mln MATTERS®
KNOWLEDGE • RESOURCES • TRAINING

Hospital Outpatient Prospective Payment System: January 2023 Update

MLN Matters Number: MM13031 | Related Change Request (CR) Number: 13031

Related CR Release Date: December 8, 2022 | Effective Date: January 1, 2023

Related CR Transmittal Number: R11737CP | Implementation Date: January 3, 2023

Related CR Title: January 2023 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Provider Types Affected

This MLN Matters Article is for physicians, hospitals, other providers, and suppliers billing Medicare Administrative Contractors (MACs) for services they provide to Medicare patients.

Provider Action Needed

Make sure your billing staff knows about payment system updates and new codes for:

- COVID-19
- Drugs, biologicals, and radiopharmaceuticals
- Devices
- Other items and services

Background

CR 13031 describes changes to and billing instructions for payment policies implemented in the January 2023 OPPS update. The January 2023 Integrated Outpatient Code Editor (I/OCE) will show the HCPCS, Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR 13031. The January 2023 revisions to I/OCE are in CR 12998.

The key points of CR 13031 are:

1. New COVID-19 CPT Vaccines and Administration Codes

The AMA has been issuing unique CPT Category I codes developed in collaboration with CMS and the CDC for each COVID-19 vaccine as well as administration codes unique to each vaccine and dose. These codes are effective upon getting FDA Emergency Use Authorization (EUA) or approval.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

On August 19, 2022, the FDA changed the EUA of the "Novavax COVID-19 Vaccine, Adjuvanted" to authorize its use for the prevention of COVID-19 for individuals 12 through 17 years of age. This changes the July 13, 2022 revision that authorized its use for the prevention of COVID-19 for individuals 18 years of age and older. CPT code 91304 describes the "Novavax COVID-19 Vaccine, Adjuvanted." and CPT codes 0041A and 0042A. You can bill CPT codes 0041A and 0042A for ages 12 and older for giving the vaccine's first and second dose, respectively.

On August 31, 2022, the AMA released 8 new codes for the bivalent COVID-19 vaccine booster doses from Moderna and Pfizer-BioNTech. The updated boosters are for the BA.4 and BA.5 Omicron subvariants and the original COVID-19 strain in a single dose.

On August 31, 2022, FDA authorized the "Moderna COVID-19 Vaccine, Bivalent" (91313) for use as a single booster dose in individuals 18 years of age and older and the "Pfizer-BioNTech COVID-19 Vaccine, Bivalent" (91312) for use as a single booster dose in individuals 12 years of age and older. CMS identifies an effective date of August 31, 2022, for the Pfizer-BioNTech and Moderna COVID-19 vaccine, bivalent administration CPT codes, 0124A and 0134A, respectively, which describe giving the bivalent vaccines as a booster dose.

Effective August 31, 2022, CPT codes 0124A and 0134A are assigned to status indicator "S" (Procedure or Service, Not Discounted When Multiple, separate APC assignment) and APC 9398 (Covid-19 Vaccine Admin Dose 2 of 2, Single Dose Product or Additional Dose) in the January 2023 I/OCE update. Patient cost-sharing won't apply to CPT codes 0124A and 0134A.

Effective August 31, 2022, we assigned CPT codes 91312 and 91313 to status indicator "L" (Not paid under OPPS. Paid at reasonable cost; not subject to deductible or coinsurance).

On October 12, 2022, FDA authorized the "Moderna COVID-19 Vaccine, Bivalent" (91314) for use as a single booster dose in individuals 6 years through 11 years and the "Pfizer-BioNTech COVID-19 Vaccine, Bivalent" (91315) for use as a single booster dose in individuals 5 years through 11 years. We use an effective date of October 12, 2022, for the Pfizer-BioNTech and Moderna COVID-19 vaccine, bivalent administration CPT codes, 0154A and 0144A, respectively. We assigned CPT codes 91314 and 91315 to status indicator "L".

