only those partial hospitalization services covered under §1861(ff) of the Act are paid by the Medicare program.

Effective January 1, 2017, non-excepted off-campus provider-based departments of a hospital are required to report a "PN" modifier on each claim line for non-excepted items and services. The use of modifier "PN"

will trigger a payment rate under the Medicare Physician Fee Schedule. We expect the PN modifier to be reported with each nonexcepted item and service including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services.

Excepted off-campus provider-based departments of a hospital must continue to report existing modifier "PO" (Services, procedures and/or surgeries provided at off-campus provider-based outpatient departments) for all excepted items and services furnished. Use of the off-campus PBD modifier became mandatory beginning January 1, 2016.

All hospitals are required to report condition code 41 in FLs 18-28 to indicate the claim is for partial hospitalization services. Hospitals use bill type 13X and CAHs use bill type 85X. The following special procedures apply.

Bills must contain an acceptable revenue code. They are as follows:

Revenue Code Description

0250	Drugs and Biologicals
043X	Occupational Therapy
0900	Behavioral Health Treatment/Services
0904	Activity Therapy
0910	Psychiatric/Psychological Services (Dates of Service prior to October 16, 2003)
0914	Individual Therapy
0915	Group Therapy
0916	Family Therapy
0918	Behavioral Health/Testing
0942	Education/Training

Hospitals other than CAHs are also required to report appropriate HCPCS codes as follows:

Revenue Code	Description	HCPCS Code
043X	Occupational Therapy	*G0129 (PHP/IOP)

0900	Behavioral Health Treatment/Services	****90791 or ***** 90792, 97153, 97154, 97155, 97156, 97157, 97158
0904	Activity Therapy	**G0176 (PHP/IOP)
0914	Individual Psychotherapy	90785, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90880, 90899
0915	Group Therapy	G0410, G0411, 90853
0916	Family Psychotherapy	90846, 90847, 90849
0918	Behavioral Health/Testing	96112, 96116, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146, 96156, 96158, 96161, 96164, 96167, 97151, 97152
0942	Education/Training	G0023, G0024, G0140, G0146, ***G0177, G0451, *G0539, G0540,* 96202, 96203, 97550, 97551, 97552

The A/B MAC (A) will edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. The A/B MAC (A) will not edit for matching the revenue code to HCPCS.

*The definition of code G0129 is as follows:

Occupational therapy services requiring skills of a qualified occupational therapist, furnished as a component of a partial hospitalization or intensive outpatient treatment program, per session (45 minutes or more).

**The definition of code G0176 is as follows:

Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental problems, per session (45 minutes or more).

***The definition of code G0177 is as follows:

Training and educational services related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more).

****The definition of code 90791 is as follows:

Psychiatric diagnostic evaluation (no medical services) completed by a non-physician.

*****The definition of code 90792 is as follows:

Psychiatric diagnostic evaluation (with medical services) completed by a physician.

Codes G0129 and G0176 are used only for intensive outpatient programs or partial hospitalization programs.

Code G0177 may be used in intensive outpatient programs, partial hospitalization programs, and outpatient mental health settings.

Revenue code 0250 does not require HCPCS coding. However, Medicare does not cover drugs that can be self-administered.

Edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. Do not edit for the matching of revenue code to HCPCS.

B. <u>Professional Services</u>

The professional services listed below when provided in all hospital outpatient departments are separately covered and paid as the professional services of physicians and other practitioners. These professional services are unbundled and these practitioners (other than physician assistants (PA) bill the Medicare A/B MAC (B) directly for the professional services furnished to hospital outpatient partial hospitalization patients. The hospital can also serve as a billing agent for these professionals by billing the A/B MAC (B) on their behalf under their billing number for their professional services. The professional services of a PA can be billed to the A/B MAC (B) only by the PA's employer. The employer of a PA may be such entities or individuals as a physician, medical group, professional corporation, hospital, SNF, or nursing facility. For example, if a physician is the employer of the PA and the PA renders services in the hospital, the physician and not the hospital would be responsible for billing the A/B MAC (B) on Form CMS-1500 for the services of the PA. The following direct professional services are unbundled and not paid as partial hospitalization services.

- Physician services that meet the criteria of 42 CFR 415.102, for payment on a fee schedule basis;

- Physician assistant (PA) services as defined in §1861(s)(2)(K)(i) of the Act;

- Nurse practitioner and clinical nurse specialist services, as defined in §1861(s)(2)(K)(ii) of the Act; and

- Clinical psychologist services as defined in §1861(ii) of the Act.

The services of other practitioners (including clinical social workers, marriage and family therapists, mental health counselors, and occupational therapists), are bundled when furnished to hospital patients, including partial hospitalization patients. The hospital must bill the contractor for such nonphysician practitioner services as partial hospitalization services. Make payment for the services to the hospital.

C. Outpatient Mental Health Treatment Limitation

The outpatient mental health treatment limitation may apply to services to treat mental, psychoneurotic, and personality disorders when furnished by physicians, clinical psychologists, NPs, CNSs, and PAs to partial hospitalization patients. However, the outpatient mental health treatment limitation does not apply to such mental health treatment services billed to the A/B MAC (A) by a CMHC or hospital outpatient department as partial hospitalization services.

D. Reporting of Service Units

Hospitals report the number of times the service or procedure, as defined by the HCPCS code, was performed. CAHs report the number of times the revenue code visit was performed.

NOTE: Service units are not required to be reported for drugs and biologicals (Revenue Code 0250).

E. Line Item Date of Service Reporting

Hospitals other than CAHs are required to report line item dates of service per revenue code line for partial hospitalization claims. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are reported in FL 45 “Service Date” (MMDDYY). See §260.5 for a detailed explanation.

