CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 12421	**Date: December 21, 2023**
	Change Request 13488

SUBJECT: January 2024 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 2024 Outpatient Prospective Payment System (OPPS) update. The January 2024 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, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2024

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	4/10.2.3 /Comprehensive APCs

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:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 12421	Date: December 21, 2023	Change Request: 13488

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I. GENERAL INFORMATION

A. Background: This Change Request (CR) implements instructions on coding changes and policy updates that are effective January 1, 2024 for the Hospital OPPS. The updates include coding and policy changes for new services, pass-through drug and devices, Covid-19 treatments, PLA codes and other items and services. The January 2024 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming January 2024 I/OCE CR.

B. Policy: 1. Changes to Covid-19 CPT Vaccines and Administration Codes

The American Medical Association (AMA) has been issuing unique Current Procedural Terminology (CPT) Category I codes, which are developed based on collaboration with the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC), for each coronavirus vaccine as well as administration codes unique to each such vaccine and dose. These codes are effective upon receiving Emergency Use Authorization (EUA) or approval from the Food and Drug Administration (FDA).

Based on recent recommendations made by the Food and Drug Administration (FDA), the Current Procedural Terminology (CPT®) Editorial Panel (the Panel) has approved new monovalent COVID-19 vaccine product CPT codes for Pfizer and Moderna vaccines and one new CPT code describing the service to administer the vaccines. The Panel approved CPT codes 91318, 91319, 91320, 91321, 91322, and 90480. CPT codes: 91318, 91319, and 91320 were approved for the new monovalent vaccine products from Pfizer; and CPT codes 91321 and 91322 were approved for the new monovalent vaccine products from Moderna. In addition, a new vaccine administration code (CPT code 90480) was approved for reporting the administration of any COVID-19 vaccine for any patient (pediatric or adult), replacing all previously approved specific vaccine administration codes.

The new vaccine product and administration codes become effective upon receiving authorization or approval from the FDA. FDA approval was received on 9/11/23.

Therefore, effective September 11, 2023, CPT codes: 91318, 91319, 91320, 91321, and 91322 are assigned to status indicator “L;” and CPT code 90480 is assigned to status indicator “S,” and APC 9398 in the January 2024 I/OCE Update.

All previously approved COVID-19 vaccine product and vaccine administration codes are deleted from the January 2024 I/OCE update effective November 1, 2023. The exception is vaccine product code CPT code 91304, which represents the Novavax COVID-19 vaccine product, which remains active.

The Novavax COVID-19 vaccine continues to be available for use; however, the vaccine administration codes (CPT codes 0041A, 0042A, and 0044A) that were previously used for reporting its administration are deleted. CPT code 90480 should be used to report administration of the Novavax vaccine.

Table 1, attachment A, lists the deleted COVID-19 vaccine products and administration codes.

Table 2, attachment A, lists the long descriptors for the active codes. These codes, along with their short descriptors, status indicators, and payment rates (where applicable) are also listed in the January 2024 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 2024 Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center (ASC) final rule for the latest definitions.

2. Updates to Covid-19 Ambulatory Payment Classifications (APCs)

Effective January 1, 2024, only two COVID-19 APCs listed below remain active based on the deletion of the COVID-19 vaccine administration codes that are listed in table 1, attachment A.

In addition, since the long descriptor for HCPCS code M0201 was revised effective January 1, 2024, as listed in table 3, attachment A, and M0201 is the only code that is assigned to APC 9399, we are revising the APC title for APC 9399 to match the descriptor of HCPCS code M0201 effective January 1, 2024. See the updated APC title for APC 9399 in table 4, attachment A.

3. CPT Proprietary Laboratory Analyses (PLA) Coding Changes Effective January 1, 2024

The AMA CPT Editorial Panel established 19 new PLA codes, specifically, CPT codes 0420U through 0438U, effective January 1, 2024.

Table 5, attachment A, lists the long descriptors and status indicators for the codes. The codes have been added to the January 2024 I/OCE with an effective date of January 1, 2024. In addition, the codes, along with their short descriptors and status indicators, are listed in the January 2024 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 2024 OPPS/ASC final rule for the latest definitions.

4. OPPS Device Pass-through

a. New Device Pass-Through Category Effective January 1, 2024

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 2024 of the CY 2024 OPPS/ASC final rule with comment period, for the January 2024 update, we approved five new devices for pass-through status under the OPPS, specifically, HCPCS codes C1600, C1601, C1602, C1603, and C1604. For the full discussion on the criteria used to evaluate device pass-through applications, refer to the CY 2024 OPPS/ASC final rule with comment period, which was published in the **Federal Register** on November 22, 2023. Refer to Table 6A, attachment A, for the long descriptor, status indicator, APC, and offset amount for these five HCPCS codes.

Furthermore, we are adding these five new device category codes and their pass-through expiration dates to Table 7, attachment A. Refer to Table 7 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 2024 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 Eight Device Category HCPCS Codes Effective January 1, 2024

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. Three expiring codes are listed below in Table 6B, attachment A and noted in Table 7. We note that these device category HCPCS codes will remain active; however, their payment will be included in the primary service.

Section 4141 of the Consolidated Appropriations Act of 2023 amended Section 1833(t)(6) of the Social Security Act to extend pass-through status for certain devices for a 1-year period beginning on January 1, 2023. The pass-through status of these devices that received this extension are expiring on December 31, 2023. These five codes are displayed in Table 6B, attachment A and noted in Table 7. We note that even though the pass-through status will expire on December 31, 2023, these device category HCPCS codes will remain active; and their payment will be included in the primary service.

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. As we state in Chapter 4 of the Medicare Claims Processing Manual, specifically, section 10.4, 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 7. 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).

5. Changes to the Inpatient-Only list (IPO) for CY 2024

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 2024, CMS is adding ten procedures to the IPO list. The changes to the IPO list for CY 2024 are included in Table 8, attachment A.

6. Comprehensive APC (C-APC) Exclusions Update

In section 10.2.3 of the Medicare Claims Processing Manual, 100-04, Chapter 4, the C-APC exclusions section was updated. This update removed a paragraph that excluded over-the-counter (OTC) COVID-19 tests and new COVID-19 treatments from C-APCs. After the public health emergency, which ended on May 11, 2023, payment for these COVID-19 tests and treatments is now packaged into the payment for a C-APC when these services are billed on the same outpatient claim.

7. New HCPCS Code Describing 3D Predictive Model Generation for Pre-Planning of a Cardiac Procedure

CMS is establishing a new HCPCS code, C9793, to describe 3D predictive model generation for pre-planning of a cardiac procedure. Table 9, attachment A, lists the official long descriptor, status indicator, and APC assignment for HCPCS code C9793. For information on OPPS status indicators, please refer to OPPS Addendum D1 of the CY 2024 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 2024 update of the OPPS Addendum B.

8. New HCPCS Codes Describing Biology-Guided Radiation Therapy Service

In the CY 2024 OPPS/ASC final rule with comment period, CMS established two new HCPCS codes, C9794 and C9795, to describe a biology-guided radiation therapy service.

Table 10, attachment A, lists the official long descriptors, status indicators, and APC assignments for HCPCS codes C9794 and C9795. For information on OPPS status indicators, please refer to OPPS Addendum D1 of the CY 2024 OPPS/ASC final rule for the latest definitions. These codes, along with their short descriptors, status indicators, and payment rates, are also listed in Addendum B of the CY 2024 OPPS/ASC final rule with comment period.

9. Clarification on Billing of HCPCS code G0330 for Payment under the OPPS

As stated in the CY 2023 OPPS/ASC final rule with comment period, CMS created HCPCS code G0330 to describe facility services for dental rehabilitation procedure(s) furnished to patients who require monitored anesthesia (e.g., general, intravenous sedation (monitored anesthesia care)) and use of an operating room. HCPCS code G0330 does not describe the professional services of dentists and other dental professionals; rather, HCPCS code G0330 only describes facility services furnished by hospital outpatient departments and ambulatory surgery centers paid under the OPPS or ASC payment systems, respectively. Additionally, HCPCS code G0330 must only be used to describe facility fees for rehabilitation services that meet Medicare payment and coverage requirements. Table 11, attachment A, lists the long descriptor, status indicator, and APC assignment for HCPCS code G0330. For information on OPPS status indicators, please refer to OPPS Addendum D1 of the CY 2024 OPPS/ASC final rule for the latest definitions. HCPCS code G0330, as well as its short descriptor, status indicator, and payment rate, are also listed in Addendum B of the CY 2024 OPPS/ASC final rule with comment period.