Effective October 12, 2022, CPT codes 0144A and 0154A are assigned to status indicator "S", APC 9398. Patient cost-sharing won't apply to CPT codes 0144A and 0154A

On October 12, 2022, the FDA amended the EUA of the "Moderna COVID-19 Vaccine, Bivalent" (91313) to authorize its use as a single booster for ages 12 years and older. This is a change from the August 31, 2022 revision that authorized its use as a single booster dose for ages 18 years and older. You can bill CPT code 0134A for administering the "Moderna COVID-19 Vaccine, Bivalent" for ages 12 years and older.

The AMA released new vaccine administration code (0044A) for the administration of a booster dose of the "Novavax COVID-19 Vaccine, Adjuvanted" (91304). On October 19, 2022, the FDA

amended the EUA of the "Novavax COVID-19 Vaccine, Adjuvanted" to authorize its use as a first booster dose for individuals 18 years and older. We use an effective date of October 19, 2022, for CPT code 0044A for patients ages 18 years and older.

Effective October 19, 2022, we assigned CPT code 0044A to status indicator "S", APC 9398. Patient cost-sharing won't apply to CPT code 0044A.

On November 16, 2022, the AMA released a new vaccine product code (91316) and a new vaccine administration code (0164A) for a booster dose of the Moderna bivalent vaccine to address severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) COVID-19 for patients aged 6 months through 5 years. These codes will be effective upon getting FDA's EUA. We assigned CPT codes 0164A and 91316 to status indicator "E1" (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) in the January 2023 IOCE update.

Table 1 of CR 13031 lists the long descriptors for the codes. These codes, along with their short descriptors, status indicators, and payment rates (where applicable) are also in the January 2023 OPPS Addendum B. For information on the OPPS status indicators, refer to OPPS Addendum D1 of the CY 2023 OPPS/Ambulatory Surgical Center (ASC) final rule for the latest definitions.

2. Updated Payment rates for COVID-19 Vaccine Administration APCs 9397 and 9398 and New COVID-19 Vaccine Home Administration APC 9399.

Effective January 1, 2023, we're updating payment rates for COVID-19 vaccine administration APCs 9397 and 9398. We're also creating new COVID-19 vaccine home administration APC 9399 and re-assigning HCPCS code, 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) from APC 1494 to new APC 9399. Table 2 of CR 13031 lists the APC titles for the three COVID-19 vaccine administration APCs. The COVID-19 vaccine administration APCs along with their status indicators and payment rates are in the January 2023 OPPS Addendum A.

The COVID-19 vaccine administration CPT codes assigned to these 3 APCs, along with their short descriptors, status indicators, APCs, and payment rates are listed in the January 2023 OPPS Addendum B.

3. CPT Proprietary Laboratory Analyses (PLA) Coding Changes Effective January 1, 2023

The AMA CPT Editorial Panel established 9 new PLA codes, CPT codes 0355U through 0363U, effective January 1, 2023. Table 3 in CR 13031 lists the long descriptors and status indicators for the codes. Also, the codes, along with their short descriptors and status indicators, are listed in the January 2023 OPPS Addendum B.

4. Status Indicator Change for CPT PLA Code 0343U

We're changing the status indicator for CPT PLA code, 0343U from "E1" (Not paid by Medicare

when submitted on outpatient claims (any outpatient bill type)) to indicator “A” (Not paid under OPPS. Paid by MACs under a fee schedule or payment system other than OPPS) effective October 1, 2022. Table 4 of CR 13031 lists the official long descriptor and status indicator for CPT code 0343U. Short descriptor and status indicator for CPT code 0343U are in Addendum B of the January 2023 OPPS Update.

