CY 2023 Medicare Hospital Outpatient Prospective Payment System (HOPPS)/Ambulatory Surgery Center (ASC) Proposed Rule (CMS-1772-P)

W.L. GORE and Associates

INTRODUCTORY SUMMARY AND BACKGROUND

On July 15, 2022, the Centers for Medicare & Medicaid Services (CMS) issued the proposed rule for the Medicare Hospital Outpatient Prospective Payment System (HOPPS) and Ambulatory Surgery Centers (ASCs) for calendar year (CY) 2023.

CMS is required to annually review and update the payment rates for services payable under the Hospital Outpatient Prospective Payment System (HOPPS) and those payable in ASCs as specified in section 1833 of the Social Security Act. In addition, CMS is required to update the requirements for the Hospital Outpatient Quality Reporting (OQR) Program and the ASC Quality Reporting (ASCQR) Program.

The prospective payment system (PPS) was developed and implemented to replace the reasonable cost-based payment methodology. HOPPS was implemented for services effective August 1, 2000. Under HOPPS, CMS pays for hospital Part B services on a rate-per-service basis according to the Ambulatory Payment Classification (APC) in which the service is assigned. The Healthcare Common Procedure Coding System (HCPCS), which includes Current Procedural Terminology (CPT®) codes, are used to identify and group the services within each APC. APCs are organized by similar clinical relevance and resource use. Special payments for new technology items and services under HOPPS may be made by transitional pass-through payments and new technology APCs.

For ASCs, the surgical procedures on the ASC list for covered procedures are sorted into surgical specialty groups using CPT® and HCPCS code range definitions.

Certain hospitals are excluded from payment under HOPPS including critical access hospitals (CAHs); hospitals located in Maryland and paid under Maryland's All-Payer or Total Cost of Care Model; hospitals located outside the 50 states, the District of Columbia and Puerto Rico; and Indian Health Service (IHS) hospitals.

2023 HOPPS/ASC Proposed Rule

The CY 2023 proposed rule is located in its entirety at the following link: https://www.federalregister.gov/public-inspection/2022-15372/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment.

This document in PDF form is 886 pages in length. The format of the information is intended to summarize the proposed changes so readers are encouraged to view the document in its entirety for further details.

HOPPS Payment Rates

There are approximately 8,911 facilities paid under HOPPS including general acute care hospitals, children's hospitals, cancer hospitals, community mental health centers (CMHCs) and Ambulatory Surgery Centers (ASCs).

Typically CMS would use the most updated claims and cost report data available to determine the HOPPS and ASC rate setting. The best available claims data is 2 years' prior to the CY that is the focus of this rulemaking. CMS believes the CY 2021 claims data was not impacted by the COVID-19 PHE. Therefore, CMS has proposed to use CY 2021 claims data to set CY 2023 HOPPS and ASC payment rates.

Conversion Factor

To set the HOPPS conversion factor (CF) for CY 2023, CMS proposes to increase the CY 2021 conversion factor of $84.177 by 2.7 percent, while adjusting the conversion factor to ensure any revisions made to the wage index and rural adjustment were made on a budget neutral basis. The proposed overall budget neutrality factor is 1.0010 for wage index changes, and an additional budget neutrality factor of 0.9995 to account for the proposed policy to cap wage index reduction for hospitals at 5 percent on an annual basis. Thus, the proposed CF for CY 2023 for hospitals that meet the hospital OQR program requirements is $86.785 in the calculation for national unadjusted rates. For those hospitals that fail to meet the hospital OQR program requirements, the CF is $85.093, which is a different in -1.692 in the CF relative to hospitals that meet the requirement.

Proposed Payment Rates

For CY 2023, CMS is proposing HOPPS payment rates for hospitals that meet applicable quality reporting requirements by 2.7 percent under the Outpatient Department (OPD) fee schedule. This update is based on the projected inpatient hospital market basket increase of 3.1 percent minus a 0.4 percentage point adjustment for multi-factor productivity (MFP). Based on this increase, the estimated total payments to HOPPS providers for CY 2023 will be $86.2 billion. This represents a $6.2 billion increase from estimated CY 2022 HOPPS payments.