We received comments to the CY 2024 OPPS/ASC proposed rule requesting further clarification on the billing of HCPCS code G0330. In the CY 2024 OPPS/ASC final rule with comment period, we clarified that hospital outpatient departments should bill any other more specific CPT and/or CDT codes assigned to APCs that describe the service performed, instead of HCPCS code G0330, whenever possible. HCPCS code G0330 should only be billed when no other more specific code is available to describe the service

performed. Therefore, even when the dental service(s) furnished by a hospital outpatient department may be described by HCPCS code G0330, if there is a more specific CDT or CPT code, or combination of CDT or CPT codes, already assigned to APCs that describe the services performed, providers should bill the more specific CDT or CPT code(s) instead of HCPCS code G0330. Because many CDT and CPT codes that describe dental services are already assigned to APCs, we believe that the billing of HCPCS code G0330 will be limited. In the limited circumstances where billing of HCPCS code G0330 is appropriate, HCPCS code G0330 should only be billed once per claim.

10. Technical Changes to Hospital Billing for Marriage and Family Therapist Services and Mental Health Counselor Services

Section 4121(a) of Division FF, Title IV, Subtitle C of the Consolidated Appropriations Act of 2023 (CAA, 2023) (Pub. L. 117-328, December 29, 2022), Coverage of Marriage and Family Therapist Services and Mental Health Counselor Services under Part B of the Medicare Program, provides for Medicare coverage of and payment for the services of mental health care professionals who meet the qualifications for marriage and family therapists (MFTs) and mental health counselors (MHCs) when billed by these professionals. Specifically, section 4121(a)(1) of the CAA, 2023, amended section 1861(s)(2) of the Act by adding a new benefit category under Medicare Part B in new subparagraph (II) to include marriage and family therapist services (as defined in an added section 1861(lll)(1) of the Act) and mental health counselor services (as defined in an added section 1861(lll)(3) of the Act).

Accordingly, we are amending the regulation at 42 CFR 419.22 to add the services of MFTs as defined in 1861(lll)(1) and the services of MHCs as defined in section 1861(lll)(3) to the list of hospital services excluded from payment under the OPPS, at new sections (w) and (x), respectively. Additionally, we are amending the regulation at 42 CFR 410.27(g) to revise the definition of "nonphysician practitioner" to include MFTs and MHCs, consistent with section 4121 of the CAA, 2023, and the amendments to the regulations at §§ 410.53 and 410.54 that we are adopting in the CY 2024 PFS final rule. More details can be found in CR 13222.

11. Changes to Partial Hospitalization Program (PHP) and Establishment of Intensive Outpatient Program (IOP) Payment Policies

Section 4124 of Division FF of the Consolidated Appropriations Act, 2023, established Medicare coverage for IOP services furnished by a hospital to its outpatients, or by a community mental health center (CMHC), an FQHC or an RHC, as a distinct and organized intensive ambulatory treatment service offering less than 24-hour daily care in a location other than an individual's home or inpatient or residential setting, effective January 1, 2024.

The CY 2024 OPPS final rule includes the scope of benefits, physician certification requirements, coding and billing, and payment rates under the IOP benefit. In addition, the CY 2024 OPPS final rule includes updates to the PHP payment rates, coding and billing requirements, and related payment policies. More details can be found in CR 13222.

12. Drugs, Biologicals, and Radiopharmaceuticals

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

Fifteen 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, 2024. These drugs and biologicals will receive drug pass-through status starting January 1, 2024. These HCPCS codes are listed in Table 12, attachment A.

b. Existing HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals Starting Pass-Through Status as of January 1, 2024

There are four existing HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals in the outpatient setting that will have their pass-through status start on January 1, 2024. These codes are listed in Table 13, attachment A. Therefore, effective January 1, 2024, 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, 2023

There are eleven HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals in the outpatient setting that will have their pass-through status end on December 31, 2023. These codes are listed in Table 14, attachment A. Therefore, effective January 1, 2024, 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 2024 OPPS/ASC final rule for the latest definition. These codes, along with their short descriptors and status indicators are also listed in the January 2024 Update of the OPPS Addendum B.

d. Newly Established HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals as of January 1, 2024

Sixty-five new drug, biological, and radiopharmaceutical HCPCS codes will be established on January 1, 2024. These HCPCS codes are listed in Table 15, attachment A.

e. HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals Deleted as of December 31, 2023

One drug, biological, and radiopharmaceutical HCPCS code will be deleted on December 31, 2023. This HCPCS code is listed in Table 16, attachment A.

f. New HCPCS Codes and Change to the Existing HCPCS Code for HIV PrEP Effective January 2, 2024

There are nine new HCPCS codes for HIV PrEP effective January 2, 2024. These codes are listed in Table 17, attachment A. These codes, along with their short descriptors and status indicators are also listed in the January 2024 update of the OPPS Addendum B. The descriptor and status indicator for the existing HCPCS code, J0739 are also changing effective January 2, 2024. These changes are listed in table 17, attachment A.

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

For CY 2024, 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 2024, 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, 2024, payment rates for many drugs and biologicals have changed from the values published in the CY 2024 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from second quarter of CY 2023. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2024 Fiscal Intermediary Standard System (FISS) release. CMS is not publishing the updated payment rates in this Change Request implementing the January 2024 update of the OPPS. However, the updated payment rates effective January 1, 2024, can be found in the January 2024 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

i. 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.

13. 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 $47 or the per-day cost of $807 for CY 2024.

14. Payment Adjustment for Certain Cancer Hospitals Beginning CY 2024

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 2024, the target PCR, after including the reduction required by Section 16002(b), is 0.88.

15. Method to Control for Unnecessary Increases in Utilization of Outpatient Services/G0463 with Modifier PO

In CY 2019, CMS finalized a policy to use our authority under section 1833(t)(2)(F) of the Act to apply an amount equal to the site-specific Physician Fee Schedule (PFS) payment rate for nonexcepted items and services furnished by a nonexcepted off-campus Provider-Based Department (PBD) (the PFS payment rate) for the clinic visit service, as described by HCPCS code G0463, when provided at an off-campus PBD excepted from section 1833(t)(21) of the Act (departments that bill the modifier "PO" on claim lines). We completed the phase-in of the policy in CY 2020.

The PFS-equivalent amount paid to nonexcepted off-campus PBDs is approximately 40 percent of OPPS payment (60 percent less than the OPPS rate) for CY 2024. Specifically, the total 60-percent payment reduction will apply in CY 2024, which means these departments will be paid 40 percent of the OPPS rate (100 percent of the OPPS rate minus the 60-percent payment reduction that applies in CY 2024) for the clinic visit service in CY 2024.

We note that in the CY 2024 OPPS/ASC final rule, we finalized the continued exemption of rural sole community hospitals from the payment reduction associated with this policy. Therefore, the payment reduction described in this section will continue to not apply to rural sole community hospitals in the CY 2024 OPPS.

16. Changes to OPPS Pricer Logic

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 2024. 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).

b. New OPPS payment rates and copayment amounts will be effective January 1, 2024. 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 2024 inpatient deductible of $1,632. For most OPPS services, copayments are set at 20 percent of the APC payment rate.

c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2024. 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.

d. The fixed-dollar threshold for OPPS outlier payments decreases in CY 2024 relative to CY 2023. The estimated cost of a service must be greater than the APC payment amount plus $7,750 in order to qualify for outlier payments.

e. For outliers for CMHCs (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2024; however, there are changes to the processing of CMHC outlier claims to extend the CMHC outlier policy to intensive outpatient services. 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.

f. Continuing our established policy for CY 2024, 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, 2024, CMS is adopting the Fiscal Year (FY) 2024 Inpatient Prospective Payment System (IPPS) post-reclassification wage index values with application of the CY 2024 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.

h. Effective January 1, 2024, rural sole community hospitals will not receive payment reductions for HCPCS code G0463 when billed with modifier “PO” based on our final CY 2024 policy to continue to exempt rural sole community hospitals from the method to control for unnecessary increases in volume policy.

17. Update the Outpatient Provider Specific File (OPSF)

Effective January 1, 2024, contractors shall maintain the accuracy of the provider records in the Outpatient Provider Specific File (OPSF) as changes occur in data element values.

a) Updating the OPSF for the Supplemental Wage Index and Supplemental Wage Index Flag Fields

In CY 2024, 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 2023 OPPS wage index in the Supplemental Wage Index field in order to properly apply all wage index policies and determine the hospital’s CY 2024 OPPS wage index. Therefore, for CY 2024, 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, 2024. 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, 2024.

1. If the MAC receives approval from the CMS Central Office to assign an OPPS provider a special wage index in CY 2023 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 2023 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, 2024.

2. If the MAC did not email CMS during CY 2023 for a provider's CY 2023 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-2024-ipps-final-rule-home-page the 2023 wage index should be obtained from the Table 2 associated with the FY 2024 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 2023 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 2023 (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, 2024.