5. a. New Device Pass-Through Category Effective January 1, 2023

Section 1833(t)(6)(B) of the Social Security Act (the Act) requires, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. It also requires us to create more categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

We approved 3 new devices (HCPCS codes C1747, C1826, and C1827) for pass-through status under the OPPS effective January 1,2023. See Table 5A of CR 13031 for the long descriptor, status indicator, APC, and offset amount for these 3 HCPCS codes.

We’re adding 3 new device category codes and their pass-through expiration dates to Table 6 of CR 13031. We’re updating the device category long descriptor for HCPCS code C1831, which was effective October 1, 2021, from "Personalized, anterior and lateral interbody cage (implantable)" to "Interbody cage, anterior, lateral or posterior, personalized (implantable)" effective January 1, 2023. See Table 6 of CR 13031 for a 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 us to 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’s 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 for Designated Devices

We assign certain designated new devices to APCs 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 decides 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. See Addendum P (Device-Intensive Procedures for CY 2023) of the CY 2023 OPPS/ASC final rule with comment period for the most current OPPS HCPCS Offset file.

d. Alternative Pathway for Devices with FDA Breakthrough Designation

For devices that have FDA marketing authorization and a Breakthrough Device designation from the FDA, we provide an alternative pathway to qualify for device pass-through payment status, under which devices wouldn't 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 getting pass-through payment status effective on or after January 1, 2020. See the current information on the device criteria to qualify for pass-through status under the OPPS.

e. Expiring Pass-through Status for 6 Device Category HCPCS Codes Effective January 1, 2023

Section 1833(t)(6)(B) of the Act, requires that under the OPPS, categories of devices are eligible for transitional pass-through payments for at least 2, but not more than 3 years. These codes are in Table 5B of CR 13031. We note that these device category HCPCS codes will remain active, however, we include their payment 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 should report the device category HCPCS codes on the claim whenever they're provided in the Hospital Outpatient Department Setting (HOPD) setting. It's 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 provide, whether we pay for the services separately or 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, see Table 6 of CR 13031.

6. Dental Coding Updates

a) New HCPCS Code Describing Facility Services for Dental Rehabilitation Procedure(s)

For CY 2023, we established HCPCS code G0330 to describe facility services for dental rehabilitation procedures performed on a patient who requires monitored anesthesia (for example: general, intravenous sedation (monitored anesthesia care)) and use of an operating room. We established the code to enable HOPDs to bill the technical, facility-fee component of dental rehabilitation services only. We believe this code will mainly be used to describe the facility fees for services performed on vulnerable populations, including patients with disabilities, who require these procedures to be performed under anesthesia due to special health needs.

Table 7 of CR 13031, lists the long descriptor, status indicator, and APC assignment for HCPCS code G0330. For information on the payment amount associated with HCPCS code G0330, refer to the January 2023 OPPS Addendum B.

b) Clarification of CPT Code 41899 (APC 5161)

In the CY 2023 OPPS/ASC final rule, we clarified that CPT code 41899 (Unlisted procedure, dentoalveolar structures) may be used more broadly to describe other dental or dental-related procedures on the teeth and gums, not otherwise described by other HCPCS codes currently assigned to APCs. This would include those performed in the clinical dental scenarios as we described in the CY 2023 Medicare Physician Fee Schedule (PFS) Final Rule, as well as covered non-surgical dental services and surgical dental services you provide to patients who don't require monitored anesthesia and the use of an operating room. As a reminder, you should continue to use existing, specific codes on Dental Procedures and Nomenclature (CDT) codes already assigned to APCs when available, instead of reporting CPT code 41899. For more information, refer to the CY 2023 OPPS/ASC final rule with comment period.

7. Changes to the Inpatient-Only list (IPO) for CY 2023

The Medicare Inpatient Only (IPO) list includes procedures you typically only provide in the inpatient setting and therefore aren't paid under the OPPS. For CY 2023, we're removing 11 procedures from the IPO list. We're adding 8 procedures to the IPO list. The changes to the IPO list for CY 2023 are in Table 8 of CR 13031.

