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What's Next for the OPPS

A Look at the 2023 Final Rule

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Jennifer Bishop

RHIT, CCS, CCS-P, CHRI

Updates Affecting OPPS Payment

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

Updates Affecting OPPS Payment

- Final OPPS Conversion Factor of $85.585 – Up from $84.177 for 2022
- Predicted increase of 4.5% in OPPS payments to providers
- The 2% reduction will still apply to hospitals not meeting quality reporting requirements – CF of $83.934
- The 7.1% adjustment for rural sole community hospitals will continue
- Adjustment for cancer hospitals will continue (payment-to-cost ratio equal to 0.90)

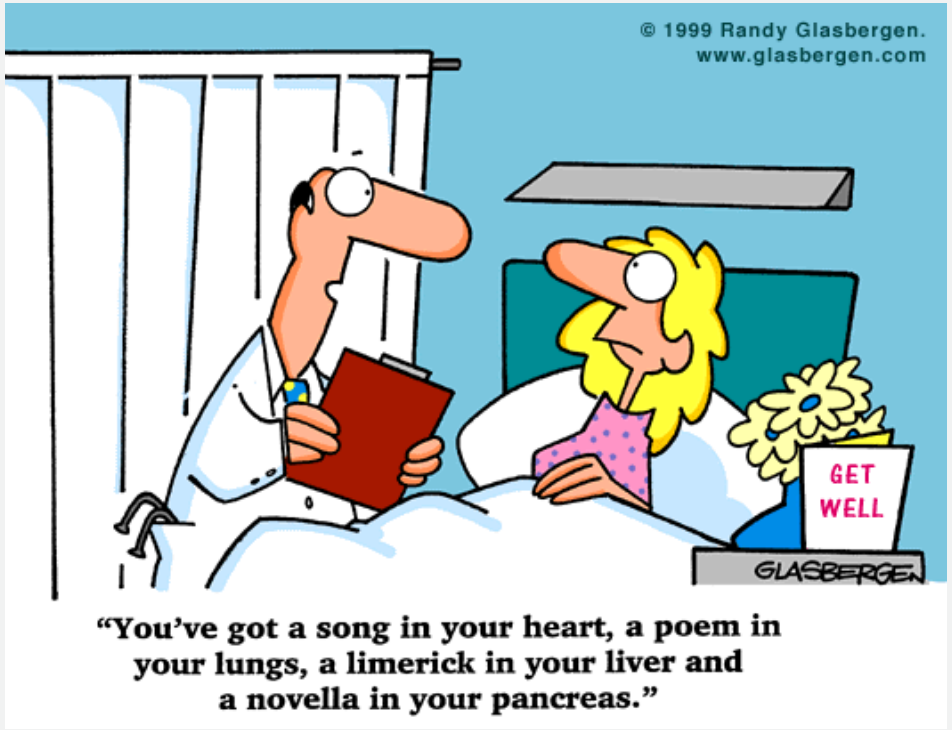
Updates Affecting OPPS Payment

- IPPS wage index adjustments will be used to calculate OPPS adjustments on 1/1/2023
- Continuing to use revised delineations per the OMB (built from 2010 census results)
- Wage index decreases will be capped at 5%; no cap on increases
- All changes are budget neutral
  - Decrease in conversion factor of .9691 will be implemented to offset the 340B drug changes

Updates Affecting OPPS Payment

- Hospital outlier payments will be triggered when a hospital's cost of furnishing a service exceeds 1.75 times the APC payment amount AND exceeds fixed dollar amount of $8,625 (up from $6,175 for CY 2022)
- Outlier payments continue to be calculated as 50% of the amount by which the cost of the service exceeds 1.75 times the APC payment amount

Updates to Comprehensive APCs (C-APCs)



Final Changes to C-APCs

- **One New C-APC is being added for CY 2023**
  - APC 5372 – Level II Urology and Related Services
    - 0596T/0597T – Insertion or replacement of female intra-urethral valve pump
    - 50389 – Removal of nephrostomy tube
    - 50396 – Manometry through nephrostomy/pyelostomy
    - 50430/50431 – Antegrade nephrostogram/ureterogram
    - 50572 – Renal endoscopy through nephrotomy/pyelotomy
    - 51710 – Complicated change of cystostomy tube
    - 51728/51729 – Complex cystometrogram
    - 52000 – Cystourethroscopy
    - 52010 – Cystourethroscopy with ejaculatory duct catheterization
    - 52285 – Cystourethroscopy with treatment of female urethral syndrome
    - 53080 – Drainage of perineal urinary extravasation
    - 53620 – Dilation of urethral stricture in male
    - 54160 – Neonatal circumcision by surgical excision

Final Changes to C-APCs

- **Current packaging exception for COVID-19 treatments will continue through the end of the current PHE**
  - Treatment must be a drug or biological authorized to treat COVID-19
  - Treatment must be authorized for use in the outpatient setting or not be limited to the inpatient setting
- **New packaging exception added for new drugs reported using C9399**
  - C9399 drugs will be manually priced at 95% of AWP