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

We have made the Supplemental Wage Index assignments (based on the CY 2023 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 2023 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, 2024.

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 2024, 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, 2024, 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 2024 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 2024 IPPS are also reflected in the OPSF on a CY 2024 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.

18. Wage Index Policies in the CY 2024 OPPS Final Rule

In the FY 2024 IPPS and CY 2024 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 0.8667 across all hospitals and applied a 5 percent cap for CY 2024 on any wage index values that decreased relative to CY 2023.

19. Revenue Code Reporting for Cardiac CT CPT Codes 75572, 75573, and 75574

We recently identified an outdated return-to-provider (RTP) HCPCS-to-revenue code edit that resulted in certain claims submissions being limited to specific revenue codes for CPT codes 75572, 75573, and 75574. These claims were returned to the providers for resubmission. The outdated edit has been removed; and providers, when appropriate, may begin billing these codes with any appropriate revenue code.

20. 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.

II. 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	
13488 - 04.1	Medicare contractors shall access the OPPS Pricer via the Cloud to pay 2024 payment rates on claims with statement from dates on or after January 1, 2024.	X		X						
13488 - 04.2	Medicare contractors shall adjust, as appropriate, claims brought to their attention with any retroactive changes that were received prior to	X		X						

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	implementation of the January 2024 OPPS PRICER.									
13488 - 04.3	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 2024, this includes all changes to the OPSF identified in Section 17 of this Change Request.	X		X						
13488 - 04.4	Medicare contractors shall manually insert the rate for J1413 in the HCPCS file after a claim is received. The claim will suspend a reason code 36467. When a contractor receives a claim with J1413, obtain the rate from addendum B and insert the rate in the HCPCS file to continue processing the claim.	X		X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13488 - 04.5	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN	X		X		

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	Connects newsletter content per the manual section referenced above.					

IV. 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

V. CONTACTS

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

VI. 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. ─ Deleted COVID-19 Vaccine Product & Vaccine Administration Codes

Vaccine CPT Code	Long Descriptor	Vaccine Administration CPT Code(s)	Age Range	Manufacturer
91300	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, diluent reconstituted, for intramuscular use	0001A (1st Dose) 0002A (2nd Dose) 0003A (3rd Dose) 0004A (Booster)	12 years and older	Pfizer, Inc
91305	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use	0051A (1st Dose) 0052A (2nd Dose) 0053A(3rdDose) 0054A (Booster)	12 years and older	Pfizer, Inc
91312	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, bivalent spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use	0121A (1st Dose) 0124A (Additional Dose)	12 years and older	Pfizer, Inc
91307	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, trissucrose formulation, for intramuscular use	0071A (1st Dose) 0072A (2nd Dose) 0073A (3rd Dose) 0074A (Booster)	5 through 11 years	Pfizer, Inc
91315	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, bivalent spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use	0151A (1st Dose) 0154A (Additional Dose)	5 through 11 years	Pfizer, Inc

Vaccine CPT Code	Long Descriptor	Vaccine Administration CPT Code(s)	Age Range	Manufacturer
91308	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 3 mcg/0.2 mL dosage,	0081A (1st Dose) 0082A (2nd Dose) 0083A (3rd Dose)	6 months through 4 years	Pfizer, Inc

	diluent reconstituted, trissucrose formulation, for intramuscular use			
91317	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, bivalent spike protein, preservative free, 3 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use	0171A (1st Dose) 0172A (2nd Dose) 0173A (3rd Dose) 0174A (Additional Dose)	6 months through 4 years	Pfizer, Inc
91301	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5 mL dosage, for intramuscular use	0011A (1st Dose) 0012A (2nd Dose) 0013A (3rd Dose)	12 years and older	Moderna, Inc
91306	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.25 mL dosage, for intramuscular use	0064A (Booster)	18 years and older	Moderna, Inc
91313	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, bivalent, preservative free, 50 mcg/0.5 mL dosage, for intramuscular use	0134A (Additional Dose	12 years and older	Moderna, Inc
91314	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, bivalent, preservative free, 25 mcg/0.25 mL dosage, for intramuscular use	0141A (1st Dose) 0142A(2nd Dose) 0144A (Additional Dose)	6 months through 11 years	Moderna, Inc
91311	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 25 mcg/0.25 mL dosage, for intramuscular use	0111A (1st Dose) 0112A (2nd Dose) 0113A (3rd Dose)	6 months through 5 years	Moderna, Inc

91316	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, bivalent, preservative free, 10 mcg/0.2 mL dosage, for intramuscular use	0164A (Additional Dose)	6 months through 5 years	Moderna, Inc
91309	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.5 mL dosage, for intramuscular use	0091A (1st Dose) 0092A (2nd Dose) 0093A (3rd Dose)	6 years through 11 years	Moderna, Inc
		0094A (Booster)	18 years and older	
91302	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, 5x1010 viral particles/0.5 mL dosage, for intramuscular use	0021A (1st Dose) 0022A (2nd Dose)	18 years and older	Astra Zeneca, Plc
91303	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, 5x1010 viral particles/0.5 mL dosage, for intramuscular use	0031A (Single Dose) 0034A (Booster)	18 years and older	Janssen
N/A		0041A (1st Dose) 0042A (2nd Dose)	12 years and older	Novavax, Inc
Vaccine CPT Code	Long Descriptor	Vaccine Administration CPT Code(s)	Age Range	Manufacturer
		0044A (Booster)	18 years and older	
91310	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, monovalent, preservative free, 5 mcg/0.5 mL dosage, adjuvant AS03 emulsion, for intramuscular use	0104A (Booster)	18 years and older	Sanofi Pasteur

Table 2. ─ Active Covid-19 Vaccine Product and Administration CPT Codes

CPT Code	Type	Labeler	Long Descriptor
91304	Vaccine/ Product Code	Novavax	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, 5 mcg/0.5 mL dosage, for intramuscular use
91318	Vaccine/ Product Code	Pfizer-BioNTech	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 3 mcg/0.3 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use
91319	Vaccine/ Product Code	Pfizer-BioNTech	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use
91320	Vaccine/ Product Code	Pfizer-BioNTech	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use
91321	Vaccine/ Product Code	Moderna	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, preservative free, 25 mcg/0.25 mL dosage, for intramuscular use
91322	Vaccine/ Product Code	Moderna	Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, preservative free, 50 mcg/0.5 mL dosage, for intramuscular use

90480	Administration/ Immunization Code	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, single dose

Table 3. ─ Old and New Long Descriptors for HCPCS Code M0201, Effective January 1, 2024

HCPCS Code	Old Long Descriptor	New Long Descriptor
M0201	Covid-19 vaccine administration inside a patient's home; reported only once per individual home per date of service when only covid-19 vaccine administration is performed at the patient's home	Administration of pneumococcal, influenza, hepatitis B, and/or covid-19 vaccine inside a patient's home; reported only once per individual home per date of service when such vaccine administration(s) are performed at the patient's home

Table 4. ─ COVID-19 APCs Effective January 1, 2024

APC	APC Title	SI
9398	Covid-19 Vaccine Admin Dose 2 of 2, Single Dose Product or Additional Dose	S
9399	Influenza, Hepatitis B, and/or Covid-19 Vaccine Home Administration	S

Table 5. ─ PLA Coding Changes Effective January 1, 2024

CPT Code	Long Descriptor	OPPS SI
0420U	Oncology (urothelial), mRNA expression profiling by real-time quantitative PCR of MDK, HOXA13, CDC2, IGFBP5, and CXCR2 in combination with droplet digital PCR (ddPCR) analysis of 6 single-nucleotide polymorphisms (SNPs) genes TERT and FGFR3, urine, algorithm reported as a risk score for urothelial carcinoma	A
0421U	Oncology (colorectal) screening, quantitative real-time target and signal amplification of 8 RNA markers (GAPDH, SMAD4, ACY1, AREG, CDH1, KRAS, TNFRSF10B, EGLN2) and fecal hemoglobin, algorithm reported as a positive or negative for colorectal cancer risk	E1
0422U	Oncology (pan-solid tumor), analysis of DNA biomarker response to anti-cancer therapy using cell-free circulating DNA, biomarker comparison to a previous baseline pre-treatment cell-free circulating DNA analysis using next-generation sequencing, algorithm reported as a quantitative change from baseline, including specific alterations, if appropriate	A