F. Payment

Starting in CY 2024 and subsequent years, the payment structure for partial hospitalization services provided in hospital outpatient departments and CMHCs has been set to four (4) separate APCs: Community Mental Health Center PHP APCs 5853 (Level 1 Partial Hospitalization Program (up to 3 services)) and 5854 (Level 2 Partial Hospitalization Program (4 or more services)) and Hospital-based PHP APCs 5863 (Level 1 Partial

Hospitalization Program (up to 3 services)) and 5864 (Level 2 Partial Hospitalization Program (4 or more services)). The following chart displays the CMHC and hospital-based PHP APCs:

Hospital-Based and Community Mental Health Center PHP APCs

CY 2024 APC	Group Title
5853	Partial Hospitalization (3 or fewer services per day) for CMHCs
5854	Partial Hospitalization (4 or more services per day) for CMHCs
5863	Partial Hospitalization (3 or fewer services per day) for hospital-based PHPs
5864	Partial Hospitalization (4 or more services per day) for hospital-based PHPs

Apply Part B deductible, if any, and coinsurance.

G. Data for CWF and PS&R

Include revenue codes, HCPCS/CPT codes, units, and covered charges in the financial data section (fields 65a - 65j), as appropriate. Report the billed charges in field 65h, "Charges," of the CWF record.

Include in the financial data portion of the PS&R UNIBILL, revenue codes, HCPCS/CPT codes, units, and charges, as appropriate.

Future updates will be issued in a Recurring Update Notification.

260.1.1 - Bill Review for Partial Hospitalization Services Provided in Community Mental Health Centers (CMHC)

(Rev. 13032; Issued: 01-03-25; Effective: 01-01-25; Implementation: 01-06-25)

A. General

Medicare Part B coverage for partial hospitalization services provided by CMHCs is available effective for services provided on or after October 1, 1991.

B. Special Requirements

Section 1866(e)(2) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act recognizes CMHCs as "providers of services" but only for furnishing partial hospitalization or intensive outpatient services. Applicable provider ranges are 1400-1499, 4600-4799, and 4900-4999.

C. Billing Requirements

The CMHCs bill for partial hospitalization services under bill type 76X. CMHCs are required to report condition code 41 in FLs 18-28 to indicate the claim is for partial hospitalization program services. The A/B MACs (A) follow bill review instructions in chapter 25 of this manual, except for those listed below.

The acceptable revenue codes are as follows:

Revenue Code	**Description**
0250	Drugs and Biologicals
043X	Occupational Therapy
0900	Behavioral Health Treatments/Services
0904	Activity Therapy
0910	Psychiatric/Psychological Services (Dates of Service prior to October 16, 2003)
0914	Individual Therapy
0915	Group Therapy
0916	Family Therapy
0918	Behavioral Health/Testing
0942	Education/Training

The CMHCs are also required to report appropriate HCPCS codes as follows:

Revenue Codes	**Description**	**HCPCS Code**
043X	Occupational Therapy	*G0129 (PHP/IOP)
0900	Behavioral Health Treatments/Services	****90791 or *****90792, 97153, 97154, 97155, 97156, 97157, 97158
0904	Activity Therapy	**G0176 (PHP/IOP)
0914	Individual Psychotherapy	90785, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90865, 90880, 90899
0915	Group Psychotherapy	G0410, G0411, 90853
0916	Family Psychotherapy	90846, or 90847, 90849
0918	Behavioral Health/Testing	96112, 96116, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 9614696156, 96158,

		96161, 96164, 96167, 97151, 97152
0942	Education/Training	G0023, G0024, G0140, G0146, ***G0177, *G0539, G0540,* G0451, 96202, 96203, 97550, 97551, 97552

The A/B MAC(s) (A) edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. They do not edit for the matching of revenue codes to HCPCS.

Definitions of each of the asterisked HCPCS codes follow:

*The definition of code G0129 is as follows:
Occupational therapy services requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization or intensive outpatient treatment program, per session (45 minutes or more).

**The definition of code G0176 is as follows:
Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more).

***The definition of code G0177 is as follows:
Training and educational services related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more).

****The definition of code 90791 is as follows:
Psychiatric diagnostic evaluation (no medical services) completed by a non-physician.

*****The definition of code 90792 is as follows:
Psychiatric diagnostic evaluation (with medical services) completed by a physician.

Codes G0129 and G0176 are used only for intensive outpatient or partial hospitalization programs.

Code G0177 may be used in partial hospitalization programs, intensive outpatient programs, and outpatient mental health settings.

Revenue code 0250 does not require HCPCS coding. However, drugs that can be self-administered are not covered by Medicare.

HCPCS includes CPT-4 codes. See the ASC X12 837 institutional claim guide for how to report HCPCS electronically. CMHCs report HCPCS codes on Form CMS-1450 in FL44, "HCPCS/Rates." HCPCS code reporting is effective for claims with dates of service on or after April 1, 2000.

The A/B MACs (A) are to advise their CMHCs of these requirements. CMHCs should complete the remaining items on the claim in accordance with the ASC X12 837 Institutional Claim implementation guide and the Form CMS-1450 instructions in Chapter 25 of this manual.

The professional services listed below are separately covered and are paid as the professional services of physicians and other practitioners. These professional services are unbundled and these practitioners (other

than physician assistants (PAs)) bill the A/B MAC (B) directly for the professional services furnished to CMHC partial hospitalization patients. The ASC X12 837 professional claim format or the paper form 1500 is used.

The CMHC can also serve as a billing agent for these professionals by billing the A/B MAC (B) on their behalf for their professional services. The professional services of a PA can be billed to the A/B MAC (B) only by the PAs employer. The employer of a PA may be such entities or individuals as a physician, medical group, professional corporation, hospital, SNF, or nursing facility. For example, if a physician is the employer of the PA and the PA renders services in the CMHC, the physician and not the CMHC would be responsible for billing the A/B MAC (B) for the services of the PA.