Updates to OPPS APC-Specific Policies

Changes to New Technology APC Groups

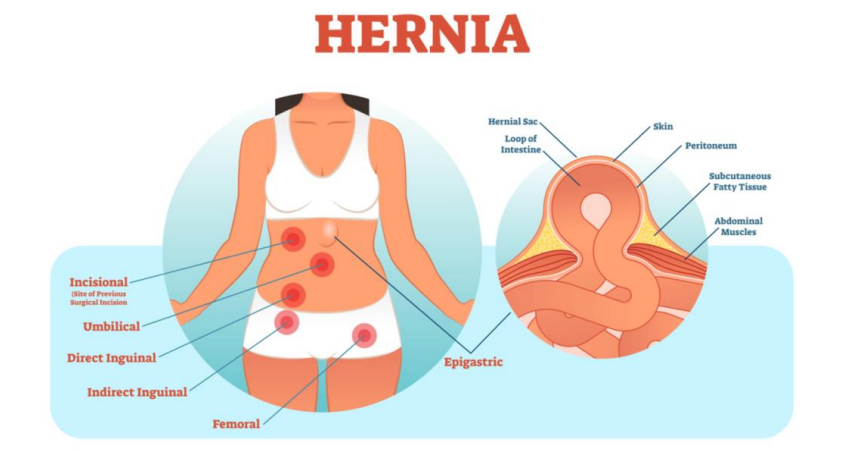
HCPCS	Description	2023 APC	2023 $	2022 APC	2022 $
C9770	Vitrectomy, mechanical, pars plana approach, with subretinal injection of pharmacologic/biologic agent	1562	$3,751	1561	$3,251
78431	Myocardial imaging, PET, perfusion study; multiple studies at rest and stress, with concurrently acquired CT transmission scan	1523	$2,751	1522	$2,251
78432	Myocardial imaging, PET, combined perfusion with metabolic evaluation study, dual radiotracer	1520	$1,851	1523	$2,751
78433	Myocardial imaging, PET, combined perfusion with metabolic evaluation study, dual radiotracer; with concurrently acquired CT transmission scan	1521	$1,951	1523	$2,751

Changes to New Technology APC Groups

HCPCS	Description	2023 APC	2023 $	2022 APC	2022 $
G2082	Office or other outpatient visit for an established patient that requires the supervision of a physician or other QHP and provision of up to 56 mg of esketamine nasal self-administration	1512	$1,051	1508	$651
G2083	Office or other outpatient visit for an established patient that requires the supervision of a physician or other QHP and provision of greater than 56 mg of esketamine nasal self-administration	1516	$1,451	1511	$951
0424T	Insertion or replacement of neurostimulator system for treatment of central sleep apnea; complete system	1581*	$55,001	5465	$30,063

* Temporary assignment pending more claims data

Hernia Repairs



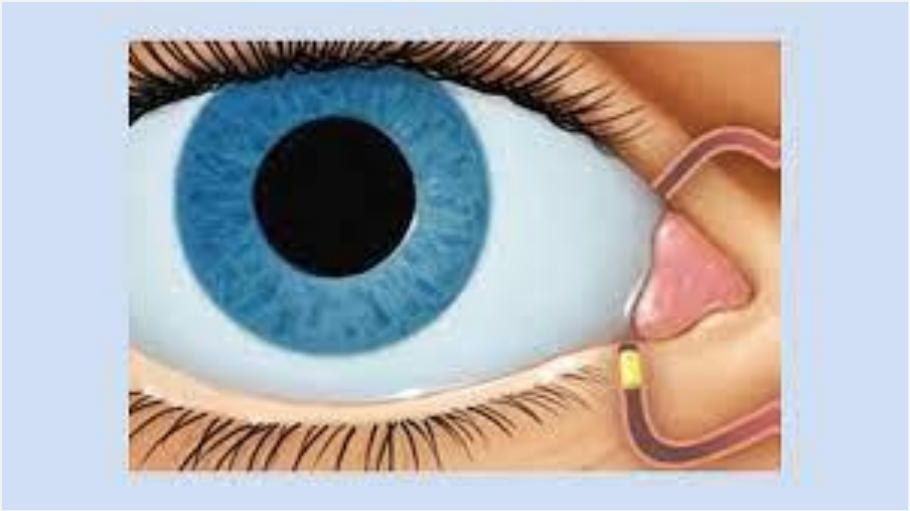
- **18 abdominal hernia repair codes are being deleted and replaced with 15 new codes**

- Current coding based on hernia type, approach, patient age, recurrence, and hernia state (reducible versus incarcerated)
- For 2023, coding will be based on size, location, recurrence, and hernia state (reducible versus incarcerated)
- CMS is using hernia state as primary differentiator for payment pending claims data

Hernia Repairs

APC 5341 - $3542	APC 5361 - $5,212	Inpatient Only Px	Packaged Service
49591 – Initial reducible abdominal hernia <3 cm	49592 – Initial incarcerated abdominal hernia <3 cm	49596 – Initial incarcerated abdominal hernia >10 cm	49623 – Removal of mesh or prosthesis at time of hernia repair
49593 – Initial reducible abdominal hernia 3-10 cm	49594 – Initial incarcerated abdominal hernia 3-10 cm	49616 – Recurrent incarcerated abdominal hernia 3-10 cm	
49595 – Initial reducible abdominal hernia >10 cm	49614 – Recurrent incarcerated abdominal hernia <3 cm	49617 – Recurrent reducible abdominal hernia >10 cm	
49613 – Recurrent reducible abdominal hernia <3 cm		49618 – Recurrent incarcerated abdominal hernia >10 cm	
49615 – Recurrent reducible abdominal hernia 3-10 cm		49621 – Reducible parastomal hernia	
		49622 – Incarcerated parastomal hernia	

Lacrimal Ophthalmic Insert (Dextenza)



- **68841 – Insertion of drug-eluting implant into lacrimal canaliculus**

- Reassigned from APC 5694 (2022) to 5503 (2023)
- Status Indicator Q1 not changing
- Reimbursement change from $326 (2022) to $2,114 (2023)
- J1096 (Dextenza) will no longer receive separate reimbursement

Artificial Iris Insertion

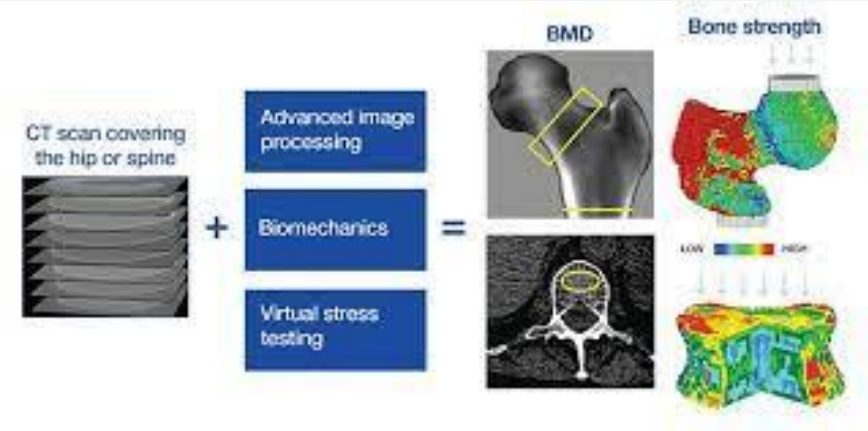
- **0616T – Insertion of iris prosthesis without IOL insertion**
- **0617T – Insertion of iris prosthesis with IOL insertion**
- **0618T – Insertion of iris prosthesis with IOL exchange**