0423U	Psychiatry (eg, depression, anxiety), genomic analysis panel, including variant analysis of 26 genes, buccal swab, report including metabolizer status and risk of drug toxicity by condition	A
0424U	Oncology (prostate), exosomebased analysis of 53 small noncoding RNAs (sncRNAs) by quantitative reverse transcription polymerase chain reaction (RTqPCR), urine, reported as no molecular evidence, low-, moderate- or elevated-risk of prostate cancer	A
0425U	Genome (eg, unexplained constitutional or heritable disorder or syndrome), rapid sequence analysis, each comparator genome (eg, parents, siblings)	A
0426U	Genome (eg, unexplained constitutional or heritable disorder or syndrome), ultra-rapid sequence analysis	A
0427U	Monocyte distribution width, whole blood (List separately in addition to code for primary procedure)	Q4
0428U	Oncology (breast), targeted hybrid-capture genomic sequence analysis panel, circulating tumor DNA (ctDNA) analysis of 56 or more genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability, and tumor mutation burden	A
0429U	Human papillomavirus (HPV), oropharyngeal swab, 14 high-risk types (ie, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, and 68)	Q4
0430U	Gastroenterology, malabsorption evaluation of alpha-1-antitrypsin, calprotectin, pancreatic elastase and reducing substances, feces, quantitative	Q4
0431U	Glycine receptor alpha1 IgG, serum or cerebrospinal fluid (CSF), live cell-binding assay (LCBA), qualitative	Q4
0432U	Kelch-like protein 11 (KLHL11) antibody, serum or cerebrospinal fluid (CSF), cell-binding assay, qualitative	Q4
0433U	Oncology (prostate), 5 DNA regulatory markers by quantitative PCR, whole blood, algorithm, including prostate-specific antigen, reported as likelihood of cancer	A

0434U	Drug metabolism (adverse drug reactions and drug response), genomic analysis panel, variant analysis of 25 genes with reported phenotypes	A
0435U	Oncology, chemotherapeutic drug cytotoxicity assay of cancer stem cells (CSCs), from cultured CSCs and primary tumor cells, categorical drug response reported based on cytotoxicity percentage observed, minimum of 14 drugs or drug combinations	Q4
0436U	Oncology (lung), plasma analysis of 388 proteins, using aptamerbased proteomics technology, predictive algorithm reported as clinical benefit from immune checkpoint inhibitor therapy	Q4
0437U	Psychiatry (anxiety disorders), mRNA, gene expression profiling by RNA sequencing of 15 biomarkers, whole blood, algorithm reported as predictive risk score	A
0438U	Drug metabolism (adverse drug reactions and drug response), buccal specimen, gene-drug interactions, variant analysis of 33 genes, including deletion/duplication analysis of CYP2D6, including reported phenotypes and impacted genedrug interactions	A

Table 6A. -- Device Pass-Through Category HCPCS Codes and Associated Device Offset Amounts

HCPCS Code	Long Descriptor	SI	APC	Device Offset Amount(s)
C1600	Catheter, transluminal intravascular lesion preparation device, bladed, sheathed (insertable)	H	2041	CPT code 36902 $1451.86
C1601	Endoscope, single-use (i.e. disposable), pulmonary, imaging/illumination device (insertable)	H	2042	CPT code 31626 $652.77
C1602	Orthopedic/device/drug matrix/absorbable bone void filler, antimicrobial-eluting (implantable)	H	2043	CPT code 24134 $647.55
C1603	Retrieval device, insertable, laser (used to retrieve intravascular inferior vena cava filter)	H	2044	CPT code 37193 $782.64
C1604	Graft, transmural transvenous arterial bypass (implantable), with all delivery system components	H	2045	CPT code 0505T $4947.41

(1) HCPCS Code C1600

Device category HCPCS code C1600 should always be billed with the following CPT codes:

HCPCS Code	Long Descriptor	SI	APC	Device Offset Amount
36902	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit,	J1	5192	$1,451.86

	including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty			
36903	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment	J1	5193	$5,298.55
36905	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	J1	5193	$3,010.38
36906	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and	J1	5194	$8,149.83

	radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit			

(2) HCPCS Code C1601

Device category HCPCS code C1601 should always be billed with the following CPT codes:

HCPCS Code	Long Descriptor	SI	APC	Device Offset Amount
31615	Tracheobronchoscopy through established tracheostomy incision	T	5162	$0.16
31622	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)	J1	5153	$8.57
31623	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings	J1	5153	$6.47
31624	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial alveolar lavage	J1	5153	$2.91
31625	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites	J1	5153	$14.88
31626	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple	J1	5155	$652.77
31628	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe	J1	5154	$36.04
31629	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)	J1	5154	$44.96
31630	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with tracheal/bronchial dilation or closed reduction of fracture	J1	5154	$421.03
31631	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)	J1	5155	$1,688.99
31634	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, with assessment of air leak, with administration of occlusive substance (eg, fibrin glue), if performed	J1	5155	$1,161.42

31635	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of foreign body	J1	5153	$14.39
31636	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of bronchial stent(s) (includes tracheal/bronchial dilation as required), initial bronchus	J1	5155	$2,808.68
31638	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)	J1	5155	$907.75
31640	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with excision of tumor	J1	5154	$132.02
31641	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with destruction of tumor or relief of stenosis by any method other than excision (eg, laser therapy, cryotherapy)	J1	5154	$251.90
31643	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of catheter(s) for intracavitary radioelement application	J1	5153	$10.51
31645	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with therapeutic aspiration of tracheobronchial tree, initial	J1	5153	$12.61
31646	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with therapeutic aspiration of tracheobronchial tree, subsequent, same hospital stay	T	5152	$0.00
31647	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe	J1	5155	$3,704.69
31648	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe	J1	5154	$87.77
31652	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (ebus) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), one or two mediastinal and/or hilar lymph node stations or structures	J1	5154	$27.12
31653	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (ebus) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), 3	J1	5154	$27.83

	or more mediastinal and/or hilar lymph node stations or structures			
31660	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe	J1	5155	$3,220.16
31661	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes	J1	5155	$3,055.83
31785	Excision of tracheal tumor or carcinoma; cervical	J1	5165	$83.14
31627	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation (list separately in addition to code for primary procedure[s])	N	NA	NA
31632	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), each additional lobe (list separately in addition to code for primary procedure)	N	NA	NA
31633	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), each additional lobe (list separately in addition to code for primary procedure)	N	NA	NA
31637	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; each additional major bronchus stented (list separately in addition to code for primary procedure)	N	NA	NA
31649	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), each additional lobe (list separately in addition to code for primary procedure)	Q2	NA	NA
31651	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe (list separately in addition to code for primary procedure[s])	N	NA	NA
31654	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transendoscopic endobronchial ultrasound (ebus) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s) (list separately in addition to code for primary procedure[s])	N	NA	NA
31780	Excision tracheal stenosis and anastomosis; cervical	C	NA	NA

31781	Excision tracheal stenosis and anastomosis; cervicothoracic	C	NA	NA
31786	Excision of tracheal tumor or carcinoma; thoracic	C	NA	NA
31800	Suture of tracheal wound or injury; cervical	C	NA	NA
31805	Suture of tracheal wound or injury; intrathoracic	C	NA	NA
32815	Open closure of major bronchial fistula	C	NA	NA

Additionally, we provide the following guidance for code C1601: Single-use (i.e., disposable) endoscope with imaging (including linked color imaging if utilized), illumination, and working channels. This single-use (i.e., disposable) endoscope can be used for procedures that take place in the tracheobronchial tree.

(3) HCPCS Code C1602

Device category HCPCS code C1602 should always be billed with the following CPT codes:

HCPCS Code	Long Descriptor	SI	APC	Device Offset Amount
21510	Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), thorax	C	NA	NA
23035	Incision, bone cortex (eg, osteomyelitis or bone abscess), shoulder area	J1	5112	$0.00
23170	Sequestrectomy (eg, for osteomyelitis or bone abscess), clavicle	J1	5113	$779.03
23172	Sequestrectomy (eg, for osteomyelitis or bone abscess), scapula	J1	NA	NA
23174	Sequestrectomy (eg, for osteomyelitis or bone abscess), humeral head to surgical neck	J1	5114	$0.00
23180	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), clavicle	J1	5114	$0.00
23182	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), scapula	J1	5114	$411.71
23184	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), proximal humerus	J1	5114	$0.00
23935	Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), humerus or elbow	J1	5113	$97.15
24134	Sequestrectomy (eg, for osteomyelitis or bone abscess), shaft or distal humerus	J1	5114	$647.55
24136	Sequestrectomy (eg, for osteomyelitis or bone abscess), radial head or neck	J1	5113	$0.00
24138	Sequestrectomy (eg, for osteomyelitis or bone abscess), olecranon process	J1	5114	$165.64
24140	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), humerus	J1	5113	$143.72
24145	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), radial head or neck	J1	5114	$0.00