8. MiVu Mucosal Integrity Testing System (APC 5303): Clarification on the Reporting of HCPCS Code C9777

In the CY 2022 OPPS/ASC final rule (86 FR 63517 and 63558), we said when you do a MiVu test and an esophagoscopy or esophagogastroduodenoscopy (EGD) together, HOPDs should report only HCPCS code C9777 and shouldn't report a separate HCPCS code for the esophagoscopy or esophagogastroduodenoscopy. We're clarifying to indicate that a diagnostic esophagoscopy or EGD is included in HCPCS code C9777, and therefore, shouldn't be reported separately. The code, along with the short descriptor and status indicator assignment is in the January 2023 OPPS Addendum B.

9. Payment for Behavioral Health Services Provided Remotely to Patients in Their Homes

Starting January 1, 2023, we'll consider behavioral health services provided remotely by clinical staff of HOPDs, including staff of critical access hospitals (CAHs), through the use of telecommunications technology to patients in their homes, covered outpatient services for which payment is made under the OPPS. We'll only make payment for behavioral health services provided remotely to patients in their homes if the patient gets an in-person service within 6 months prior to the first time you provide the behavioral health services remotely.

When there's an ongoing clinical relationship between you and the patient at the time the Public Health Emergency (PHE) ends, the in-person requirement for ongoing, not newly initiated, treatment will apply. We'll require in-person service without the use of telecommunications technology within 12 months of each behavioral health service provided remotely by hospital clinical staff. Exceptions to the in-person visit requirement will be permitted when the hospital clinical staff member and patient agree that the risks and burdens of an in-person service

outweigh the benefits of it, among other requirements.

We'll allow audio-only interactive telecommunications systems for these services in instances where the patient is unable to use, doesn't wish to use, or doesn't have access to two-way, audio, video technology. The codes are in Table 9 of CR 13031.

10. Software as a Service (SaaS)

As discussed in the CY 2023 OPPS/ASC final rule, we're adopting a policy that Software as a Service (SaaS) add-on codes aren't among the "certain services described by add-on codes" for which we package payment with the related procedures or services under the regulation at 42 CFR 419.2(b)(18). Effective January 1, 2023, we're paying separately for select SaaS CPT add-on codes. See Table 10 of CR 13031 for a list of recognized SaaS CPT codes, their add-on codes, status indicator and APC assignments.

11. Drugs, Biologicals, and Radiopharmaceuticals

a. New CY 2023 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals Receiving Pass-Through Status

Starting on January 1, 2023, there are 3 new HCPCS codes for reporting drugs and biologicals in the hospital outpatient setting where there haven't previously been specific codes available. These drugs and biologicals will get drug pass-through status starting January 1, 2023. These HCPCS codes are in Table 11 of CR 13031.

b. Existing HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals Starting Pass-Through Status as of January 1, 2023

There are 2 existing HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals in the outpatient setting that will have their pass-through status start on January 1, 2023. These codes are in Table 12 of CR 13031. Effective January 1, 2023, the status indicator for these codes is changing to "G" (Pass-Through Drugs and Biologicals. Paid under OPPS; separate APC payment).

c. Existing HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals with Pass-Through Status Ending on December 31, 2022

There are 32 HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals in the outpatient setting with pass-through status ending on December 31, 2022. These codes are in Table 13 of CR 13031. Effective January 1, 2023, the status indicator for these codes is changing from "G" to either "K" (Nonpass-Through Drugs and Nonimplantable Biologicals, Including Therapeutic Radiopharmaceuticals. Paid under OPPS; separate APC payment) or "N" (Items and Services Packaged into APC Rates. Paid under OPPS; payment is packaged into payment for other services.).

d. Newly Established HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals as of January 1, 2023

We established 45 new drug, biological, and radiopharmaceutical HCPCS codes are established on January 1, 2023. These HCPCS codes are in Table 14 of CR 13031.

e. HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals Deleted on December 31, 2022

We're deleting 4 drug, biological, and radiopharmaceutical HCPCS codes on December 31, 2022. These HCPCS codes are listed in Table 15 of CR 13031.