CMS is also proposing to continue implementing a statutory 2.0 percentage reduction for hospitals failing to meet the hospital outpatient quality reporting requirements set forth by the Hospital Outpatient Quality Reporting (OQR) Program. This is accomplished by applying a reporting factor of 0.9805 to the OPPS payments and copayments for all applicable services.

Wage Index

Under HOPPS, the wage index is an assigned value that is used when determining the reimbursement amount for any given code (CPT® or HCPCS) in a specific hospital or ASC. This value will vary depending on the geographic location of the hospital or ASC and whether it is designated as an urban or rural location. The wage index is then valued with the labor adjustments and the APC assigned values to calculate the overall reimbursement rate for the service in a specific geographic location.

HOPPS wage index updates are proposed by CMS as part of the fiscal year (FY) 2023 inpatient prospective payment system (IPPS) wage index adjustments and updated Office of Management and Budget (OMB) delineations. These changes are relative to the changes between urban and rural located hospitals. CMS is proposing to continue a 5 percent cap on wage index decreases. The wage index for FY 2023 would not be less than 95 percent of the finalized wage index for FY 2022 and would continue for subsequent years where

the wage index for a given year would not be less than 95 percent of the final wage index for the prior year. This adjustment would also apply to outpatient hospitals. This cap ensures the changes to be finalized are done to "soften" any decreases that could have an overall impact to a specific value change.

CMS estimates the proposed rule update of the wage indexes (based on the FY 2023 IPPS proposed rule wage indexes) result in increased payments of 3.0 percent for urban hospitals and increased payments of 2.6 percent for rural hospitals under HOPPS. For nonteaching hospitals, this update would result in an increased payment of 3.2 percent; minor teaching hospitals would result in increased payments of 3.0 percent; and major teaching hospitals would experience increased payments of 2.6 percent. These wage indexes include the continued implementation of the OMB labor market area delineations based on 2010 census data.

For CY 2023, CMS proposes to continue applying a wage index of 1.000 for frontier state hospitals (Montana, Wyoming, North Dakota, South Dakota, and Nevada) if the applicable wage index is less than 1.000. This policy has been in place since CY 2011. This ensures the lower population states are not "penalized" for reimbursement due to the low number of people per square mile when compared to other states.

Rural Adjustments

The rural adjustment factor of 7.1% to the HOPPS payments to certain rural sole community hospitals (SCHs), including essential access community hospitals (EACHs) was established in CY 2000 in a budget neutral manner. CMS is proposing to continue this current policy for CY 2023. This will continue until data supports a different factor should be applied. This payment adjustment will continue to exclude separately payable drugs, biologicals, brachytherapy sources, items paid at charges reduced to cost and devices paid under the pass-through payment policy. In addition, CMS is proposing a budget neutrality factor for the rural adjustment at 1.0000.

340B Acquired Drugs and Biologicals Update

Section 340B of the Public Health Service Act (PHSA) allows participating hospitals and other providers to purchase certain covered outpatient drugs from manufacturers at discounted prices. In the CY 2018 HOPPS/ASC final rule with comment period, CMS reexamined the appropriateness of paying the average sales price (ASP) plus 6% for drugs acquired through the 340B Program, given that 340B hospitals acquire these drugs at steep discounts. Beginning January 1, 2018, CMS adopted a policy to pay an adjusted amount of ASP minus 22.5% for certain separately payable drugs or biologicals acquired through the 340B Program. CMS continued this policy in CYs 2019 through 2022.

The HOPPS 340B policy has been the subject of litigation, recently resulting in a Supreme Court ruling which held that the HHS may not vary payment rates for drugs and biologicals among groups of hospitals in the absence of having conducted a survey of hospital's acquisition costs. The Supreme Court's decision concerned payment rates for CYs 2018 and 2019 and has implications for the CY 2023 payment rates.