- Reassigned from APC 5491/5492 (2022) to 5495 (2023)
- Status Indicator J1 not changing
- Reimbursement change from $2,121/$4,000 (2022) to $18,090 (2023)

New and Unclassified Blood Products

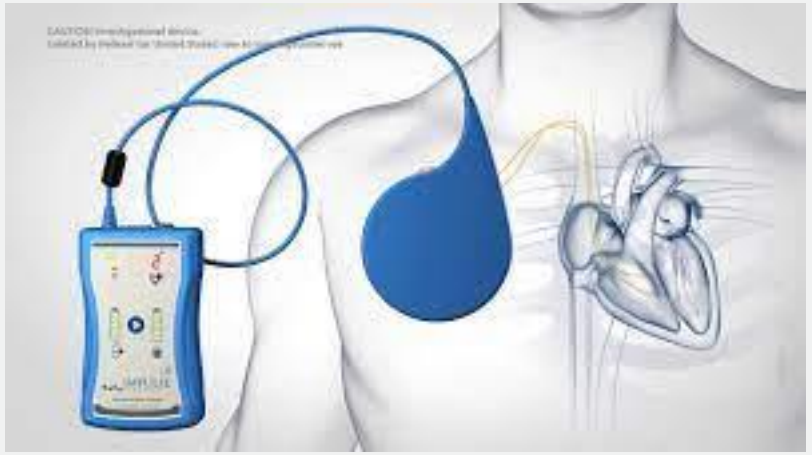
- **P9099 will continue to be used for unclassified blood products**
  - APC 9537 not changing
  - Status indicator of R not changing
  - Reimbursement change from $8 (2022) to $55 (2023)
- **New blood products will have temporary HCPCS codes created and will be crosswalked to existing products pending cost data**

Bone Density Tests



- **New codes 0743T, 0749T and 0750T which describe bone mineral density studies using data from existing studies analyzed by computer software, will be assigned to status indicator “E1”**
- **Existing codes 0554T-0558T will also continue to be assigned to status indicator “E1”**
  - CMS does not believe these meet the definition of payable bone mass measurements for Medicare beneficiaries
  - Interested parties should request reconsideration of this stance through the established NCD process

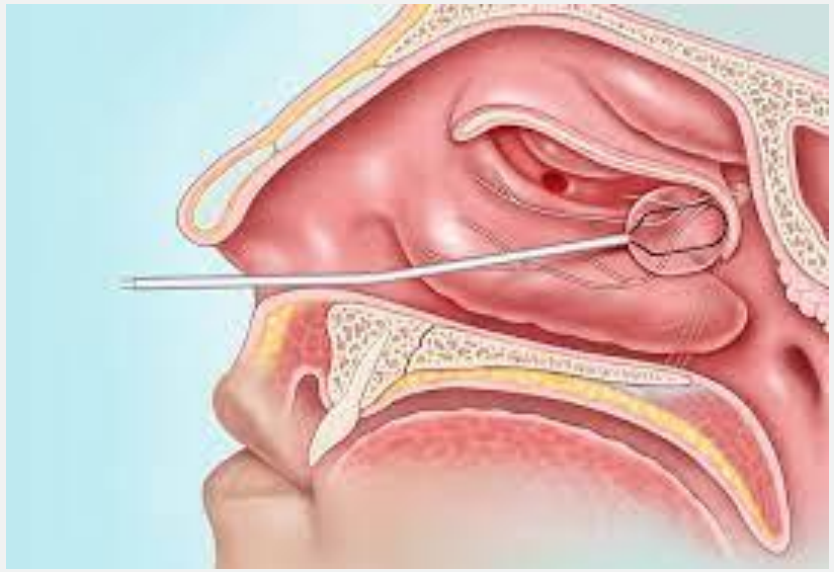
Cardiac Contractility Modulation



- **0408T – Insertion or replacement of permanent cardiac contractility modulation system**

- Reassigned from APC 5231 (2022) to APC 5232 (2023)
- Status indicator J1 remains unchanged
- Reimbursement change from $23,551 (2022) to $32,076 (2023)

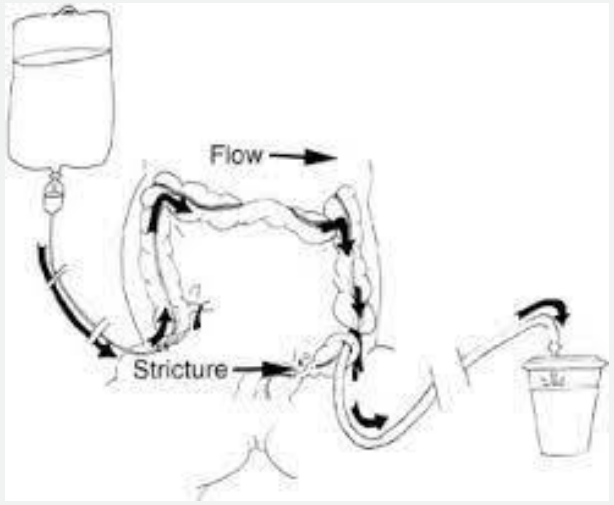
ClaraFix Procedure



- **C9771 – Nasal/sinus endoscopy, cryoablation nasal tissue(s) and/or nerve(s)**

  - Reassigned from APC 5164 (2022) to APC 5165 (2023)
  - Status indicator J1 remains unchanged
  - Reimbursement change from $2,794 (2022) to $5,340 (2023)

Colonic Lavage



- **0736T – Colonic lavage, 35 or more liters of water, gravity-fed, including insertion of rectal catheter**