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

For CY 2023, payment for the majority of nonpass-through drugs, biologicals, and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 % (or ASP + 6 % of the reference product for biosimilars. In CY 2023, a single payment of ASP + 6 % for pass-through drugs, biologicals, and radiopharmaceuticals is made to provide payment for the acquisition cost and pharmacy overhead costs of these pass-through items (or ASP + 6 % of the reference product for biosimilars). We update payments for drugs and biologicals based on ASPs quarterly as later quarter ASP submissions become available.

Effective January 1, 2023, payment rates for many drugs and biologicals have changed from the values published in the CY 2023 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 2022. In cases where adjustments to payment rates are necessary, changes to the payment rates will be in the January 2023 Fiscal Intermediary Standard System (FISS) release. The updated payment rates effective January 1, 2023, are in the January 2023 update of the OPPS Addendum A and Addendum B.

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

Some drugs and biologicals paid based on ASP methods 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 first date of the quarter. You may resubmit claims affected by adjustments to a prior quarter's payment files.

h. Drugs and Biologicals Reported using HCPCS Code C9399 (Unclassified drugs or biologicals)

Starting January 1, 2023, HCPCS code C9399 (Unclassified drugs or biologicals) have been added to the comprehensive APC (C-APC) exclusions list. See the updated language in Chapter 4, Section 10.2.3 of the Medicare Claims Processing Manual for a list of all comprehensive APC exclusions, including the new exclusion of any drug or biological described by HCPCS code C9399.

i. New Modifier JZ Available for Use as of January 1, 2023

Starting January 1, 2023, modifier JZ will be available for voluntary provider use when you don't discard any amount of drug from a single dose or single use packaging. You must report the JZ modifier for all applicable drugs with no discarded drug amounts starting no later than July 1, 2023.

j. Billing Instructions for 340B-Acquired Drugs

As we note in the CY 2023 OPPS/ASC final rule with comment period, separately payable Part B drugs (assigned SI "K"), other than vaccines (assigned SI "L" (Not paid under OPPS. Paid at reasonable cost; not subject to deductible or coinsurance) or "M" (Items and Services Not Billable to the MAC Not paid under OPPS.)) and drugs on pass-through payment status (assigned SI "G") that are acquired through the 340B Program or through the 340B prime vendor program, will be generally paid at ASP plus 6%, when billed by a hospital we pay under the OPPS.

For CY 2023, we're maintaining the requirement for 340B providers to report the JG and TB modifiers for informational purposes. Under the OPPS, select entities including rural sole community hospitals, children's hospitals, and PPS-exempt cancer hospitals should continue to bill the modifier TB on claim lines for drugs acquired through the 340B Program. All other 340B providers should continue to report the modifier JG.

12. Skin Substitutes

The payment for skin substitute products that don't 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 2 groups:

- High-cost skin substitute products
- Low-cost skin substitute products.

We assign new skin substitute HCPCS codes into the low-cost skin substitute group unless pricing data shows the cost of the product is above either the mean unit cost of $47 or the per day cost of $837 for CY 2023.

a. New Skin Substitute Products as of January 1, 2023

There are 4 new skin substitute HCPCS codes that will be active as of January 1, 2023. These codes are in Table 16 of CR 13031.

b. Deletion of HCPCS Code C1849 (Skin substitute, synthetic, resorbable, per square centimeter) Effective December 31, 2022

We're deleting HCPCS code C1849 (Skin substitute, synthetic, resorbable, per square centimeter) as of December 31, 2022. HCPCS code C1849 is listed in Table 17 of CR 13031.

c. Skin substitute assignments to high cost and low costs groups for CY 2023

Table 18 of CR 13031 lists the skin substitute products and their assignment as either a high-cost or a low-cost skin substitute product, when applicable.