Utilizing the separately paid line items with modifier "JG" in the CY 2021 claims available for HOPPS ratesetting, which is the modifier used to identify drugs purchased under the 340B Drug Discount Program, the estimated payment differential would be an increase of approximately $1.96 billion in HOPPS drug payments. To ensure budget neutrality CMS would apply this offset of approximately $1.96 billion to decrease the HOPPS conversion factor, resulting in a budget neutrality adjustment of 0.9596 to the HOPPS conversion

factor, for a revised conversion factor of $83.279. In comparison, CMS proposed the CF for CY 2023, with payments for 340B drugs at ASP -22.5 percent would be $86.785.

CMS is proposing an alternate payment file for CY 2023 HOPPS rates which take in to account the shift from average sales price (ASP) -22.5 percent to ASP +6 percent, resulting in CMS returning money to hospitals. The changes would have to be done in a budget neutral manner, meaning CMS would have to make decreases elsewhere under HOPPS to pay the adjustments. CMS indicated they were still formally proposing the rates as they were published, but also alerted stakeholders to the pending changes. CMS will also need to determine how to address the 2018-2022 payment rates relative to the 340B Drug Discount Program at the time and how the additional monies paid out are transferred in a budget neutral manner moving forward.

Ambulatory Payment Classification (APC) Relative Payment Weights

It is required in Section 1833 of the Act to revise the relative payment weight for the APCs at least annually. APCs group services which are considered clinically comparable to each other in terms of resource utilization and associated cost. Ancillary services or items which are necessary components of the primary service are packaged into the APC rates and not separately reimbursed. Packaging encourages cost effectiveness and resource efficiency. CMS instructs providers to apply current procedure-to-procedure edits and then report all remaining services on the claim form.

CMS will only pay for those services which are considered not packaged into another service. Packaged services are those services that are "integral, ancillary, supportive, dependent and adjunctive" to the primary service. Under the current Comprehensive APC (C-APC) policy, CMS designates a service described by a CPT® or HCPCS code as the primary procedure when the service is identified by HOPPS status indicator (SI) "J1." There are services which are not covered under the C-APC policy and will not be paid, including certain mammography and ambulance services; and services that are required to be separately paid, including brachytherapy seeds and pass-through payment drugs and devices.

In addition to C-APCs, packaged services that are currently provided under HOPPS are reviewed annually in terms of integral, ancillary, supportive, dependent, or adjunctive items and services. For CY 2023, CMS proposes no changes to the overall packaging policy. This means the continuation of conditionally packaging the costs of selected newly identified ancillary services into payment for a primary service. While CMS is not proposing any changes to the current packaging policy, they are soliciting comments and data for potential modifications to the packaging policy.

New and Revised Codes

As part of the rulemaking process, CMS reviews new CPT® and HCPCS codes and assigns each an interim status indicator (SI) and APC. CPT® and HCPCS code changes that affect HOPPS are published through the annual rulemaking cycle, as well as the HOPPS quarterly update Change Requests (CRs). A summary of the current process for updating coding through the HOPPS quarterly update CRs, seeking public comments and finalizing codes under HOPPS is listed in the table below:

TABLE 7: COMMENT AND FINALIZATION TIMEFRAME FOR NEW AND REVISED OPPS-RELATED HCPCS CODES

OPPS Quarterly Update CR	Type of Code	Effective Date	Comments Sought	When Finalized
April 2022	HCPCS (CPT and Level II codes)	April 1, 2022	CY 2023 OPPS/ASC proposed rule	CY 2023 OPPS/ASC final rule with comment period
July 2022	HCPCS (CPT and Level II codes)	July 1, 2022	CY 2023 OPPS/ASC proposed rule	CY 2023 OPPS/ASC final rule with comment period
October 2022	HCPCS (CPT and Level II codes)	October 1, 2022	CY 2023 OPPS/ASC final rule with comment period	CY 2024 OPPS/ASC final rule with comment period
January 2023	CPT Codes	January 1, 2023	CY 2023 OPPS/ASC proposed rule	CY 2023 OPPS/ASC final rule with comment period
	Level II HCPCS Codes	January 1, 2023	CY 2023 OPPS/ASC final rule with comment period	CY 2024 OPPS/ASC final rule with comment period

For the April 2022 update, 48 new HCPCS codes were established and made effective on April 1, 2022. For the July 2022 update, 63 new codes were established and made effective July 1, 2022. CMS recognized several of these new HCPCS codes for proposed OPPS payment under APCs, and CMS is seeking comments on these proposed APC and status indicator assignments.