The following professional services are unbundled and not paid as partial hospitalization services:

- Physician services that meet the criteria of 42 CFR 415.102, for payment on a fee schedule basis;

- PA services, as defined in §1861(s)(2)(K)(i) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act;

- Nurse practitioner and clinical nurse specialist services, as defined in §1861(s)(2)(K)(ii) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act; and,

- Clinical psychologist services, as defined in §1861(ii) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act.

The services of other practitioners (including clinical social workers and occupational therapists) are bundled when furnished to CMHC patients. The CMHC must bill the A/B MAC (A) for such nonphysician practitioner services as partial hospitalization services. The A/B MAC (A) makes payment for the services to the CMHC.

D. Outpatient Mental Health Treatment Limitation

The outpatient mental health treatment limitation **may apply** to services to treat mental, psychoneurotic, and personality disorders when furnished by physicians, clinical psychologists, NPs, CNSs, and PAs to partial hospitalization patients. However, the outpatient mental health treatment limitation **does not** apply to such mental health treatment services billed to the A/B MAC (A) as partial hospitalization services.

E. Reporting of Service Units

Visits should no longer be reported as units. Instead, CMHCs report in the field, "Service Units," the number of times the service or procedure, as defined by the HCPCS code, was performed when billing for partial hospitalization services identified by revenue code in subsection C.

EXAMPLE: A beneficiary received psychological testing performed by a physician for a total of 3 hours during one day (HCPCS code 96130, first hour; HCPCS code 96131 for 2 additional hours). The CMHC reports revenue code 0918, HCPCS code 96130, and 1 unit; and a second line on the claim showing revenue code 918, HCPCS code 96131, and 2 units.

When reporting service units for HCPCS codes where the definition of the procedure does not include any reference to time (either minutes, hours or days), CMHCs should not bill for sessions of less than 45 minutes.

The CMHC need not report service units for drugs and biologicals (Revenue Code 0250).

NOTE: Information regarding the Form CMS-1450 form locators that correspond with these fields is found in Chapter 25 of this manual. See the ASC X12 837 Institutional Claim implementation guide for related guidelines for the electronic claim.

F. Line Item Date of Service Reporting

Dates of service per revenue code line for partial hospitalization claims that span two or more dates. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are reported in "Service Date". See examples below of reporting line item dates of service. These examples are for group therapy services provided twice during a billing period.

For claims, report as follows:

Revenue Code	HCPCS	Dates of Service	Units	Total Charges
0915	G0410	20240505	1	$80
0915	G0410	20240529	2	$160

NOTE: Information regarding the Form CMS-1450 form locators that correspond with these fields is found in Chapter 25 of this manual. See the ASC X12 837 Institutional Claim Implementation Guide for related guidelines for the electronic claim.

The A/B MACs (A) return to provider claims that span two or more dates if a line item date of service is not entered for each HCPCS code reported or if the line item dates of service reported are outside of the statement covers period. Line item date of service reporting is effective for claims with dates of service on or after June 5, 2000.

G. Payment

Section 1833(a)(2)(B) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act provides the statutory authority governing payment for partial hospitalization services provided by a CMHC. A/B MAC(s) (A) made payment on a reasonable cost basis until OPPS was implemented. The Part B deductible and coinsurance applied.

Payment principles applicable to partial hospitalization services furnished in CMHCs are contained in §2400 of the Medicare Provider Reimbursement Manual.

The A/B MACs (A) make payment on a per diem basis under the hospital outpatient prospective payment system for partial hospitalization services. CMHCs must continue to maintain documentation to support medical necessity of each service provided, including the beginning and ending time.

Effective January 1, 2011, there were four separate APC payment rates for PHP: two for CMHCs (for Level I and Level II services based on only CMHC data) and two for hospital-based PHPs (for Level I and Level II services based on only hospital-based PHP data).

The two CMHC APCS for providing partial hospitalization services were: APC 5851 (Level 1 Partial Hospitalization (3 services)) and APC 5852 (Level 2 Partial Hospitalization (4 or more services)). Effective January 1, 2017, APCs 5851 and 5852 were combined into one new APC 5853 (Partial Hospitalization (3 or more services) for CMHCs).

Effective January 1, 2024, there are two APC payment rates for CMHC PHPs: APC 5853 (Level 1 Partial Hospitalization (3 or fewer services per day)) and APC 5854 (Level 2 Partial Hospitalization (4 or more services per day)).

Community Mental Health Center PHP APC

APC	Group Title
5853	Partial Hospitalization (3 or fewer services per day) for CMHCs
5854	Partial Hospitalization (4 or more services per day) for CMHCs

NOTE: Occupational therapy services provided to partial hospitalization patients are not subject to the prospective payment system for outpatient rehabilitation services, and therefore the financial limitation required under §4541 of the Balanced Budget Act (BBA) does not apply.

H. Medical Review

The A/B MACs (A) follow medical review guidelines in Pub. 100-08, Medicare Program Integrity Manual.

I. Coordination with CWF

See chapter 27 of this manual. All edits for bill type 74X apply, except provider number ranges 4600-4799 are acceptable only for services provided on or after October 1, 1991.

261.1 - Special Intensive Outpatient Program Billing Requirements for Hospitals, Community Mental Health Centers, and Critical Access Hospitals

(Rev. 13032; Issued: 01-03-25; Effective: 01-01-25; Implementation: 01-06-25)

Medicare Part B coverage is available for hospital outpatient intensive outpatient program services.

A. Billing Requirement

Section 1861 (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act defines the services under the intensive outpatient program benefit in a hospital.

Section 1866(e)(2) of the Act (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) recognizes CMHCs as "providers of services" but only for furnishing intensive outpatient program and partial hospitalization services. See §261.1.1 of this chapter for CMHC intensive outpatient program bill review directions.