13. Status Indicator Changes

For CY 2023, we're revising the definition of status indicator "A" to include unclassified drugs and biologicals reportable under HCPCS code C9399. When HCPCS code C9399 is on a claim, the OCE suspends the claim for manual pricing by the MAC. The MAC prices the claim at 95% of the drug or biological's average wholesale price (AWP) using the Red Book or an equivalent recognized compendium and processes the claim for payment. The payment at 95% of AWP is made under the OPPS.

We're revising the definition of status indicator "F" by removing hepatitis B vaccines. Hepatitis B vaccines aren't subject to deductible and coinsurance similar to other preventive vaccines, but services currently listed under the definition of status indicator "F" are subject to deductible and coinsurance. We're also revising the definition of status indicator "L" by adding hepatitis B vaccines to the list of other preventive vaccines that aren't subject to deductible and coinsurance.

14. New C-APC Procedures effective January 1, 2023

There are 19 new procedure C-APC codes. The HCPCS codes, descriptors and OPPS status indicators are listed in Table 19 of CR 13031. The C-APC payment rates for the codes are in the January 2023 Addendum J

15. Payment Adjustment Amount under the Inpatient PPS (IPPS) and OPPS for Domestic NIOSH-approved Surgical N95 Respirators

We established new payment adjustments under the OPPS and IPPS for the additional resource costs you face in procuring domestic National Institute of Occupational Safety and Health (NIOSH)-approved surgical N95 respirators for cost reporting periods starting on or after January 1, 2023. We base this payment adjustment on the estimated difference in the reasonable cost you incur for domestic NIOSH-approved surgical N95 respirators purchased during the cost reporting period as compared to other NIOSH-approved surgical N95 respirators purchased during the cost reporting period. To calculate the payment adjustment for each eligible cost reporting period, we're creating a new supplemental cost reporting form that will collect from hospitals more information to be used along with other information already collected on the hospital cost report to calculate the IPPS and OPPS payment adjustment amounts.

Under the finalized policy, we also indicated we'd provide these payments biweekly as interim lump-sum payments to the hospital and reconciled at cost report settlement for cost reporting periods starting on or after January 1, 2023. Any IPPS and or OPPS provider can make a request for these biweekly interim lump sum payments for an applicable cost reporting period, as provided under 42 CFR 413.64 and 42 CFR 412.116(c).

16. Payment Adjustment for Certain Cancer Hospitals Starting CY 2023

For certain cancer hospitals that get interim monthly payments associated with the cancer hospital adjustment, Section 16002(b) of the 21st Century Cures Act requires that, for CY 2018 and subsequent CYs, the target Payment-to-Cost Ratio (PCR) we use in the calculation of the interim monthly payments and at final cost report settlement is reduced by 0.01. For CY 2023, the target PCR, after including the reduction required by Section 16002(b), is 0.89.

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

In CY 2019, we finalized a policy to apply an amount equal to the site-specific PFS payment rate for nonexcepted items and services provided 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% of OPPS payment (60% less than the OPPS rate) for CY 2023. Specifically, the total 60% payment reduction will apply in CY 2023, which means we pay these departments 40% of the OPPS rate (100% of the OPPS rate minus the 60% payment reduction that applies in CY 2023) for the clinic visit service in CY 2023.

Note that in the CY 2023 OPPS/ASC final rule, we finalized an exemption of rural sole community hospitals from the payment reduction associated with this policy. Therefore, the payment reduction described in this section doesn't apply to rural sole community hospitals in the CY 2023 OPPS.