Significance of code G0463

CMS is proposing to continue using HCPCS code *G0463 (Hospital outpatient clinic visits for assessment and management of a patient)* as the standardized code for the HOPPS relative payment weights in CY 2023; and is proposed to continue to be reimbursed a payment rate of 40% of the HOPPS rate for all off-campus outpatient departments, excepted and nonexcepted. The proposed rate for G0463 in 2023 is $122.82.

CMS is proposing for CY 2023 to exempt excepted off-campus provider-based departments (PBDs) (departments that bill the modifier "PO" on claim lines) of rural Sole Community Hospitals and designated as rural for Medicare payment purposes. CMS recognizes the use of the clinic visit in some settings is supported even if it means the rate is higher than in another. This is due to concerns for beneficiaries and access to quality care. To ensure this is possible there are several special payment provisions for rural providers, the exemption of the clinic visit payment policy is one of them. Rather than paid at 40 percent of the HOPPS rate, the clinic visit payment policy that applies a Physician Fee Schedule-equivalent payment rate for the clinic visit service, these settings would be paid at 100 percent of the HOPPS rate.

APC "2 Times Rule"

Items and services within an APC group cannot be considered resource utilization comparable if the highest mean cost for an item or service within the same APC group is more than 2 times greater than the lowest median cost. This is called the "2 times rule."

In the proposed rule, CMS identified 23 APCs in which the 2 times rule violation was found based on CY 2021 claims data available. The 2 times rule does not allow the codes to be assigned to an APC where the highest costing code is more than 2 times that of the lowest costing code. When a 2 times rule violation is identified, CMS and the Hospital Outpatient Payment (HOP) Panel will reassign codes or create a new APC. CMS only considers HCPCS codes that are significant based on the number of claims when determining if there is a 2 times rule violation. The following table lists the APCs identified in violation of the 2 times rule in which CMS proposed to make an exception for CY 2023:

TABLE 8: PROPOSED CY 2023 APC EXCEPTIONS TO THE 2 TIMES RULE

Proposed CY 2023 APC	Proposed CY 2023 APC Title
5012	Clinic Visits and Related Services
5071	Level 1 Excision/ Biopsy/ Incision and Drainage
5301	Level 1 Upper GI Procedures
5521	Level 1 Imaging without Contrast
5522	Level 2 Imaging without Contrast
5523	Level 3 Imaging without Contrast
5524	Level 4 Imaging without Contrast
5571	Level 1 Imaging with Contrast
5611	Level 1 Therapeutic Radiation Treatment Preparation
5612	Level 2 Therapeutic Radiation Treatment Preparation
5627	Level 7 Radiation Therapy
5673	Level 3 Pathology
5691	Level 1 Drug Administration
5692	Level 2 Drug Administration
5721	Level 1 Diagnostic Tests and Related Services
5731	Level 1 Minor Procedures
5734	Level 4 Minor Procedures
5741	Level 1 Electronic Analysis of Devices
5791	Pulmonary Treatment
5811	Manipulation Therapy
5821	Level 1 Health and Behavior Services
5822	Level 2 Health and Behavior Services
5823	Level 3 Health and Behavior Services

New Technology APCs

Starting with the CY 2002 HOPPS final rule, criteria for assigning a complete or comprehensive service to a new technology APC was implemented:

1) Service must be truly new, meaning it cannot be appropriately reported by an existing HCPCS code assigned to a clinical APC and does not appropriately fit within an existing clinical APC;
2) Service is not eligible for transitional pass-through payment (although a truly new, comprehensive service could qualify for assignment to a new technology APC even if it involves a device or drug that could on its own, qualify for a pass-through payment); and
3) Service falls within the scope of Medicare benefits under the Act and is reasonable and necessary.