Hospitals and CAHs report condition code "92" in FLs 18-28 (or electronic equivalent) to indicate the claim is for intensive outpatient program services. They must also report a revenue code and the charge for each individual covered service furnished. In addition, hospital outpatient departments are required to report HCPCS codes. CAHs are not required to report HCPCS code for this benefit.

Under component billing, hospitals are required to report a revenue code and the charge for each individual covered service furnished under an intensive outpatient program. In addition, hospital outpatient departments are required to report HCPCS codes. Component billing assures that only those intensive outpatient program services covered under §1861(ff) of the Act are paid by the Medicare program.

Effective January 1, 2024, for intensive outpatient program services, non-excepted off-campus provider-based departments of a hospital are required to report a "PN" modifier on each claim line for non-excepted items and services. The use of modifier "PN" will trigger a payment rate under the Medicare Physician Fee Schedule. We expect the PN modifier to be reported with each non-excepted item and service including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services.

Effective January 1, 2024, for intensive outpatient program services, excepted off-campus provider-based departments of a hospital must continue to report existing modifier "PO" (Services, procedures, and/or surgeries provided at off-campus provider-based outpatient departments) for all excepted items and services furnished.

All hospitals are required to report condition code "92" in FLs 18-28 to indicate the claim is for intensive outpatient program services. Hospitals use bill type 013X and CAHs use bill type 085X. The following special procedures apply.

Bills must contain an acceptable revenue code. They are as follows:

Revenue Code	Description
0250	Drugs and Biologicals
043X	Occupational Therapy
0900	Behavioral Health Treatment/Services

Revenue Code	Description
0904	Activity Therapy
0910	Psychiatric/Psychological Services (Dates of Service prior to October 16, 2003)
0914	Individual Therapy
0915	Group Therapy
0916	Family Therapy
0918	Behavioral Health/Testing
0942	Education/Training

Hospitals other than CAHs are also required to report appropriate HCPCS codes as follows:

Revenue Code	Description	HCPCS Code
043X	Occupational Therapy	*G0129 (PHP/IOP)
0900	Behavioral Health Treatment/Services	****90791 or ***** 90792, 97153, 97154, 97155, 97156, 97157, 97158
0904	Activity Therapy	**G0176 (PHP/IOP)
0914	Individual Psychotherapy	90785, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90865, 90880, 90899
0915	Group Therapy	G0410, G0411, 90853
0916	Family Psychotherapy	90846, 90847, 90849
0918	Behavioral Health/Testing	96112, 96116, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146, 96156, 96158, 96161, 96164, 96167, 97151, 97152
0942	Education/Training	G0023, G0024, G0140, G0146, ***G0177, G0451, *G0539, G0540,* 96202, 96203, 97550, 97551, 97552

The A/B MAC (A) will edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. The A/B MAC (A) will not edit for matching the revenue code to HCPCS.

*The definition of code G0129 is as follows:

Occupational therapy services requiring skills of a qualified occupational therapist, furnished as a component of a partial hospitalization or intensive outpatient treatment program, per session (45 minutes or more).

**The definition of code G0176 is as follows:

Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental problems, per session (45 minutes or more).

***The definition of code G0177 is as follows:

Training and educational services related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more).

****The definition of code 90791 is as follows:

Psychiatric diagnostic evaluation (no medical services) completed by a nonphysician.

*****The definition of code 90792 is as follows:

Psychiatric diagnostic evaluation (with medical services) completed by a physician.

Codes G0129 and G0176 are used only for intensive outpatient programs or partial hospitalization programs.

Code G0177 may be used in intensive outpatient programs, partial hospitalization programs, and outpatient mental health settings.

Revenue code 0250 does not require HCPCS coding. However, Medicare does not cover drugs that can be self-administered.

Edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. Do not edit for the matching of revenue code to HCPCS.

B. Professional Services

The professional services listed below when provided in all hospital outpatient departments are separately covered and paid as the professional services of physicians and other practitioners. These professional services are unbundled and these practitioners (other than physician assistants (PA)) bill the Medicare A/B MAC (B) directly for the professional services furnished to hospital outpatient intensive outpatient program patients. The hospital can also serve as a billing agent for these professionals by billing the A/B MAC (B) on their behalf under their billing number for their professional services. The professional services of a PA can be billed to the A/B MAC (B) only by the PA's employer. The employer of a PA may be such entities or individuals as a physician, medical group, professional corporation, hospital, SNF, or nursing facility. For example, if a physician is the employer of the PA and the PA renders services in the hospital, the physician and not the hospital would be responsible for billing the A/B MAC (B) on Form CMS-1500 for the services of the PA. The following direct professional services are unbundled and not paid as intensive outpatient program services.

- Physician services that meet the criteria of 42 CFR 415.102, for payment on a fee schedule basis;

- Physician assistant (PA) services as defined in §1861(s)(2)(K)(i) of the Act;

- Nurse practitioner and clinical nurse specialist services, as defined in §1861(s)(2)(K)(ii) of the Act; and

- Clinical psychologist services as defined in §1861(ii) of the Act.

The services of other practitioners (including clinical social workers, marriage and family therapists, mental health counselors, and occupational therapists) are bundled when furnished to hospital patients, including intensive outpatient program patients. The hospital must bill the contractor for such nonphysician practitioner services as partial hospitalization services. Make payment for the services to the hospital.

C. Outpatient Mental Health Treatment Limitation

The outpatient mental health treatment limitation may apply to services to treat mental, psychoneurotic, and personality disorders when furnished by physicians, clinical psychologists, NPs, CNSs, and PAs to intensive outpatient program patients. However, the outpatient mental health treatment limitation does not apply to such mental health treatment services billed to the A/B MAC (A) by a CMHC or hospital outpatient department as intensive outpatient program services.

D. Reporting of Service Units

Hospitals report the number of times the service or procedure, as defined by the HCPCS code, was performed. CAHs report the number of times the revenue code visit was performed.