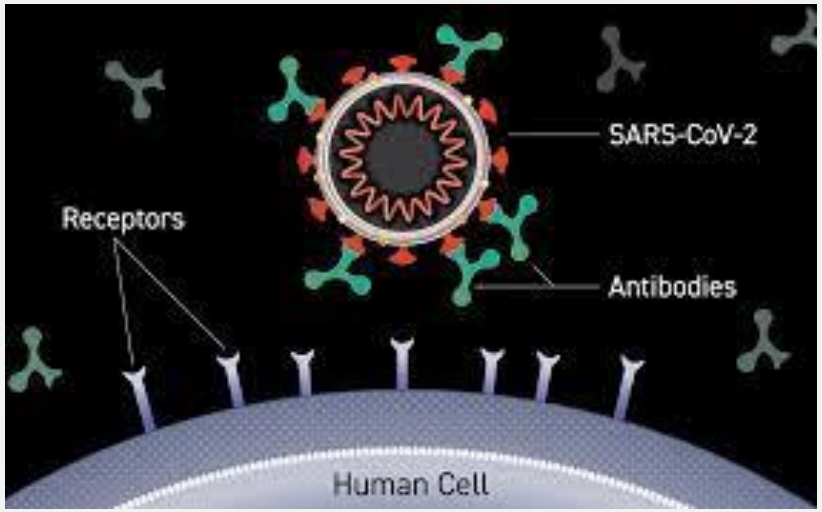
- Reassigned from APC 5733 (2022) to APC 5721 (2023)
- Status indicator changed from “Q1” (2022) to “S” (2023)
- Reimbursement change from $57 (2022) to $145 (2023)

COVID-19 Vaccine Administration

Site-neutral payment for COVID-19 vaccine administration will continue for CY 2023

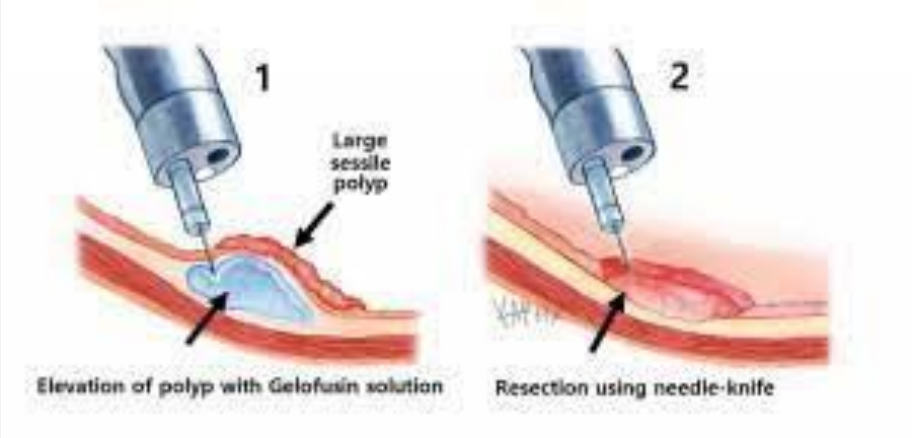
- **If the Emergency Use Authorization (EUA) is terminated in CY 2022, payment rate will be $31.14 for COVID-19 vaccine administration**
  - APC 9397 (first dose) and APC 9398 (additional dose)
- **If the EUA is not terminated in CY 2022, payment rate will be $41.52**
- **New APC 9399 created for home administration of COVID-19 vaccine with payment rate of $36.85**
  - HCPCS code M0201 is the only code currently assigned

Monoclonal Antibodies for COVID-19



- **CMS will continue to pay for monoclonal antibody COVID-19 pre-exposure prophylaxis products under the Part B vaccine benefit after the EUA declaration is terminated so long as products remain FDA authorized**
  - New Technology APCs 1503-1507 depending on route of administration and care setting

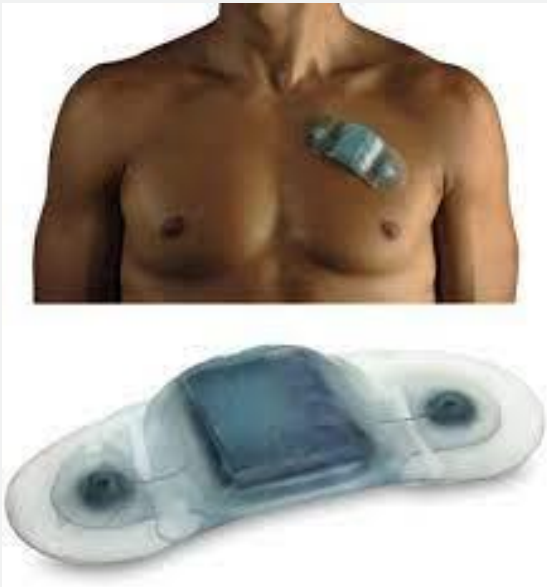
Endoscopic Submucosal Dissection



C9779 – Endoscopic submucosal dissection, including endoscopy or colonoscopy, mucosal closure, when performed

- Reassigned from APC 5313 (2022) to APC 5303 (2023)
- Status indicator remains J1
- Reimbursement change from $2,495 (2022) to $3,261 (2023)

External Electrocardiographic Recording



93242 – External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; recording

- Reassigned from APC 5732 (2022) to APC 5733 (2023)
- Status indicator remains Q1
- Reimbursement change from $57 (2022) to $34 (2023)

Eye Movement Analysis (EyeBOX)

0615T – Eye-movement analysis without spatial calibration, with interpretation and report

- APC 5734 unchanged
- Status indicator changed from Q1 (2022) to S (2023) which will allow for separate payment even when provided on the same date as other payable services

IB-Stim Application

0720T – Percutaneous electrical nerve field stimulation, cranial nerves, without implantation

- Reassigned from APC 5722 (2022) to APC 5724 (2023)
- Status indicator remains S
- Reimbursement change from $270 (2022) to $934 (2023)

InSpace Subacromial Tissue Spacer

- **C9781 – Arthroscopy, shoulder, surgical with implantation of subacromial spacer, includes debridement, subacromial decompression, acromioplasty, and biceps tenodesis when performed**