Typically a procedure remains in the new technology APC until sufficient claims data is received to justify reassignment to a clinically appropriate APC.

For CY 2023, CMS is proposing to retain services within the new technology APC groups until sufficient claims data is received to justify reassignment to a clinically appropriate APC. This policy provides flexibility to reassign a service to a clinical APC in less than 2 years if sufficient claims data is received.

Device-Intensive Procedures

In the CY 2019 HOPPS final rule and for subsequent years, CMS modified criteria for device-intensive procedures to potentially allow a greater number of procedures to qualify as device-intensive. In years' past, one of the main criteria used to consider devices for device-intensive criteria was that only devices that remained in the patient (even temporarily) after the procedure would qualify. This is no longer a consideration. The modified criteria for device-intensive procedures is now in force:

- Procedure must involve implantable device assigned to a CPT® or HCPCS code;
- Device must be surgically inserted or implanted (either permanently or temporarily);
- Device offset amount must be significant, which is defined as exceeding 30 percent of the procedure's mean cost (down from 40 percent);
- Device has received FDA marketing authorization and investigational device exemption (IDE), and meets exemption from premarket review;
- Device is integral to the procedure performed;
- Device is used for one patient only;
- Device comes into contact with human tissue;
- Device is NOT equipment, an instrument, apparatus, implement, item of the type for which depreciation and financing expenses are recovered as depreciable assets; and
- Device is NOT material or supply furnished incident to a service (suture, surgical kit, scalpel or clip, other than a radiological site marker).

For consistency with CMS' broader proposal to use CY 2021 claims data for CY 2023 HOPPS and ASC ratesetting, CMS is proposing to use CY 2021 claims data information to determine device offset percentages and assign device-intensive status. CMS is also proposing to continue recognition of HCPCS C1889 (*Implantable/insertable device, not otherwise classified*) for billing of the device as part of a device intensive procedure when there is no specific Level II HCPCS Category C-code to represent it.

For device-intensive procedures in which a provider receives full or partial credit for a replaced device, the policy was finalized in CY 2017 and in subsequent years to reduce HOPPS payment. Currently, facilities are required to continue to report the credit amount in the amount portion for value code "FD" when the facility received a

credit for a replaced device that is 50 percent or greater than the cost of the device. For CY 2023, CMS is not proposing any changes to these policies regarding payment for no cost/full credit and partial credit devices.

Pass-Though Payments for Devices

In the CY 2017 HOPPS final rule and for subsequent years, CMS finalized the policy to allow for quarterly expiration of pass-through status for devices, in order to afford a pass-through payment period that is as close to a full 3 years as possible for all pass-through devices. In addition, a policy was finalized to package the costs of the expired pass-through devices into the procedure costs in which those devices are reported in the claims data for payment rate setting.

There are currently 11 device categories eligible for pass-through payment. Of interest for cardiology is code C1761 (*Catheter, transluminal intravascular lithotripsy, coronary*). For CY 2023, CMS received 9 applications for device pass-through payments. CMS is soliciting public comment on these applications and will make final determinations on these applications in the CY 2023 HOPPS final rule. Beginning for HOPPS device pass-through applications received on or after January 1, 2023, CMS is proposing to publicly post online the completed application forms and related materials that we receive from applicants, excluding certain copyrighted or other materials that applicants indicate cannot otherwise be released to the public.