24147	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), olecranon process	J1	5113	$66.31
25035	Incision, deep, bone cortex, forearm and/or wrist (eg, osteomyelitis or bone abscess)	J1	5114	$805.01
25150	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis); ulna	J1	5113	$18.20
25151	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis); radius	J1	5113	$101.46
26230	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis); metacarpal	J1	5113	$64.76
26992	Incision, bone cortex, pelvis and/or hip joint (eg, osteomyelitis or bone abscess)	C	NA	NA
27070	Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (eg, osteomyelitis or bone abscess); superficial	C	NA	NA
27071	Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (eg, osteomyelitis or bone abscess); deep (subfascial or intramuscular)	C	NA	NA
27303	Incision, deep, with opening of bone cortex, femur or knee (eg, osteomyelitis or bone abscess)	C	NA	NA
27360	Partial excision (craterization, saucerization, or diaphysectomy) bone, femur, proximal tibia and/or fibula (eg, osteomyelitis or bone abscess)	J1	5113	$169.00
27607	Incision (eg, osteomyelitis or bone abscess), leg or ankle	J1	5113	$557.28
27640	Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); tibia	J1	5113	$329.37
27641	Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); fibula	J1	5113	$72.78
28005	Incision, bone cortex (eg, osteomyelitis or bone abscess), foot	J1	5113	$214.65
28120	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus	J1	5113	$218.35
28122	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus	J1	5113	$104.86

(4) HCPCS Code C1603

Device category HCPCS code C1603 should always be billed with the following CPT codes:

HCPCS Code	Long Descriptor	SI	APC	Device Offset Amount
37193	Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	J1	5183	$782.64

(5) HCPCS Code C1604

Device category HCPCS code C1604 should always be billed with the following CPT codes:

HCPCS Code	Long Descriptor	SI	APC	Device Offset Amount
0505T	Endovenous femoral-popliteal arterial revascularization, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed, with crossing of the occlusive lesion in an extraluminal fashion	J1	5193	$4947.41

Table 6B. -- Expiring Pass-through Status for Eight Device Category HCPCS Code Effective January 1, 2024

HCPCS Code	Long Descriptor	Device Pass-through Status Expiration Date
C1825*	Generator, neurostimulator (implantable), non-rechargeable with carotid sinus baroreceptor stimulation lead(s)	12/31/2023
C1052*	Hemostatic agent, gastrointestinal, topical	12/31/2023
C1062*	Intravertebral body fracture augmentation with implant (e.g., metal, polymer)	12/31/2023
C1734^	Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue-to bone (implantable)	12/31/2023
C1824^	Generator, cardiac contractility modulation (implantable)	12/31/2023
C1839^	Iris prosthesis	12/31/2023
C1982^	Catheter, pressure-generating, one-way valve, intermittently occlusive	12/31/2023
C2596^	Probe, image-guided, robotic, waterjet ablation	12/31/2023

*Codes that are expiring after receiving transitional pass-through payments for three years.

^Codes that are expiring after 1-year extension of the pass-through status.

Table 7. -- List of Device Category HCPCS Code s and Definitions Used for Present and Previous Pass-Through Payment ***

	HCPCS Codes	Category Long Descriptor	Date First Populate d	Pass- Through Expiration Date***
1.	C1883*	Adaptor/extension, pacing lead or neurostimulator lead (implantable)	8/1/2000	12/31/2002
2.	C1765*	Adhesion barrier	10/01/00 – 3/31/2001; 7/1/2001	12/31/2003
3.	C1713*	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)	8/1/2000	12/31/2002
4.	L8690	Auditory osseointegrated device, includes all internal and external components	1/1/2007	12/31/2008
5.	C1832	Autograft suspension, including cell processing and application, and all system components	1/1/2022	12/31/2024
6.	C1715	Brachytherapy needle	8/1/2000	12/31/2002
7.	C1716#	Brachytherapy source, non-stranded, Gold-198, per source	10/1/2000	12/31/2002
8.	C1717#	Brachytherapy source, non-stranded, high dose rate Iridium-192, per source	1/1/2001	12/31/2002
9.	C1718#	Brachytherapy source, Iodine 125, per source	8/1/2000	12/31/2002
10.	C1719#	Brachytherapy source, non-stranded, non-high dose rate Iridium-192, per source	10/1/2000	12/31/2002
11.	C1720#	Brachytherapy source, Palladium 103, per source	8/1/2000	12/31/2002
12.	C2616#	Brachytherapy source, non-stranded, Yttrium-90, per source	1/1/2001	12/31/2002
13.	C2632	Brachytherapy solution, iodine – 125, per mCi	1/1/2003	12/31/2004
14.	C1721	Cardioverter-defibrillator, dual chamber (implantable)	8/1/2000	12/31/2002
15.	C1882*	Cardioverter-defibrillator, other than single or dual chamber (implantable)	8/1/2000	12/31/2002
16.	C1722	Cardioverter-defibrillator, single chamber (implantable)	8/1/2000	12/31/2002
17.	C1888*	Catheter, ablation, non-cardiac, endovascular (implantable)	7/1/2002	12/31/2004
18.	C1726*	Catheter, balloon dilatation, non-vascular	8/1/2000	12/31/2002
19.	C1727*	Catheter, balloon tissue dissector, non-vascular (insertable)	8/1/2000	12/31/2002
20.	C1728	Catheter, brachytherapy seed administration	1/1/2001	12/31/2002
21.	C1729*	Catheter, drainage	10/1/2000	12/31/2002
22.	C1730*	Catheter, electrophysiology, diagnostic, other than 3D mapping (19 or fewer electrodes)	8/1/2000	12/31/2002
23.	C1731*	Catheter, electrophysiology, diagnostic, other than 3d mapping (20 or more electrodes)	8/1/2000	12/31/2002
24.	C1732*	Catheter, electrophysiology, diagnostic/ablation, 3D or vector mapping	8/1/2000	12/31/2002
25.	C1733*	Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, other than cool-tip	8/1/2000	12/31/2002
26.	C2630*	Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, cool-tip	10/1/2000	12/31/2002

27.	C1886	Catheter, extravascular tissue ablation, any modality (insertable)	01/1/2012	12/31/2013
28.	C1887*	Catheter, guiding (may include infusion/perfusion capability)	8/1/2000	12/31/2002
29.	C1750	Catheter, hemodialysis/peritoneal, long-term	8/1/2000	12/31/2002
30.	C1752	Catheter, hemodialysis/peritonea l, short-term	8/1/2000	12/31/2002
31.	C1751	Catheter, infusion, inserted peripherally, centrally or midline (other than hemodialysis)	8/1/2000	12/31/2002
32.	C1759	Catheter, intracardiac echocardiography	8/1/2000	12/31/2002
33.	C1754	Catheter, intradiscal	10/1/2000	12/31/2002
34.	C1755	Catheter, intraspinal	8/1/2000	12/31/2002
35.	C1753	Catheter, intravascular ultrasound	8/1/2000	12/31/2002
36.	C2628	Catheter, occlusion	10/1/2000	12/31/2002
37.	C1756	Catheter, pacing, transesophageal	10/1/2000	12/31/2002
38.	C2627	Catheter, suprapubic/cystoscopic	10/1/2000	12/31/2002
39.	C1757	Catheter, thrombectomy/embolectomy	8/1/2000	12/31/2002
40.	C2623	Catheter, transluminal angioplasty, drug-coated, non-laser	4/1/2015	12/31/2017
41.	C1885*	Catheter, transluminal angioplasty, laser	10/1/2000	12/31/2002
42.	C1725*	Catheter, transluminal angioplasty, non-laser (may include guidance, infusion/perfusion capability)	8/1/2000	12/31/2002
43.	C1714	Catheter, transluminal atherectomy, directional	8/1/2000	12/31/2002
44.	C1724	Catheter, transluminal atherectomy, rotational	8/1/2000	12/31/2002
45.	C1761	Catheter, transluminal intravascular lithotripsy, coronary	7/1/2021	6/30/2024
46.	C1760*	Closure device, vascular (implantable/insertable)	8/1/2000	12/31/2002
47.	L8614	Cochlear implant system	8/1/2000	12/31/2002
48.	C1762*	Connective tissue, human (includes fascia lata)	8/1/2000	12/31/2002
49.	C1763*	Connective tissue, non-human (includes synthetic)	10/1/2000	12/31/2002
50.	C1881	Dialysis access system (implantable)	8/1/2000	12/31/2002
51.	C1884*	Embolization protective system	1/01/2003	12/31/2004
52.	C1749	Endoscope, retrograde imaging/illumination colonoscope device (implantable)	10/1/2010	12/31/2012
53.	C1748	Endoscope, single-use (i.e. disposable), Upper GI, imaging/illumination device (insertable)	7/1/2020	6/30/2023
54.	C1764	Event recorder, cardiac (implantable)	8/1/2000	12/31/2002
55.	C1822	Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system	1/1/2016	12/31/2017
56.	C1767**	Generator, neurostimulator (implantable), non-rechargeable	8/1/2000	12/31/2002
57.	C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system	1/1/2006	12/31/2007
58.	C1825	Generator, neurostimulator (implantable), non-rechargeable with carotid sinus baroreceptor stimulation lead(s)	1/1/2021	12/31/2023
59.	C1823	Generator, neurostimulator (implantable), nonrechargeable , with transvenous sensing and stimulation leads	1/1/2019	12/31/2022
60.	C1768	Graft, vascular	1/1/2001	12/31/2002
61.	C1769	Guide wire	8/1/2000	12/31/2002
62.	C1052	Hemostatic agent, gastrointestinal, topical	1/1/2021	12/31/2023
63.	C1770	Imaging coil, magnetic resonance (insertable)	1/1/2001	12/31/2002