- Reassigned from APC 5114 (2022) to APC 5115 (2023)
- Status indicator remains J1
- Reimbursement change from $6,397 (2022) to $13,048 (2023)

Medical Physics Dose

- **76145 – Medical physics dose evaluation for radiation exposure that exceeds institutional review threshold, including report**

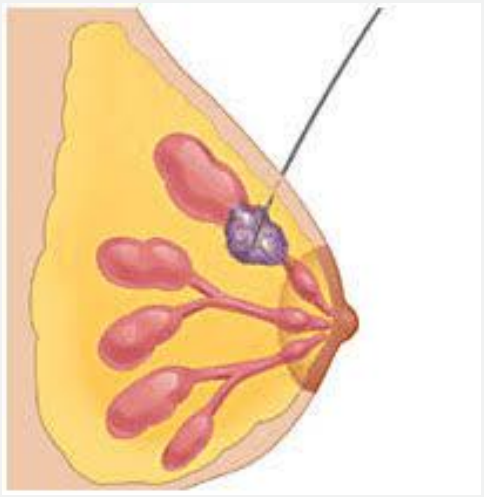
- Reassigned from APC 5612 (2022) to APC 5723 (2023)
- Status indicator remains S
- Reimbursement change from $346 (2022) to $483 (2023)

Pathology Services

- **88121 – Cytopathology, in situ hybridization, urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen, using computer-assisted technology**

- Reassigned from APC 5673 (2022) to APC 5672 (2023)
- Status indicator remains Q1
- Reimbursement change from $297 (2022) to $157 (2023)

Placement of Breast Localization Devices



- **19281 – Placement of breast localization device(s), percutaneous, first lesion, including mammographic guidance**
- Reassigned from APC 5071 (2022) to APC 5072 (2023)
- Status indicator remains Q1
- Reimbursement change from $636 (2022) to $1,500 (2023)
- Codes 19283, 19285, and 19287 will remain in APC 5071

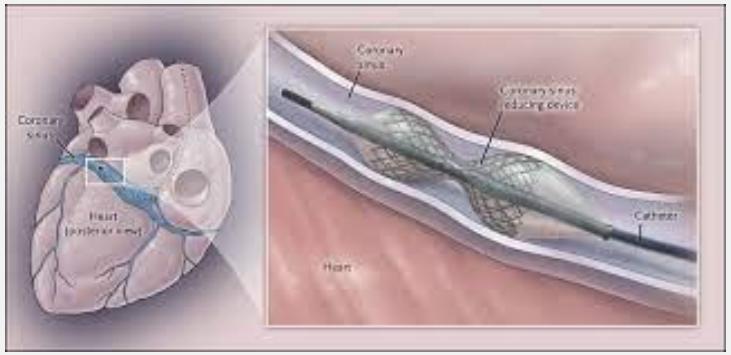
ProSense™ Cryoablation Procedure

- **0581T – Ablation, malignant breast tumor(s), percutaneous, cryotherapy, including imaging guidance when performed, unilateral**
  - Assigned to APC 5091 (2023)
  - Status indicator changed from E1 to J1
  - Reimbursement change from $0 (2022) to $3,438 (2023)

Total Ankle Replacement

- **27702 – Arthroplasty, ankle; with implant**
- Reassigned from APC 5115 (2022) to APC 5116 (2023)
- Status indicator remains J1
- Reimbursement change from $12,593 (2022) to $21,898 (2023)

Coronary Sinus Reduction Device



- **0645T – Will be used to report patients in a non-randomized cohort study for the COSIRA-II device**
- Assigned to APC 5194 (2023)
- Status indicator change from E1 (2022) to J1 (2023)
- Reimbursement change from $0 (2022) to $17,178 (2023)

Dental Services

- **New code being created to describe facility services for dental rehabilitation procedures furnished to patients who require monitored anesthesia and use of operating room (G0330)**
  - APC 5871 – Status Indicator S with payment of $1,722
  - May only be used to bill for services that meet Medicare coverage requirements

- **Code 41899 will remain in APC 5161**
  - Status indicator T with payment of $208
  - Should only be used to identify dental services that do not meet criteria for G0330
  - May only be billed to Medicare when a covered dental service is being performed

Urology Services

- **Eight procedures moving from APC 5375 with payment of $4,506 (2022) to 5376 with payment rate of $8,558 (2023)**
  - 50576 - Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy
  - 51860 - Cystorrhaphy, suture of bladder wound, injury or rupture; simple
  - 53449 - Repair of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff
  - 53452 - Periurethral transperineal adjustable balloon continence device; unilateral insertion, including cystourethroscopy and imaging guidance
  - 54316 – Urethroplasty for second stage hypospadias repair with free skin graft obtained from site other than genitalia
  - 54344 – Repair of hypospadias complication(s); requiring mobilization of skin flaps and urethroplasty with flap or patch graft
  - 55880 – Ablation of malignant prostate tissue, transrectal, with high intensity focused ultrasound, including ultrasound guidance
  - C9769 - Cystourethroscopy, with insertion of temporary prostatic implant/stent with fixation/anchor and incisional struts

OPPS Payment For Devices

Pass-Through Status for Devices

There are 8 Devices with Continuing Pass-Through Status for 2023

HCPCS Code	Long Descriptor	Product Name	Expiration Date
C1052	Hemostatic agent, gastrointestinal, topical	Hemospray®	12/31/23
C1062	Intravertebral body fracture augmentation with implant (e.g., metal, polymer)	SpineJack® System	12/31/23
C1748	Endoscope, single-use (that is, disposable), Upper GI, imaging/illumination device (insertable)	EXALT™ duodenoscope	6/30/23
C1761	Catheter, transluminal intravascular lithotripsy, coronary	Shockwave C^2 Intravascular Lithotripsy Catheter	6/30/24
C1825	Generator, neurostimulator (implantable), non-rechargeable with carotid sinus baroreceptor stimulation lead(s)	BaroStim™ Neo Device	12/31/23
C1831	Interbody cage, anterior, lateral, or posterior, personalized (implantable)	aprevo™	9/30/24
C1832	Autograft suspension, including cell processing and application, and all system components	RECELL® System	12/31/24
C1833	Monitor, cardiac, including intracardiac lead and all system components (implantable)	AngelMed Guardian™	12/31/24