Changes to the Inpatient Only List

Procedures and services typically provided in an inpatient setting and not paid by Medicare under HOPPS are identified in the inpatient only (IPO) list. This list was created to identify procedures that *"were those determined to require inpatient care, such as those that are highly invasive, result in major blood loss or temporary deficits of organ systems (such as neurological impairment or respiratory insufficiency), or otherwise require intensive or extensive postoperative care. There are some services designated as inpatient only that, given their clinical intensity, would not be expected to be performed in the hospital outpatient setting. For example, we have traditionally considered certain surgically invasive procedures on the brain, heart, and abdomen, such as craniotomies, coronary-artery bypass grafting, and laparotomies, to require inpatient care."*

The complete IPO list can be found as Addendum E to the CY 2023 HOPPS proposed rule. Annual review of this list by CMS identifies services which should be removed or added based on the most recent data and medical evidence available, and the goal is to ensure inpatient only designations are consistent with current standards of practice. The current criteria used to determine if a procedure or service should be removed from the IPO and assigned to an APC group for payment under HOPPS includes:

- Most outpatient departments are equipped to provide the services to the Medicare population;
- The simplest procedure described by the code may be furnished in most outpatient departments;
- The procedure is related to codes that have already been removed from the IPO list;
- A determination is made that the procedure is being furnished in numerous hospitals on an outpatient basis;
- A determination is made that the procedure can be appropriately and safely furnished in an ASC and is on the list of approved ASC services or has been proposed by us for addition to the ASC list.

Over the years, some stakeholders have requested to maintain the IPO list as a tool in which to ensure quality of care for Medicare beneficiaries. Other stakeholders have requested to eliminate the IPO list and defer to the

clinical judgment of physicians for decisions regarding site of service. In CY 2021, CMS proposed and finalized the policy to eliminate the IPO list over a 3-year transitional period beginning on January 1, 2021, with the full list eliminated by January 1, 2024. For CY 2021, 298 services and procedures (including musculoskeletal) were removed from the IPO list. However, in the CY 2022 HOPPS final rule, CMS stopped the elimination of the IPO list and the 298 removed services and procedures were put back on the IPO list.

Based on the established criteria, CMS is proposing to remove 10 services from the IPO list (integumentary and musculoskeletal) for CY 2023. CMS is seeking comments regarding these proposed services for removal. In addition, CMS is proposing to add 8 services to the IPO list that were newly created by the AMA CPT® Editorial Panel for CY 2023.

The full list of IPO services is provided by CMS on their website in Addendum E, part of the 2023 NFRM OPPS Addenda or Table 48 of the final rule. The table contains the list of services to be added back to the IPO list. Of interest are the new hernia repair codes including insertion of mesh (49X06, 49X10-49X14):

Addendum E.- HCPCS Codes That Would Be Paid Only as Inpatient Procedures for CY 2023			
HCPCS Code	**Short Descriptor**	**Comment Indicator**	**Status Indicator**
49X06	Rpr aa hrn 1st > 10 ncr/strn	NP*	C
49X10	Rpr aa hrn rcr 3-10 ncr/strn	NP*	C
49X11	Rpr aa hrn rcr > 10 rdc	NP*	C
49X12	Rpr aa hrn rcr > 10 ncr/strn	NP*	C
49X13	Rpr parastomal hernia rdc	NP*	C
49X14	Rpr parastomal hrna ncr/strn	NP*	C

*NP = New code for CY 2023

Ambulatory Surgery Center (ASC) Payment Rates

For Ambulatory Surgery Center (ASC) payments CY 2019 through 2023, CMS has updated their policy for using a market basket update to calculate rates. For CY 2023, CMS is proposing to adopt a policy to update the ASC payment system using the hospital market basket update. Based on this methodology, CMS is proposing to increase payment rates under the ASC payment system by 2.7 percent for ASCs that meet the quality reporting requirements under the ASCQR Program. This proposed increase is based on a hospital market basket percentage increase of 3.1 percent reduced by a productivity adjustment of 0.4 percentage point. Based on this increase, the estimated total payments to ASCs for CY 2023 will be $5.4 billion. This represents a $130 million increase from estimated CY 2022 ASC Medicare payments.

In addition, CMS proposes to adjust the conversion factor (CF) by the proposed wage index budget neutrality factor of 1.0010 in addition to the projected hospital market basket update of 2.7 percent, which results in a CY 2023 ASC CF of $51.315 for ASCs meeting the ASCQR program. For those ASCs who do not meet the ASCQR program, the proposed CF is $50.315.