64.	C2624	Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components	1/1/2015	12/31/2016
65.	C1891	Infusion pump, non-programmable, permanent (implantable)	8/1/2000	12/31/2002
66.	C2626*	Infusion pump, non-programmable, temporary (implantable)	1/1/2001	12/31/2002
67.	C1772	Infusion pump, programmable (implantable)	10/1/2000	12/31/2002
68.	C1818*	Integrated keratoprosthesis	7/1/2003	12/31/2005
69.	C1821	Interspinous process distraction device (implantable)	1/1/2007	12/31/2008
70.	C1062	Intravertebral body fracture augmentation with implant (e.g., metal, polymer)	1/1/2021	12/31/2023
71.	C1893	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, other than peel-away	10/1/2000	12/31/2002
72.	C1892*	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, peel-away	1/1/2001	12/31/2002
73.	C1766	Introducer/sheath, guiding, intracardiac electrophysiologica l, steerable, other than peel-away	1/1/2001	12/31/2002
74.	C1894	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, non-laser	8/1/2000	12/31/2002
75.	C2629	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, laser	1/1/2001	12/31/2002
76.	C1776*	Joint device (implantable)	10/1/2000	12/31/2002
77.	C1895	Lead, cardioverter-defibrillator, endocardial dual coil (implantable)	8/1/2000	12/31/2002
78.	C1777	Lead, cardioverter-defibrillator, endocardial single coil (implantable)	8/1/2000	12/31/2002
79.	C1896	Lead, cardioverter-defibrillator, other than endocardial single or dual coil (implantable)	8/1/2000	12/31/2002
80.	C1900*	Lead, left ventricular coronary venous system	7/1/2002	12/31/2004
81.	C1778	Lead, neurostimulator (implantable)	8/1/2000	12/31/2002
82.	C1897	Lead, neurostimulator test kit (implantable)	8/1/2000	12/31/2002
83.	C1898	Lead, pacemaker, other than transvenous VDD single pass	8/1/2000	12/31/2002
84.	C1779*	Lead, pacemaker, transvenous VDD single pass	8/1/2000	12/31/2002
85.	C1899	Lead, pacemaker/cardioverter-defibrillator combination (implantable)	1/1/2001	12/31/2002
86.	C1780*	Lens, intraocular (new technology)	8/1/2000	12/31/2002
87.	C1840	Lens, intraocular (telescopic)	10/1/2011	12/31/2013
88.	C2613	Lung biopsy plug with delivery system	7/1/2015	12/31/2017
89.	C1878*	Material for vocal cord medialization, synthetic (implantable)	10/1/2000	12/31/2002
90.	C1781*	Mesh (implantable)	8/1/2000	12/31/2002
91.	C1833	Monitor, cardiac, including intracardiac lead and all system components (implantable)	1/1/2022	12/31/2024
92.	C1782*	Morcellator	8/1/2000	12/31/2002
93.	C1784*	Ocular device, intraoperative, detached retina	1/1/2001	12/31/2002
94.	C1783	Ocular implant, aqueous drainage assist device	7/1/2002	12/31/2004
95.	C2619	Pacemaker, dual chamber, non rate-responsive (implantable)	8/1/2000	12/31/2002
96.	C1785	Pacemaker, dual chamber, rate-responsive (implantable)	8/1/2000	12/31/2002
97.	C2621*	Pacemaker, other than single or dual chamber (implantable)	1/1/2001	12/31/2002

98.	C2620	Pacemaker, single chamber, non rate-responsive (implantable)	8/1/2000	12/31/2002
99.	C1786	Pacemaker, single chamber, rate-responsive (implantable)	8/1/2000	12/31/2002
100.	C1787*	Patient programmer, neurostimulator	8/1/2000	12/31/2002
101.	C1831	Interbody cage, anterior, lateral or posterior, personalized (implantable)	10/1/2021	9/30/2024
102.	C1788	Port, indwelling (implantable)	8/1/2000	12/31/2002
103.	C1830	Powered bone marrow biopsy needle	10/1/2011	12/31/2013
104.	C2618	Probe, cryoablation	4/1/2001	12/31/2003
105.	C2614	Probe, percutaneous lumbar discectomy	1/1/2003	12/31/2004
106.	C1789	Prosthesis, breast (implantable)	10/1/2000	12/31/2002
107.	C1813	Prosthesis, penile, inflatable	8/1/2000	12/31/2002
108.	C2622	Prosthesis, penile, non-inflatable	10/1/2001	12/31/2002
109.	C1815	Prosthesis, urinary sphincter (implantable)	10/1/2000	12/31/2002
110.	C1816	Receiver and/or transmitter, neurostimulator (implantable)	8/1/2000	12/31/2002
111.	C1771*	Repair device, urinary, incontinence, with sling graft	10/1/2000	12/31/2002
112.	C2631*	Repair device, urinary, incontinence, without sling graft	8/1/2000	12/31/2002
113.	C1841	Retinal prosthesis, includes all internal and external components	10/1/2013	12/31/2015
114.	C1814*	Retinal tamponade device, silicone oil	4/1/2003	12/31/2005
115.	C1773*	Retrieval device, insertable	1/1/2001	12/31/2002
116.	C2615*	Sealant, pulmonary, liquid (implantable)	1/1/2001	12/31/2002
117.	C1817*	Septal defect implant system, intracardiac	8/1/2000	12/31/2002
118.	C1874*	Stent, coated/covered, with delivery system	8/1/2000	12/31/2002
119.	C1875*	Stent, coated/covered, without delivery system	8/1/2000	12/31/2002
120.	C1876*	Stent, non-coated/non-covered, with delivery system	8/1/2000	12/31/2002
121.	C1877	Stent, non-coated/non-covered, without delivery system	8/1/2000	12/31/2002
122.	C2625*	Stent, non-coronary, temporary, with delivery system	10/1/2000	12/31/2002
123.	C2617*	Stent, non-coronary, temporary, without delivery system	10/1/2000	12/31/2002
124.	C1819	Tissue localization excision device	1/1/2004	12/31/2005
125.	C1879*	Tissue marker (implantable)	8/1/2000	12/31/2002
126.	C1880	Vena cava filter	1/1/2001	12/31/2002
127.	C1826	Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system	1/1/2023	12/31/2025
128.	C1827	Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller	1/1/2023	12/31/2025
129.	C1747	Endoscope, single-use (i.e. disposable), urinary tract, imaging/illumination device (insertable)	1/1/2023	12/31/2025
130.	C1824^	Generator, cardiac contractility modulation (implantable)	1/1/2020	12/31/2023
131.	C1982^	Catheter, pressure-generating, one-way valve, intermittently occlusive	1/1/2020	12/31/2023
132.	C1839^	Iris prosthesis	1/1/2020	12/31/2023
133.	C1734^	Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue-to bone (implantable)	1/1/2020	12/31/2023
134.	C2596^	Probe, image-guided, robotic, waterjet ablation	1/1/2020	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

BOLD codes are still actively receiving pass-through payment.

Italicized codes have received preliminary approval for pass-through payment.

* Refer to the definition below for further information on this device category code.

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

*** 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.

^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.