Pass-Through Status for Devices

There are 6 Devices with Expiring Pass-Through Status on 12/31/22

HCPCS Code	Long Descriptor	Product Name
C1734	Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue-to-bone (implantable)	AUGMENT® bone graft
C1823	Generator, neurostimulator (implantable), nonrechargeable, with transvenous sensing and stimulation leads	remedē® System
C1824	Generator, cardiac contractility modulation (implantable)	Optimizer® Smart CCM
C1839	Iris prosthesis	ArtificialIris™
C1982	Catheter, pressure-generating, one-way valve, intermittently occlusive	Surefire® Spark™ Infusion System
C2596	Probe, image-guided, robotic, waterjet ablation	AquaBeam® System

Pass-Through Status for Devices

There are 3 New Devices with Pass-Through Status on 1/1/2023

HCPCS Code	Long Descriptor	Product Name
C1747	Endoscope, single-use (i.e. disposable), urinary tract, imaging/illumination device (insertable)	Ureterol™
C1826	Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system	Evoke® SCS System
C1827	Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller	ViviStim® System
C1834**	Pressure sensor system, includes all components (e.g., introducer, sensor), intramuscular (implantable), excludes mobile (wireless) software application	MY01 Device

** Pass-through status granted 10/1/22 but not discussed previously

Other Device Related Information

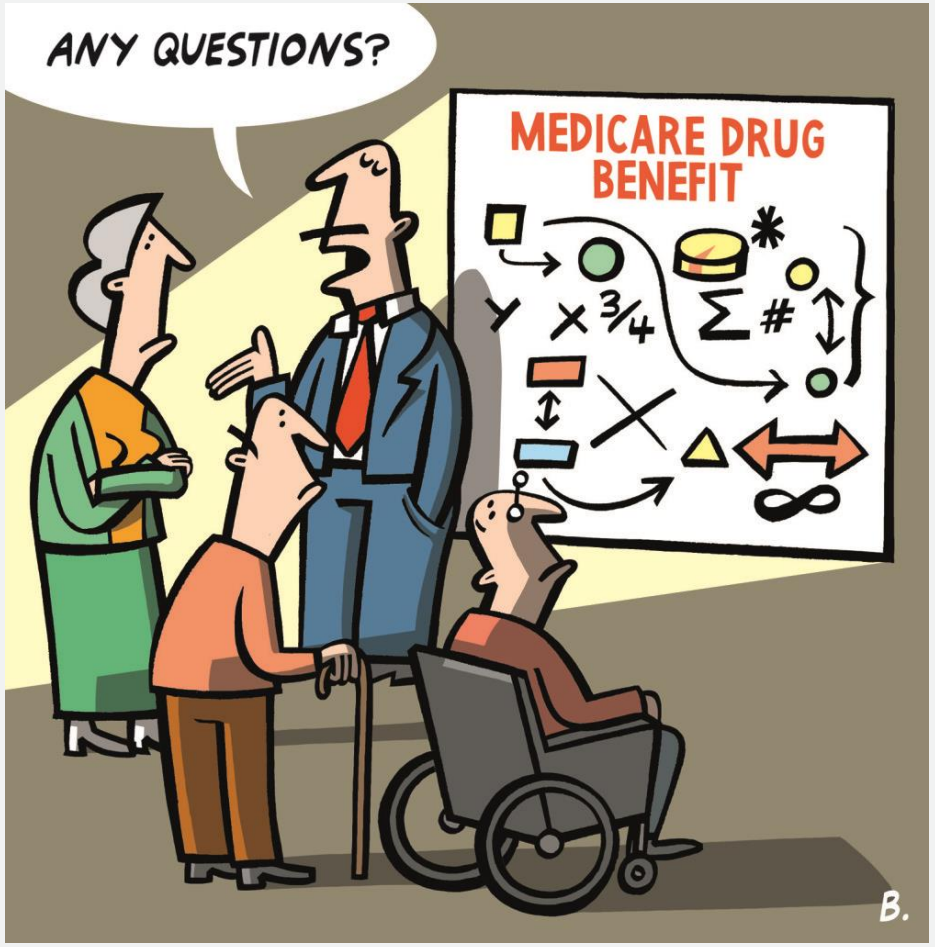
CMS does not produce a list of specific device-to-procedure and procedure-to-device edits

- Any device on the approved list will bypass edit
- CMS expects hospitals to code correctly for procedures and devices

HCPCS code C1889 may be billed with procedures that do not have device-intensive status

- Chapter 4, Section 6.1 of Claims Processing Manual states that hospitals should report C1889 for the use of device not described by a specific HCPCS code

Drugs, Biologicals & Radiopharmaceuticals



Pass-Through Packaging Threshold

- Packaging threshold for CY 2023 will increase to $135 from $130
- Packaging determinations made once a year
  - Based on 2nd Quarter 2022 ASP data from manufacturers
  - Drugs without ASP information use mean unit cost derived from claims data

Payment Boost for Eligible Biosimilars

- Biosimilars with ASP <= the reference biological price will be reimbursed at ASP + 8% for a 5-year period
  - Mandated in Inflation Reduction Act of 2022
  - Aimed at supporting biosimilar production to drive down drug costs
  - Began October 1, 2022

Reversal of Alternate Payment Methodology for 340B Drugs

Separately payable drugs acquired under the 340B Program will be reimbursed at ASP + 6% thanks to a unanimous decision by the US Supreme Court in June

- Modifier JG will continue to be assigned to 340B drugs by OPPS facilities
- Modifier TB will be assigned by rural sole community hospitals, children's hospitals, and PPS-exempt cancer hospitals
  - No payment reduction will result from modifier use
- CMS will issue a separate final rule to address necessary adjustments related to alternate payment methodology from 2018 through 2022 prior to release of CY 2024 OPPS rule

Skin Substitute Products

- HCPCS code C1849 (Synthetic skin substitute) is being deleted
- Synthetic skin substitutes will have product-specific A-codes and will be assigned to high-cost skin substitute application group