NOTE: Service units are not required to be reported for drugs and biologicals (Revenue Code 0250).

E. Line Item Date of Service Reporting

Hospitals other than CAHs are required to report line item dates of service per revenue code line for intensive outpatient program claims. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are reported in FL 45 "Service Date" (MMDDYY). See §260.5 for a detailed explanation.

F. Payment

Starting in CY 2024 and subsequent years, the payment structure for intensive outpatient program services provided in hospital outpatient departments and CMHCs has been set to four (4) separate APCs. Community Mental Health Center IOP APCs 5851 (Level 1 Intensive Outpatient Program (up to 3 services)) and 5852 (Level 2 Intensive Outpatient Program (4 or more services)) and Hospital-based IOP APCs 5861 (Level 1 Intensive Outpatient Program (up to 3 services)) and 5862 (Level 2 Intensive Outpatient Program (4 or more services)). The following chart displays the CMHC and hospital-based IOP APCs:

Hospital-Based and Community Mental Health Center IOP APCs

CY 2024 APC	Group Title
5851	Intensive Outpatient Program (up to 3 services per day) for CMHC IOPs
5852	Intensive Outpatient Program (4 or more services per day) for CMHC IOPs
5861	Intensive Outpatient Program (up to 3 services per day) for hospital-based IOPs
5862	Intensive Outpatient Program (4 or more services per day) for hospital-based IOPs

Apply Part B deductible, if any, and coinsurance.

G. Data for CWF and PS&R

Include revenue codes, HCPCS/CPT codes, units, and covered charges in the financial data section (fields 65a–65j), as appropriate. Report the billed charges in field 65h, "Charges," of the CWF record.

Include in the financial data portion of the PS&R UNIBILL, revenue codes, HCPCS/CPT codes, units, and charges, as appropriate.

Future updates will be issued in a Recurring Update Notification.

261.1.1 - Bill Review for Intensive Outpatient Program Services Provided in Community Mental Health Centers (CMHC)

(Rev. 13032; Issued: 01-03-25; Effective: 01-01-25; Implementation: 01-06-25)

A. General

Medicare Part B coverage for intensive outpatient program services provided by CMHCs is available for services provided on or after January 1, 2024.

B. Special Requirements

Section 1866(e)(2) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act recognizes CMHCs as “providers of services” but only for furnishing intensive outpatient program and partial hospitalization services. Applicable provider ranges are 1400–1499, 4600–4799, and 4900–4999.

C. Billing Requirements

CMHCs bill for intensive outpatient program services under bill type 076X. All CMHCs are required to report condition code 92 in FLs 18-28 to indicate the claim is for intensive outpatient program services. The following special procedures apply.
The A/B MACs (A) follow bill review instructions in chapter 25 of this manual, except for those listed below.

The acceptable revenue codes are as follows:

Revenue Code	Description
0250	Drugs and Biologicals
043X	Occupational Therapy
0900	Behavioral Health Treatments/Services
0904	Activity Therapy
0910	Psychiatric/Psychological Services (Dates of Service prior to October 16, 2003)
0914	Individual Therapy
0915	Group Therapy
0916	Family Therapy
0918	Behavioral Health/Testing
0942	Education/Training

CMHCs are also required to report appropriate HCPCS codes as follows:

Revenue Codes	Description	HCPCS Code
043X	Occupational Therapy	*G0129 (PHP/IOP)
0900	Behavioral Health Treatments/Services	****90791 or *****90792, 97153, 97154, 97155, 97156, 97157, 97158
0904	Activity Therapy	**G0176 (PHP/IOP)
0914	Individual Psychotherapy	90785, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90865, 90880, 90899
0915	Group Psychotherapy	G0410, G0411, 90853
0916	Family Psychotherapy	90846, 90847, 90849
0918	Behavioral Health/Testing	96112, 96116, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146, 96156, 96158, 96161, 96164, 96167, 97151, 97152
0942	Education/Training	G0023, G0024, G0140, G0146, ***G0177, G0451, *G0539, G0540,* 96202, 96203, 97550, 97551, 97552

The A/B MAC(s) (A) edit to assure that HCPCS are present when the above revenue codes are billed and that they are valid HCPCS codes. They do not edit for the matching of revenue codes to HCPCS.

Definitions of each of the asterisked HCPCS codes follow:

*The definition of code G0129 is as follows:
Occupational therapy services requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization or intensive outpatient treatment program, per session (45 minutes or more).

**The definition of code G0176 is as follows:
Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more).

***The definition of code G0177 is as follows:
Training and educational services related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more).

****The definition of code 90791 is as follows:
Psychiatric diagnostic evaluation (no medical services) completed by a nonphysician.

*****The definition of code 90792 is as follows:
Psychiatric diagnostic evaluation (with medical services) completed by a physician.

Codes G0129 and G0176 are used only for intensive outpatient program and partial hospitalization programs.

Code G0177 may be used in intensive outpatient programs, partial hospitalization programs, and outpatient mental health settings.

Revenue code 0250 does not require HCPCS coding. However, drugs that can be self-administered are not covered by Medicare.

HCPCS includes CPT-4 codes. See the ASC X12 837 institutional claim guide for how to report HCPCS electronically. CMHCs report HCPCS codes on Form CMS-1450 in FL44, "HCPCS/Rates." HCPCS code reporting is effective for claims with dates of service on or after April 1, 2000.

The A/B MACs (A) are to advise their CMHCs of these requirements. CMHCs should complete the remaining items on the claim in accordance with the ASC X12 837 Institutional Claim implementation guide and the Form CMS-1450 instructions in Chapter 25 of this manual.