Table 8. – Changes to the IPO List for CY 2024

CY 2024 CPT Code	CY 2024 Long Descriptor	Action	CY 2024 Final Status Indicator
0790T	Revision (e.g., augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed	Add to the IPO list	C
22836	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments	Add to the IPO list	C
22837	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments	Add to the IPO list	C
22838	Revision (e.g., augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed	Add to the IPO list	C
61889	Insertion of skull-mounted cranial neurostimulator pulse generator or receiver, including craniectomy or craniotomy, when performed, with direct or inductive coupling, with connection to depth and/or cortical strip electrode array(s)	Add to the IPO list	C

76984	Ultrasound, intraoperative thoracic aorta (e.g., epiaortic), diagnostic	Add to the IPO list	C
76987	Intraoperative epicardial cardiac (e.g., echocardiography) ultrasound for congenital heart disease, diagnostic; including placement and manipulation of transducer, image acquisition, interpretation and report	Add to the IPO list	C
76988	Intraoperative epicardial cardiac ultrasound (ie, echocardiography) for congenital heart disease, diagnostic; placement, manipulation of transducer, and image acquisition only	Add to the IPO list	C
76989	Intraoperative epicardial cardiac ultrasound (ie, echocardiography) for congenital heart disease, diagnostic; interpretation and report only	Add to the IPO list	C
0646T	Transcatheter tricuspid valve implantation (ttvi)/replacement with prosthetic valve, percutaneous approach, including right heart catheterization, temporary pacemaker insertion, and selective right ventricular or right atrial angiography, when performed	Add to the IPO list	C

Table 9. ─ CY 2024 OPPS Status Indicator and APC Assignment for 3D Predictive Model Generation for Pre-Planning of a Cardiac Procedure Effective January 1, 2024

HCPCS Code	Short Descriptor	Long Descriptor	SI	APC
C9793	Pre-plan 3D model w/CCTA	3D predictive model generation for pre-planning of a cardiac procedure, using data from cardiac computed tomographic angiography with report.	S	5724

Table 10. ─ CY 2024 OPPS New Technology APC and Status Indicator Assignments for Biology-Guided Radiation Therapy Service Effective January 1, 2024

HCPCS Code	Short Descriptor	Long Descriptor	SI	APC
C9794	Complex simulation w/PET-CT	Therapeutic radiology simulation-aided field setting; complex, including acquisition of PET and CT imaging data required for radiopharmaceutical-directed radiation therapy treatment planning (i.e., modeling)	S	1521
C9795	Sbrt w/positron emission del	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions	S	1525

Table 11. – CY 2024 OPPS APC and Status Indicator Assignment for HCPCS Code G0330

HCPCS Code	Short Descriptor	Long Descriptor	OPPS SI	OPPS APC
G0330	Facility svs dental rehab	Facility services for dental rehabilitation procedure(s) performed on a patient who requires monitored anesthesia (e.g., general, intravenous	J1	5164

		sedation (monitored anesthesia care)) and use of an operating room.		

Table 12. ─ New CY 2024 HCPCS Codes Effective January 1, 2024, for Certain Drugs, Biologicals, and Radiopharmaceuticals Receiving Pass-Through Status

CY 2024 HCPCS Code	CY 2024 Long Descriptor	CY 2024 SI	CY 2024 APC
C9159	Injection, Prothrombin complex concentrate (human), balfaxar, per i.u. of factor ix activity	G	0702
C9160	Injection, daxibotulinumtoxinA-lanm, 1 unit	G	0703
C9161	Injection, aflibercept hd, 1 mg	G	0704
C9162	Injection, avacincaptad pegol, 0.1 mg	G	0705
C9163	Injection, talquetamab-tgvs, 0.25 mg	G	0706
C9164	Cantharidin for topical administration, 0.7%, single unit dose applicator (3.2 mg)	G	0707
C9165	Injection, elranatamab-bcmm, 1 mg	G	0708
J0217	Injection, velmanase alfa-tycv, 1 mg	G	0710
J1412	Injection, valoctocogene roxaparvovec-rvox, per mL, containing nominal 2 × 10^13 vector genomes	G	0713
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	G	0714
J2508	Injection, pegunigalsidase alfa-iwxj, 1 mg	G	0715
J3401	Beremagene geperpavec-svdt for topical administration, containing nominal 5 x 10^9 pfu/mL vector genomes, per 0.1 mL	G	0716
J9072	Injection, cyclophosphamide, (dr. reddy's), 5 mg	G	0719
J9286	Injection, glofitamab-gxbm, 2.5 mg	G	0720
J9333	Injection, rozanolixizumab-noli, 1 mg	G	0721

Table 13. ─ Existing HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals Starting Pass-Through Status as of January 1, 2024

CY 2024 HCPCS Code	CY 2024 Long Descriptor	October 2023 SI	January 2024 SI	January 2024 APC
A9601	Flortaucipir f 18 injection, diagnostic, 1 millicurie	E2	G	0709
J0174	Injection, lecanemab-irmb, 1 mg	K	G	9157
J0349	Injection, rezafungin, 1 mg	K	G	9267
J9029	Intravesical instillation, nadofaragene firadenovec-vncg, per therapeutic dose	E2	G	0717

Table 14. ─ HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals with Pass-Through Status Ending Effective December 31, 2023

CY 2024 HCPCS Code	CY 2024 Long Descriptor	October 2023 SI	January 2024 SI	January 2024 APC
A9592	Copper cu-64, dotatate, diagnostic, 1 millicurie	G	N	N/A
J0699	Injection, cefiderocol, 10 mg	G	K	9380
J1427	Injection, viltolarsen, 10 mg	G	K	9386
J1437	Injection, ferric derisomaltose, 10 mg	G	K	9388
J1554	Injection, immune globulin (asceniv), 500 mg	G	K	9392
J9037	Injection, belantamab mafodontin-blmf, 0.5 mg	G	K	9384
J9198	Gemcitabine hydrochloride, (Infugem), 100 mg	G	K	9387
J9223	Injection, lurbinectedin, 0.1 mg	G	K	9389
J9316	Injection, pertuzumab, trastuzumab, and hyaluronidase-zzxf, per 10 mg	G	K	9390
J9349	Injection, tafasitamab-cxix, 2 mg	G	K	9385
Q2053	Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	G	K	9391

Table 15. ─ Newly Established HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals as of January 1, 2024

New HCPCS Code	Old HCPCS Code	Long Descriptor	SI	APC
90589		Chikungunya virus vaccine, live attenuated, for intramuscular use	E1	N/A
90623		Meningococcal pentavalent vaccine, conjugated Men A, C, W, Y- tetanus toxoid carrier, and Men B-FHbp, for intramuscular use	M	N/A
90683		Respiratory syncytial virus vaccine, mRNA lipid nanoparticles, for intramuscular use	E1	N/A
A9608	C9156	Flotufolastat F 18, diagnostic, 1 millicurie	G	9254
A9609		Fludeoxyglucose f18 up to 15 millicuries	N	N/A
C9159		Injection, Prothrombin complex concentrate (human), balfaxar, per i.u. of factor ix activity	G	0702
C9160		Injection, daxibotulinumtoxinA-lanm, 1 unit	G	0703
C9161		Injection, aflibercept hd, 1 mg	G	0704
C9162		Injection, avacincaptad pegol, 0.1 mg	G	0705
C9163		Injection, talquetamab-tgvs, 0.25 mg	G	0706
C9164		Cantharidin for topical administration, 0.7%, single unit dose applicator (3.2 mg)	G	0707
C9165		Injection, elranatamab-bcmm, 1 mg	G	0708
J0184	C9153	Injection, amisulpride, 1 mg	G	9247
J0217		Injection, velmanase alfa-tycv, 1 mg	G	0710
J0391		Injection, artesunate, 1 mg	K	0711
J0402	C9152	Injection, aripiprazole (abilify asimtufii), 1 mg	G	9246
J0576	C9154	Injection, buprenorphine extended-release (brixadi), 1 mg	G	9249
J0688		Injection, cefazolin sodium (hikma), not therapeutically equivalent to j0690, 500 mg	N	N/A
J0750		Emtricitabine 200mg and tenofovir disoproxil fumarate 300mg, oral, fda approved prescription,	E1	N/A