A2002 – MIRRAGEN Advanced Wound Matrix	A2005 – Microlyte Matrix
A2006 – NovoSorb SynPath Dermal Matrix	A2007 – Restrata
A2011 – SUPRA SDRM	A2012 – SUPRATHEL
A2013 – InnovaMatrix FS	A2015 – Phoenix Wound Matrix

JW and JZ Modifiers

- New JZ modifier (Zero drug amount discarded/not administered to any patient)
  - All claims with single-use vials will require a modifier
    - JW on a separate line to identify waste
    - JZ on the same claim line to identify no waste
    - Effective on January 1, 2023
    - May be used for provider audits on July 1, 2023
    - Claim edits implement on October 1, 2023

Partial Hospitalization Program

Partial Hospitalization Program

For CY 2023 only, CMS is making an equitable adjustment in order to hold reimbursement steady since reported costs continue to decline

- CMHCs providing 3 or more services per day will continue to be reimbursed under APC 5853
  - CY 2023 reimbursement rate of $142.70
- Hospital-based PHP providers providing 3 or more services per day will continue to be reimbursed under APC 5863
  - CY 2023 reimbursement rate of $268.22

Changes to Inpatient Only (IPO) List

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

Codes Removed from IPO for CY 2023

Code	Long Descriptor	2023 SI	2023 $
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (eg, for Long Face Syndrome), without bone graft	J1	$5,340
21142	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graft	J1	$5,340
21143	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, without bone graft	J1	$5,340
21194	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft	J1	$5,340
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation	J1	$5,340
21255	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage	J1	$5,340
21347	Open treatment of nasomaxillary complex fracture (LeFort II type); requiring multiple open approaches	J1	$5,340
21366	Open treatment of complicated (eg, comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with bone grafting	J1	$5,340
21422	Open treatment of palatal or maxillary fracture (LeFort I type)	J1	$5,340
22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace, lumbar; each additional interspace	N	$0
47550	Biliary endoscopy, intraoperative (choledochoscopy)	N	$0

Codes Added to IPO for CY 2023

Code	Long Descriptor	2023 SI
15778	Implantation of absorbable mesh or other prosthesis for delayed closure of defect(s) (ie external genitalia, perineum, abdominal wall) due to sot tissue infection or trauma	C
22860	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); second interspace, lumbar	C
49596	Repair of anterior abdominal hernia(s) (ie, epigastric, incision, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, incarcerated or strangulated	C
49616	Repair of anterior abdominal hernia(s) (ie, epigastric, incision, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, incarcerated or strangulated	C
49617	Repair of anterior abdominal hernia(s) (ie, epigastric, incision, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, reducible	C
49618	Repair of anterior abdominal hernia(s) (ie, epigastric, incision, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, reducible	C
49621	Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; reducible	C
49622	Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; incarcerated or strangulated	C

Two-Midnight Rule

RAC Review Exemption

- Procedures on the IPO list are appropriate for IP hospital admission **regardless of expected length of stay**
- Procedures removed from the IPO list will be exempt from “patient status” review for 2 years
  - Can still be reviewed by BFCC-QIO or RAC for medical necessity or education
  - Not to be used to determine a hospital’s compliance with the 2-midnight rule

Non-recurring Policy Changes

Remote Mental Health Services

Hospital staff may continue to provide remote mental health services following the end of the COVID-19 PHE

- Patient must be located at home
- Provider must be appropriately licensed with the state
- Post PHE, patients must have an initial in-person visit within 6 months and subsequent visits every 12 months
  - Exception for patients who started services during PHE up to 151 days following end of PHE (initial visit within 12 months)
  - Exception for patients with documentation that in-person visit would cause harm; hospitals must also document that patient has regular source of general medical care
- Audio-only communication is acceptable, but hospital must have capability to provide two-way, audio/video services

Remote Mental Health Services

HCPCS Code	Long Descriptor	2023 $
C7900	Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, initial 15-29 minutes, provided remotely by hospital staff who are licensed to provide mental health services under applicable state law(s), when the patient is in their home, and there is no associated professional service	$30
C7901	Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, initial 30-60 minutes, provided remotely by hospital staff who are licensed to provided mental health services under applicable state law(s), when the patient is in their home, and there is no associated professional service	$76
C7902	Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, each additional 15 minutes, provided remotely by hospital staff who are licensed to provide mental health services under applicable state law(s), when the patient is in their home, and there is no associated professional service	$0

Remote Cardiac & Pulmonary Rehab

- Cardiac & Pulmonary rehabilitation services are on “List of Medicare Telehealth Services”
  - Beneficiaries in rural areas will be able to receive these services via two-way, audio/video communication through December 31, 2023
  - Beneficiaries in non-rural areas will be able to receive these services for 151 days following end of COVID-19 PHE
- Supervising practitioner may meet direct supervision requirements via two-way, audio/video communication through December 31, 2023

Supervision Requirements

- Certain non-physician practitioners may supervise the performance of outpatient diagnostic services when practicing under their scope of practice and State law
  - Nurse practitioners
  - Physician assistants
  - Clinical nurse specialists
  - Certified nurse midwives
- Supervising practitioner may meet supervision requirements via two-way, audio/video communication through the end of the year in which the COVID-19 PHE ends

Software as a Service (SaaS)

- **SaaS add-on codes will be assigned to identical APCs as their standalone counterparts**
  - Services were previously packaged under Medicare's rules for add-on codes

Code	Descriptor	Trade Name	2023 SI	2023 $
0649T	Quantitative magnetic resonance for analysis of tissue composition, including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the same anatomy; single organ	Liver MultiScan	S	$951
0722T	Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained with concurrent CT examination of any structure contained in the concurrently acquired diagnostic imaging dataset	Optellum LCP	S	$651
0724T	Quantitative magnetic resonance cholangiopancreatography (QMRCP), including data preparation and transmission, interpretation and report, obtained with diagnostic magnetic resonance imaging (MRI) examination of the same anatomy	QMRCP	S	$951