18. Changes to OPPS Pricer Logic

a. Rural Sole Community Hospitals (SCH) and Essential Access Community Hospitals (EACHs) will continue to get a 7.1% payment increase for most services in CY 2023. 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.

b. New OPPS payment rates and copayment amounts will be effective January 1, 2023. All copayment amounts will be limited to a maximum of 40% of the APC payment rate. Copayment amounts for each service can't exceed the CY 2023 inpatient deductible of $1,600. For most OPPS services, copayments are set at 20% of the APC payment rate.

c. For hospital outlier payments under OPPS, there's no change in the multiple threshold of 1.75 for 2023. This threshold of 1.75 is multiplied by the total line-item APC payment to decide eligibility for outlier payments. We use this factor to decide the outlier payment, which is 50% of estimated cost less 1.75 times the APC payment amount.

d. The fixed-dollar threshold for OPPS outlier payments increases in CY 2023 relative to CY 2022. The estimated cost of a service must be greater than the APC payment amount plus $8,625 in order to qualify for outlier payments.

e. For outliers for Community Mental Health Centers (bill type 76x), there's no change in the multiple threshold of 3.4 for 2023. We multiply this threshold of 3.4 by the total line-item APC payment for APC 5853 to decide eligibility for outlier payments. We use this multiple amount to decide the outlier payment, which is 50% of estimated costs less 3.4 times the APC payment amount.

f. Continuing our established policy for CY 2023, the OPPS Pricer will apply a reduced update ratio of 0.9807 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, 2023, we're adopting the FY 2023 IPPS post-reclassification wage index values with application of the CY 2023 out-commuting adjustment to non-IPPS hospitals as implemented through the Pricer logic.

h. Effective January 1, 2023, for claims with APCs, which require implantable devices and have significant device offsets (greater than 30%), we'll apply a device offset cap based on the credit amount listed in the "FD" (Credit Received from the Manufacturer for a Replaced Medical Device) value code. The credit amount in value code "FD" which reduces the APC payment for the applicable procedure, will be capped by the device offset amount for that APC.

i. Effective January 2023, rural SCHs will no longer get payment reductions for HCPCS code G0463 when billed with modifier PO based our final CY 2023 policy to exempt rural SCHs from the method to control for unnecessary increases in volume policy.

19. Update the Outpatient Provider Specific File (OPSF)

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

In CY 2023, 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 2022 OPPS wage index in the Supplemental Wage Index field in order to properly apply all wage index policies and determine the hospital's CY 2023 OPPS wage index.

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 get hold harmless TOPs permanently. For CY 2023, cancer hospitals will continue to get an additional payment adjustment.

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

Effective for OPPS services you provide 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 get payment under the OPPS that reflects a 2% reduction from the annual OPPS update for failure to meet the HOQR program requirements. This reduction won't apply to hospitals that aren't required to submit quality data or hospitals that aren't paid under the OPPS.

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

MACs must maintain the accuracy of data, including changes to provider CCRs and, when applicable, device department CCRs. A file of OPPS hospital upper limit CCRs and the file of Statewide CCRs is available under Annual Policy Files.

e) Updating the "County Code" Field

Prior to CY 2018, to include the outmigration in a hospital's wage index, we provided a separate table that assigned wage indexes for hospitals that get the outmigration adjustment. For the CY 2023 OPPS, the OPPS Pricer will continue to assign the outmigration adjustment using the "County Code" field. MACs will make sure that every hospital has listed in the "County Code" field the Federal Information Processing Standards county code where the hospital is located to maintain this accuracy.

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

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 CY basis. Your MAC will make sure that wage index reclassifications applied under the FY 2023 IPPS are also reflected in the OPSF on a CY 2023 OPPS basis.

20. Wage Index Policies in the CY 2023 OPPS Final Rule

In the FY 2023 IPPS and CY 2023 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 0.8427 across all hospitals, and applied a 5% cap for CY 2023 on any wage index values that decreased relative to CY 2022.

21. Coverage Determinations

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

More Information

We issued CR 13031 to your MAC as the official instruction for this change.

For more information, find your MAC's website

Document History

Date of Change	Description
December 14, 2022	Initial article released.