		only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv)		
J0751		Emtricitabine 200mg and tenofovir alafenamide 25mg, oral, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv)	E1	N/A
J0799		Fda approved prescription drug, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv), not otherwise classified	E1	N/A
J0873		Injection, daptomycin (xellia) not therapeutically equivalent to j0878, 1 mg	N	N/A
J1105		Dexmedetomidine, oral, 1 mcg	K	0722
J1304	C9157	Injection, tofersen, 1 mg	G	9262
J1412		Injection, valoctocogene roxaparvovec-rvox, per mL, containing nominal 2 × 10^13 vector genomes	G	0713
J1413		Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose	G	0714
J1596		Injection, glycopyrrolate, 0.1 mg	N	N/A
J1939		Injection, bumetanide, 0.5 mg	N	N/A
J2404		Injection, nicardipine, 0.1 mg	N	N/A
J2508		Injection, pegunigalsidase alfa-iwxj, 1 mg	G	0715
J2679		Injection, fluphenazine hcl, 1.25 mg	N	N/A
J2799	C9158	Injection, risperidone (uzedy), 1 mg	G	9266
J3401		Beremagene geperpavec-svdt for topical administration, containing nominal 5 x 10^9 pfu/mL vector genomes, per 0.1 mL	G	0716
J3425		Injection, hydroxocobalamin, 10 mcg	N	N/A
J9052		Injection, carmustine (accord), not therapeutically equivalent to j9050, 100 mg	K	0718
J9072		Injection, cyclophosphamide, (dr. reddy's), 5 mg	G	0719
J9172		Injection, docetaxel (ingenus) not therapeutically equivalent to j9171, 1 mg	E2	N/A
J9255		Injection, methotrexate (accord) not therapeutically equivalent to j9250 and j9260, 50 mg	E2	N/A
J9258		Injection, paclitaxel protein-bound particles (teva) not therapeutically equivalent to j9264, 1 mg	N	N/A
J9286		Injection, glofitamab-gxbm, 2.5 mg	G	0720
J9321	C9155	Injection, epcoritamab-bysp, 0.1 mg	G	9250
J9324		Injection, pemetrexed (pemrydi rtu), 10 mg	E2	N/A
J9333		Injection, rozanolixizumab-noli, 1 mg	G	0721
J9334		Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc	K	0723
Q0516		Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription drug, per 30-days	B	N/A
Q4279		Vendaje ac, per square centimeter	N	N/A
Q4287		Dermabind dl, per square centimeter	N	N/A
Q4288		Dermabind ch, per square centimeter	N	N/A
Q4289		Revoshield + amniotic barrier, per square centimeter	N	N/A
Q4290		Membrane wrap-hydro, per square centimeter	N	N/A
Q4291		Lamellas xt, per square centimeter	N	N/A
Q4292		Lamellas, per square centimeter	N	N/A

Q4293	Acesso dl, per square centimeter	N	N/A
Q4294	Amnio quad-core, per square centimeter	N	N/A
Q4295	Amnio tri-core amniotic, per square centimeter	N	N/A
Q4296	Rebound matrix, per square centimeter	N	N/A
Q4297	Emerge matrix, per square centimeter	N	N/A
Q4298	Amnicore pro, per square centimeter	N	N/A
Q4299	Amnicore pro+, per square centimeter	N	N/A
Q4300	Acesso tl, per square centimeter	N	N/A
Q4301	Activate matrix, per square centimeter	N	N/A
Q4302	Complete aca, per square centimeter	N	N/A
Q4303	Complete aa, per square centimeter	N	N/A
Q4304	Grafix plus, per sq cm	N	N/A
Q5132	Injection, adalimumab-afzb (abrilada), biosimilar, 10 mg	E2	N/A

Table 16. ─ HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals Deleted as of December 31, 2023

CY 2022 HCPCS Code	Long Descriptor	CY 2022 SI	APC
J9160	Injection, denileukin diftitox, 300 micrograms	E2	N/A

Table 17. ─ New HCPCS Codes and Change to the Existing HCPCS Code for HIV PrEP Effective January 2, 2024

CY 2024 HCPCS Code	CY 2024 Long Descriptor	SI	APC
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	N/A
G0012	Injection of pre-exposure prophylaxis (prep) drug for hiv prevention, under skin or into muscle	S	5691
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	S	5822
J0739	Injection, cabotegravir, 1mg, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment for hiv)	A	N/A
J0750	Emtricitabine 200mg and tenofovir disoproxil fumarate 300mg, oral, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv)	A	N/A
J0751	Emtricitabine 200mg and tenofovir alafenamide 25mg, oral, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv)	A	N/A
J0799	Fda approved prescription drug, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv), not otherwise classified	A	N/A

CY 2024 HCPCS Code	CY 2024 Long Descriptor	SI	APC
Q0516	Pharmacy supplying fee for HIV Pre-exposure prophylaxis FDA approved prescription drug, per 30-days	B	N/A
Q0517	Pharmacy supplying fee for HIV Pre-exposure prophylaxis FDA approved prescription drug, per 60-days	B	N/A
Q0518	Pharmacy supplying fee for HIV Pre-exposure prophylaxis FDA approved prescription drug, per 90-days	B	N/A

Table 18. ─ Vaccine that Will Retroactively Change from Non-Payable Status to Payable Status Effective July 17, 2023, in the January 2024 I/OCE Update

HCPCS Code	Long Descriptor	Old SI	New SI	Effective Date
90380	Respiratory syncytial virus, monoclonal antibody, seasonal dose; 0.5 mL dosage, for intramuscular use	E1	M	7/17/2023
90381	Respiratory syncytial virus, monoclonal antibody, seasonal dose; 1 mL dosage, for intramuscular use	E1	M	7/17/20223

Table 19. ─ New Skin Substitute Products Low-Cost Group/High Cost Group Assignment Effective January 1, 2024

CY 2023 HCPCS Code	Short Descriptor	CY 2023 SI	Low-/High-Cost Skin Substitute
Q4279	Vendaje ac, per sq cm	N	Low
Q4287	Dermabind dl, per sq cm	N	Low
Q4288	Dermabind ch, per sq cm	N	Low
Q4289	Revoshield+ amnio, per sq cm	N	Low
Q4290	Membrane wrap hydr per sq cm	N	Low
Q4291	Lamellas xt, per sq cm	N	Low
Q4292	Lamellas, per sq cm	N	Low
Q4293	Acesso dl, per sq cm	N	Low
Q4294	Amnio quad-core, per sq cm	N	Low
Q4295	Amnio tri-core, per sq cm	N	Low
Q4296	Rebound matrix, per sq cm	N	Low
Q4297	Emerge matrix, per sq cm	N	Low
Q4298	Amnicore pro, per sq cm	N	Low
Q4299	Amnicore pro+, per sq cm	N	Low
Q4300	Acesso tl, per sq cm	N	Low
Q4301	Activate matrix, per sq cm	N	Low
Q4302	Complete aca, per sq cm	N	Low
Q4303	Complete aa, per sq cm	N	Low
Q4304	Grafix plus, per sq cm	N	Low

Table 20. ─ Skin Substitute Products Reassigned to the High-Cost Skin Substitute Group as of January 1, 2024

CY 2024 HCPCS Code	CY 2024 Short Descriptor	CY 2024 SI	Old Low-/High-Cost Skin Substitute Group	January 2024 Low-/High-Cost Skin Substitute Group
A2025	Miro3d per cubic cm	N	N/A	High
Q4278	Epieffect, per sq cm	N	Low	High

Table 21. – Skin Substitute Assignments to High-Cost and Low-Cost Groups for CY 2024

CY 2024 HCPCS Code	CY 2024 Short Descriptor	CY 2023 High-/Low-Cost Assignment	CY 2024 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	N/A	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
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	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	Low	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
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*
Q4210	Axolotl graf dualgraf 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	Low
Q4217	Woundfix biowound plus xplus	High	High
Q4218	Surgicord per sq cm	Low	High
Q4219	Surgigraft dual per sq cm	High	High*
Q4220	Bellacell HD, Surederm sq cm	Low	Low
Q4221	Amniowrap2 per sq cm	Low	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
Q4228	Bionextpatch, per sq cm	Low	Low
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
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	Low	High
Q4253	Zenith amniotic membrane psc	Low	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	Low
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	Low
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
Q4277	Woundplus e-grat, per sq cm	Low	Low
Q4278	Epieffect, per sq cm	Low	High
Q4279	Vendaje ac, per sq cm	N/A	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	Low	Low
Q4286	Nudyn sl or slw, per sq cm	Low	Low
Q4287	Dermabind dl, per sq cm	N/A	Low
Q4288	Dermabind ch, per sq cm	N/A	Low
Q4289	Revoshield+ amnio, per sq cm	N/A	Low
Q4290	Membrane wrap hydr per sq cm	N/A	Low
Q4291	Lamellas xt, per sq cm	N/A	Low
Q4292	Lamellas, per sq cm	N/A	Low
Q4293	Acesso dl, per sq cm	N/A	Low
Q4294	Amnio quad-core, per sq cm	N/A	Low
Q4295	Amnio tri-core, per sq cm	N/A	Low
Q4296	Rebound matrix, per sq cm	N/A	Low
Q4297	Emerge matrix, per sq cm	N/A	Low
Q4298	Amnicore pro, per sq cm	N/A	Low
Q4299	Amnicore pro+, per sq cm	N/A	Low
Q4300	Acesso tl, per sq cm	N/A	Low
Q4301	Activate matrix, per sq cm	N/A	Low
Q4302	Complete aca, per sq cm	N/A	Low
Q4303	Complete aa, per sq cm	N/A	Low
Q4304	Grafix plus, per sq cm	N/A	Low

* These products do not exceed either the MUC or PDC threshold for CY 2024 but are assigned to the high-cost group because they were assigned to the high-cost group in CY 2023.

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

(Rev.12421; Issued:12-21-23)

10.2.3 - Comprehensive APCs

(Rev.12421; Issued: 12-21-23; Effective: 01-01-24; Implementation: 01-02-24)

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)