Status Indicator Description Changes

- **Status Indicator A revised to include a new definition of "Unclassified drugs and biologicals reportable under HCPCS code"**
  - Will apply to HCPCS code C9399 to ensure appropriate reimbursement at 95% of AWP
- **Status Indicator F revised to remove Hepatitis B vaccines from the description**
- **Status Indicator L revised to add Hepatitis B vaccines to the description**
  - Hepatitis B vaccine should not be subject to deductible and coinsurance

Method to Control Unnecessary Increases in Hospital OP Services

Clinic visits provided in excepted off-campus provider-based clinics will continue to be reimbursed at the Physician Fee Schedule (PFS) rate

- Will apply to HCPCS code G0463, Outpatient clinic visit, when reported with modifier PO
  - For 2023, reimbursement rate will be equal to 40% of reimbursement under OPPS
    - $48.34
  - New exception for rural sole community hospitals (SCH) who will be reimbursed full OPPS payment
    - $120.86 for CY 2023
    - Still required to assign modifier PO

Current Services Requiring Prior Authorization

Botox Injections

CPT codes: 64612 64615 J0585 J0586 J0587 J0588

Panniculectomy

CPT codes: 15830 15847 15877

Vein Ablation

CPT codes: 36473 36474 36475 36476 36478 36479 36482 36483

Rhinoplasty

CPT codes 20912 21210 30400 30410 30420 30430 30435 30450 30460 30462 30465 30520

Blepharoplasty

CPT codes: 15820 15821 15822 15823 67900 67901 67902 67903 67904 67906 67908

Cervical Fusion w/Disc Removal

CPT codes: 22551 22552

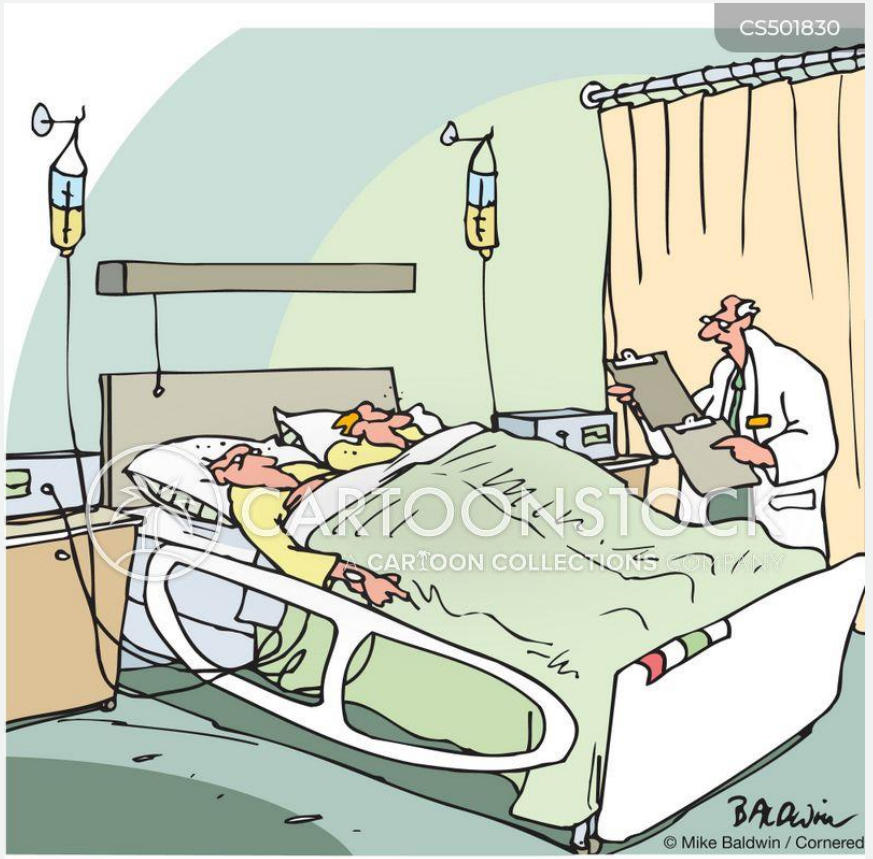
Implanted Spinal Neurostimulators

CPT code: 63650

New Service Requiring Prior Authorization

- Facet Joint Innervations
  - CPT codes: 64490, 64491, 64492, 64493, 64494, 64495, 64633, 64634, 64635, 64636
- New service added as of July 1, 2023

Hospital outpatient quality reporting program



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

Measures Retained for CY 2023 Reporting

Measure Name
OP-8: MRI Lumbar Spine for Low Back Pain
OP-10: Abdomen CT – Use of Contrast Material
OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery
OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients
OP-22: Left Without Being Seen
OP-23: Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival
OP-29: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
OP-31: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery (Voluntary reporting; reporting will be required for 2025)

Measures Retained for CY 2023 Reporting

Measure Name
OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
OP-35: Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy
OP-36: Hospital Visits after Hospital Outpatient Surgery
OP-37a-e: Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery Survey (OAS CAHPS) (Voluntary reporting; reporting will be required for 2024)
OP-38: COVID-19 Vaccination Coverage Among Health Care Personnel
OP-39: Breast Screening Recall Rates (New measure)
OP-40: ST-Segment Elevation Myocardial Infarction (STEMI) electronic clinical quality measure (eCQM) (Voluntary reporting; reporting will be required for 2024)

Rural Emergency Hospitals (REHs)

Criteria for Rural Emergency Hospital

- Facility must have been a Critical Access Hospital or a Rural Hospital with Not More Than 50 Beds
- Must provide emergency department and observation services
- Must have a staffed ER 24/7 with a physician, nurse practitioner, clinical nurse specialist or physician assistant
- Does not provide IP services
- Have a transfer agreement in place with a Level I/II trauma center
- Must meet CoP for emergency rooms

Reimbursement for REHs

- Will receive OPPS payment +5% for any covered hospital outpatient service
  - Beneficiary co-payment will exclude additional 5%
- Items currently paid at fee schedule will continue to be paid at current fee schedule amounts
  - Labs
  - Ambulance services
  - Outpatient therapy services
- Will receive additional monthly facility payment
  - $272,866 for 2023
- Reduction for services provided in off-campus PBDs will not apply

Questions?

Thank you!