The professional services listed below are separately covered and are paid as the professional services of physicians and other practitioners. These professional services are unbundled and these practitioners (other than physician assistants (PAs)) bill the A/B MAC (B) directly for the professional services furnished to CMHC intensive outpatient program patients. The ASC X12 837 professional claim format or the paper form 1500 is used. The CMHC can also serve as a billing agent for these professionals by billing the A/B MAC (B) on their behalf for their professional services. The professional services of a PA can be billed to the A/B MAC (B) only by the PA's employer. The employer of a PA may be such entities or individuals as a physician, medical group, professional corporation, hospital, SNF, or nursing facility. For example, if a physician is the employer of the PA and the PA renders services in the CMHC, the physician and not the CMHC would be responsible for billing the A/B MAC (B) for the services of the PA.

The following professional services are unbundled and not paid as partial hospitalization services:

- Physician services that meet the criteria of 42 CFR 415.102, for payment on a fee schedule basis;

- PA services, as defined in §1861(s)(2)(K)(i) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act;

- Nurse practitioner and clinical nurse specialist services, as defined in §1861(s)(2)(K)(ii) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act; and,

- Clinical psychologist services, as defined in §1861(ii) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act.

The services of other practitioners (including clinical social workers and occupational therapists) are bundled when furnished to CMHC patients. The CMHC must bill the A/B MAC (A) for such nonphysician practitioner services as intensive outpatient program services. The A/B MAC (A) makes payment for the services to the CMHC.

D. Outpatient Mental Health Treatment Limitation

The outpatient mental health treatment limitation **may apply** to services to treat mental, psychoneurotic, and personality disorders when furnished by physicians, clinical psychologists, NPs, CNSs, and PAs to intensive outpatient program patients. However, the outpatient mental health treatment limitation **does not** apply to such mental health treatment services billed to the A/B MAC (A) as intensive outpatient program services.

E. Reporting of Service Units

Visits should no longer be reported as units. Instead, CMHCs report in the field, "Service Units," the number of times the service or procedure, as defined by the HCPCS code, was performed when billing for intensive outpatient program services identified by revenue code in subsection C.

EXAMPLE: A beneficiary received psychological testing performed by a physician for a total of 3 hours during one day (HCPCS code 96130, first hour; HCPCS code 96131 for 2 additional hours). The CMHC reports revenue code 0905, HCPCS code 96130, and 1 unit; and a second line on the claim showing revenue code 0905, HCPCS code 96131, and 2 units.

When reporting service units for HCPCS codes where the definition of the procedure does not include any reference to time (either minutes, hours, or days), CMHCs should not bill for sessions of less than 45 minutes.

The CMHC need not report service units for drugs and biologicals (Revenue Code 0250).

NOTE: Information regarding the Form CMS-1450 form locators that correspond with these fields is found in Chapter 25 of this manual. See the ASC X12 837 Institutional Claim implementation guide for related guidelines for the electronic claim.

F. Line Item Date of Service Reporting

Dates of service per revenue code line for intensive outpatient claims that span two or more dates. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are reported in "Service Date". See examples below of reporting line item dates of service. These examples are for group therapy services provided twice during a billing period.

For claims, report as follows:

Revenue Code	HCPCS	Dates of Service	Units	Total Charges
0915	G0410	20240505	1	$80
0915	G0410	20240529	2	$160

NOTE: Information regarding the Form CMS-1450 form locators that correspond with these fields is found in Chapter 25 of this manual. See the ASC X12 837 Institutional Claim Implementation Guide for related guidelines for the electronic claim.

The A/B MACs (A) return to provider claims that span two or more dates if a line item date of service is not entered for each HCPCS code reported or if the line item dates of service reported are outside of the statement covers period. Line item date of service reporting is effective for claims with dates of service on or after June 5, 2000.

G. Payment

Section 1833(a)(2)(B) (http://www.socialsecurity.gov/OP_Home/ssact/title18/1800.htm) of the Act provides the statutory authority governing payment for intensive outpatient program services provided by a CMHC. A/B MAC(s) (A) make payment under OPPS. The Part B deductible and coinsurance applied.

Payment principles applicable to intensive outpatient program services furnished in CMHCs are contained in §2400 of the Medicare Provider Reimbursement Manual.

The A/B MACs (A) make payment on a per diem basis under the hospital outpatient prospective payment system for intensive outpatient program services. CMHCs must continue to maintain documentation to support medical necessity of each service provided, including the beginning and ending time.

Effective January 1, 2024, there are four separate APC payment rates for IOP: two for CMHCs (for Level I and Level II services based on only CMHC data) and two for hospital-based PHPs (for Level I and Level II services based on only hospital-based IOP data).

The two CMHC APCS for providing intensive outpatient program services are: APC 5851 (Level 1 intensive outpatient program (up to 3 services)) and APC 5852 (Level 2 intensive outpatient program (4 or more services)).

Community Mental Health Center IOP APC

APC	Group Title
5851	Intensive Outpatient Program (3 or more services per day) for CMHCs
5852	Intensive Outpatient Program (4 or more services per day) for CMHCs

NOTE: Occupational therapy services provided to Intensive Outpatient Program for CMHCs' patients are not subject to the prospective payment system for outpatient rehabilitation services, and therefore the financial limitation required under §4541 of the Balanced Budget Act (BBA) does not apply.

H. Medical Review

The A/B MACs (A) follow medical review guidelines in Pub. 100-08, Medicare Program Integrity Manual.

I. Coordination with CWF

See chapter 27 of this manual.

Medicare Claims Processing Manual
Chapter 17 - Drugs and Biologicals

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(Rev. 13032, Issued:01-03-25)

Transmittals for Chapter 17

90.2 - Drugs, Biologicals, and Radiopharmaceuticals

(Rev. 13032; Issued: 01-03-25; Effective: 01-01-25; Implementation: 01-06-25)

A. General Billing and Coding for Hospital Outpatient Drugs, Biologicals, and Radiopharmaceuticals

Hospitals should report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. It is also of great importance that hospitals billing for these products make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used in the care of the patient.

Payment for drugs, biologicals and radiopharmaceuticals under the OPPS is inclusive of both the acquisition cost and the associated pharmacy overhead or nuclear medicine handling cost. Hospitals should include these costs in their line-item charges for drugs, biologicals, and radiopharmaceuticals.

Under the OPPS, if commercially available products are being mixed together to facilitate their concurrent administration, the hospital should report the quantity of each product (reported by HCPCS code) used in the care of the patient. Alternatively, if the hospital is compounding drugs that are not a mixture of commercially available products but are a different product that has no applicable HCPCS code, then the hospital should report an appropriate unlisted drug code (J9999 or J3490). In these situations, it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, Unclassified drug or biological, is for new drugs and biologicals that are approved by FDA on or after January 1, 2004, for which a specific HCPCS code has not been assigned.

The HCPCS code list of retired codes and new HCPCS codes reported under the hospital OPPS is published quarterly via Recurring Update Notifications. The latest payment rates associated with each APC and HCPCS code may be found in the most current Addendum A and Addendum B, respectively that can be found under the CMS quarterly provider updates on the CMS Web site at:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html

Future updates will be issued in a Recurring Update Notification.

B. Pass-Through Drugs, Biologicals, and Radiopharmaceuticals

Payment for drugs, biologicals, and radiopharmaceuticals may be made under the pass-through provision which provides additional payments for drugs, biologicals, and radiopharmaceuticals that meet certain requirements relating to newness and relative costs. According to section 1833(t) of the Social Security Act, transitional pass-through payments can be made for at least 2 years, but no more than 3 years. For the process and information required to apply for transitional pass-through payment status for drugs, biologicals, and radiopharmaceuticals, go to the main OPPS Web page, currently at:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html to see the latest instructions. (**NOTE:** Due to the continuing development of the new cms.hhs.gov Web site, this link may change.) Payment rates for pass-through drugs, biologicals, and radiopharmaceuticals are updated quarterly. The all-inclusive list of billable drugs, biologicals, and radiopharmaceuticals for pass-through payment is included in the current quarterly Addendum B. The most current Addendum B can be found under the CMS quarterly provider updates on the CMS website.

C. Non Pass-Through Drugs and Biologicals

Under the OPPS, drugs and biologicals that are not granted pass-through status receive either packaged payment or separate payment. Payment for drugs and biologicals with estimated per day costs equal to or below the applicable drug packaging threshold is packaged into the payment for the associated procedure, commonly a drug administration procedure. Drugs and biologicals with per day costs above the applicable drug packaging

threshold are paid separately through their own APCs. *Additionally, certain categories of policy packaged drugs per 42 CFR § 419.2.b.*

D. Radiopharmaceuticals

1. General

Beginning in CY 2008, the OPPS divides radiopharmaceuticals into two groups for payment purposes: diagnostic and therapeutic. Diagnostic radiopharmaceuticals function effectively as products that enable the provision of an independent service, specifically, a diagnostic nuclear medicine scan. Therapeutic radiopharmaceuticals are themselves the primary therapeutic modality.

Beginning January 1, 2008, the I/OCE requires claims with separately payable nuclear medicine procedures to include a radiolabeled product (i.e., diagnostic radiopharmaceutical, therapeutic radiopharmaceutical, or brachytherapy source). Hospitals are required to submit the HCPCS code for the radiolabeled product on the same claim as the HCPCS code for the nuclear medicine procedure. Hospitals are also instructed to submit the claim so that the services on the claim each reflect the date the particular service was provided. Therefore, if the nuclear medicine procedure is provided on a different date of service from the radiolabeled product, the claim will contain more than one date of service. More information regarding these edits is available on the OPPS Web site at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html

There are rare situations where a hospital provides a radiolabeled product to an inpatient, and then the patient is discharged and later returns to the outpatient department for a nuclear medicine imaging procedure but does not require additional radiolabeled product. In these situations, hospitals are to include HCPCS code C9898 (Radiolabeled product provided during a hospital inpatient stay) with a token charge (of less than $1.01) on the same claim as the nuclear medicine procedure in order to receive payment for the nuclear medicine procedure. HCPCS code C9898 should only be reported under the circumstances described above, and the date of service for C9898 should be the same as the date of service for the diagnostic nuclear medicine procedure.

2. Diagnostic Radiopharmaceuticals

Beginning in CY 2008, payment for *all* nonpass-through diagnostic radiopharmaceuticals *was* packaged into the payment for the associated nuclear medicine procedure. *Starting in CY 2025, for a nonpass-through diagnostic radiopharmaceutical with per-day costs above the per-day diagnostic radiopharmaceutical packaging threshold for the applicable year, the OPPS will pay for diagnostic radiopharmaceuticals by calculating the mean unit cost (MUC) using the most recently available claims data for that therapeutic radiopharmaceutical, if claims data are available. If claims data are not available, CMS will determine the ASP for the diagnostic radiopharmaceutical for the quarter established under the methodology described by section 1847A of the Act. If ASP data are not available, then based on the wholesale acquisition cost (WAC), under the methodology described by section 1847A of the Act. If WAC data are not available, then based on 95 percent of the average wholesale price.*

3. Therapeutic Radiopharmaceuticals

The OPPS will continue to pay for therapeutic radiopharmaceuticals at charges adjusted to cost from January 1, 2008, through December 31, 2009
Starting in CY 2025, the OPPS will pay for nonpass-through therapeutic radiopharmaceuticals at their average sales price (ASP) for the therapeutic radiopharmaceutical for the quarter established under the methodology described by section 1847A of the Act. If that amount is not available, then CMS will calculate the mean unit cost (MUC) using the most recently available claims data for that therapeutic radiopharmaceutical.

E. Biosimilars

The payment rate for biosimilars is calculated as the Average Sales Price (ASP) of the biosimilar described by the HCPCS code + 6 percent of the ASP of the biosimilar reference product. Biosimilars will also continue to be eligible for transitional pass-through payment for which payment will be made at ASP of the biosimilar described by the HCPCS code + 6 percent of the ASP of the biosimilar reference product.

F. 340B-Acquired Drugs

January 1, 2018 *through September 27, 2022,* separately payable Part B drugs and biologicals (assigned status indicator "K"), other than vaccines (assigned status indicator "L" or "M") and drugs and biologicals on pass-through payment status (assigned status indicator "G"), that *were* acquired through the 340B Program or through the 340B prime vendor program *were* paid at the ASP minus 22.5 percent of the ASP of the drug or biological when billed by a hospital paid under the OPPS that is not excepted from the payment adjustment. Biosimilars that *were* acquired through the 340B Program or through the 340B prime vendor program *were* paid at the ASP minus 22.5 percent of the ASP of the drug or biological when billed by a hospital paid under the OPPS that is not excepted from the payment adjustment. Hospital types that *were* excepted from the 340B payment policy in CY 2018 include rural sole community hospitals (SCHs), children's hospitals, and PPS exempt cancer hospitals. Critical Access Hospitals and Maryland waiver hospitals are not paid under the OPPS and therefore *were* not impacted by this policy. Medicare *paid* separately payable drugs and biologicals that were not purchased with a 340B discount at ASP *plus* 6 percent. In addition, *starting* January 1, 2018, hospitals paid under the OPPS that are not excepted from the 340B drug payment policy for CY 2018, *were* required to report modifier "JG" (Drug or biological acquired with 340B Drug Pricing Program Discount) on the same claim line as the drug HCPCS code to identify a 340B-acquired drug. Since rural SCHs, children's hospitals and PPS-exempt cancer hospitals *were* excepted from the 340B payment adjustment in CY 2018, these hospitals *were* required to report informational modifier "TB" (Drug or Biological Acquired With 340B Drug Pricing Program Discount, Reported for Informational Purposes) for 340B-acquired drugs.
The Supreme Court held CMS could not vary the payment rates for outpatient prescription drugs by hospital group. Therefore, on November 8, 2023, CMS published the Hospital Outpatient Prospective Payment System: Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018 – 2022. Under that final rule, affected hospitals were paid a one-time lump-sum amount based on the difference between what they were paid for 340B-acquired drugs from CY 2018 through September 27, 2022, and what they would have been paid during this time-period had the 340B Drug Payment Policy never existed.
OPPS 340B acquired drugs and biologicals are currently paid no differently than drugs and biologicals not acquired through the 340B program. Beginning on January 1, 2025, all 340B covered entities, including hospital-based and non-hospital-based entities, that submit claims for separately payable Part B drugs and biologicals are to report modifier "TB" on claim lines for drugs acquired through the 340B Program.

102 - Payment for Drugs Classified as Non-Opioid Treatments for Pain Relief Under the OPPS and ASC Payment System

(Rev. 13032; Issued: 01-03-25; Effective: 01-01-25; Implementation: 01-06-25)

The Consolidated Appropriations Act (CAA), 2023 (Pub. L. 117-328), was signed into law on December 29, 2022. Section 4135(a) and (b) of the CAA, 2023, titled Access to Non-Opioid Treatments for Pain Relief, amended section 1833(t)(16) and section 1833(i) of the Social Security Act, respectively, to provide for temporary additional payments for non-opioid treatments for pain relief (as that term is defined in section 1833(t)(16)(G)(i) of the Act).

102.1 - Qualifying Criteria for Payment for Drugs and Biologicals Classified as Non-Opioid Treatments for Pain Relief Under the OPPS and ASC Payment System

(Rev. 13032; Issued: 01-03-25; Effective: 01-01-25; Implementation: 01-06-25)

Eligibility for separate payment for non-opioid pain management drugs and biologicals. From January 1, 2025, through December 31, 2027, a non-opioid drug or biological is eligible for separate payment for an applicable calendar year if CMS determines it meets the following requirements through that year's rulemaking:
(1) The drug is approved under a new drug application under section 505(c) of the Federal Food, Drug, and Cosmetic Act (FDCA), under an abbreviated new drug application under section 505(j) of the FDCA, or, in the case of a biological product, is licensed under section 351 of the Public Health Service Act. The product also has a label indication approved by the Food and Drug Administration to reduce postoperative pain, or produce postsurgical or regional analgesia, without acting upon the body's opioid receptors.
(2) The drug or biological does not have transitional pass-through payment status under 42 CFR § 419.64. In the case where a drug or biological otherwise meets the requirements under this section and has transitional pass-through payment status that expires during the calendar year, the drug or biological will qualify for separate payment during such calendar year on the first day of the next quarter following the expiration of its pass-through status.
(3) The drug or biological has payment that is packaged into a payment for a covered outpatient department (OPD) service (or group of services).

102.2 - Payment amount for Drugs Classified as Non-Opioid Treatments for Pain Relief Under the OPPS and ASC Payment System

(Rev. 13032; Issued: 01-03-25; Effective: 01-01-25; Implementation: 01-06-25)

From January 1, 2025, through December 31, 2027, the amount of payment for a qualifying non-opioid treatment for pain relief is as follows:
(1) For a qualifying drug or biological as defined in paragraph 110.1 of this chapter, the amount of payment is the amount determined under section 1847A of the Act for the drug or biological that exceeds the portion of the otherwise applicable Medicare OPD fee schedule amount, subject to the payment limitation in which payment for qualifying drugs or biologicals shall not exceed the estimated average of 18 percent of the OPD fee schedule amount of the volume weighted average of the most frequent five OPD primary procedures into which a non-opioid treatment for pain relief would be packaged. These payment limitations are including in annual OPPS/ASC rulemaking.