Complexity Adjustment Payments

CMS provides complexity adjustments to hospitals for certain services as part of comprehensive ambulatory payment classifications (C-APCs). When multiple C-APC services with the designated status indicator (SI) "J1" are performed together, CMS assigns the payment to the next highest paying C-APC of same clinical family. A C-APC assigns payment for all ancillary services pertinent to the primary service assigned SI "J1" packaged into the primary code.

In the ASC, C-APCs are not used because of system limitations for processing ASC claims for payment. ASC claims are processed as normal claims with separately payable procedure codes. When multiple procedures are performed together in an ASC, the procedure code with the lower payment is paid at 50 percent of the amount assigned. This is due to the duplicative use of resources while still providing a payment for the work done because add-on codes are not separately paid in the ASC.

Over the years CMS has received comments from stakeholders concerning the payments for services in the ASC, already paid at a much lower rate than hospitals. In addition, the lack of complexity adjustments incentivizes procedures in the hospital setting. In response, CMS evaluated differences in payments for HOPPS and ASC code pairs that included a primary procedure and add-on codes eligible for complexity adjustments under HOPPS and also performed in the ASC setting.

CMS found 26 packaged procedures in ASCs with SI "N1" that combine with 42 primary procedures as C-APCs in hospitals. CMS estimated ASCs were paid approximately 55 percent of the HOPPS rate for similar services in CY 2021. When they compared the complexity adjustment for hospitals of the C-APCs and add-on codes to the payment rates for same code combinations in ASCs, the average payment rate for the ASC was 25 to 35 percent of the HOPPS rate, which is significantly lower than the 55 precent. Because of this significant difference, CMS is proposing that combinations of a primary procedure code and add-on codes eligible for a complexity adjustment under the HOPPS would also be eligible for a proposed complexity adjustment in the ASC setting. ASC payment system code combinations eligible for additional payment would consist of a separately payable surgical procedure code and one or more packaged add-on codes from the ASC Covered Procedures List (CPL) and ancillary services list.

CMS proposed to assign each eligible code combination a new C code that describes the primary and the add-on procedure(s) performed. C codes are only valid for hospital and ASCs, they cannot be billed in office-based settings or by physicians paid under the Medicare Physician Fee Schedule (MPFS). The new C codes would be added to the ASC CPL and when an ASC bills the C code, they will be paid the higher payment rate which includes the code combination for the more complex and costlier procedure performed. CMS expects the list of codes would be adjusted annually to account for changes in procedures and payments.

If the procedures part of a C code is performed with other services not part of the C code, CMS would apply the multiple procedure reduction as part of their policy. Device intensive procedures may also be assigned a C code and the calculation of the payment rate using the HOPPS complexity-adjusted C-APC rate would account for the portion of the device when determining the full adjustment.

The full list of proposed C codes for the complexity adjustments with their corresponding proposed payment rates can be found on the CMS website in 2023 NPRM Addendum AA of the CY 2023 ASC payment – Notice of Proposed Rulemaking with Comment Period (NPRM).

Surgical Procedures Designated as Temporarily Office-Based

CMS annually reviews and updates the covered procedures for which ASC payment is made, including those procedures which may be appropriate for ASC payment and those procedures which may be designated as office based. Of those procedures designated as office-based, they can either be permanent (being performed predominately in physicians' offices, i.e., more than 50 percent of the time); or temporary (designated as such in the CY 2019/CY 2020 final rules or fewer than 50 claims for procedure in data reviewed). CMS uses payment indicators as part of this designation:

- G2 – Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.
- P2 – Office-based surgical procedure added to ASC list in CY 2008 or later with Medicare Physician Fee Schedule (MPFS) nonfacility practice expense (PE) relative value units (RVUs); payment based on OPPS relative payment weight.
- P3 – Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs.
- R2 – Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight.

Typically, CMS would use the most updated claims and cost report data available to determine the OPPS and ASC rate setting. As a result, CMS is proposing to use the CY 2021 for ASC ratesetting. Because of this, CMS has identified 6 surgical procedures that meet criteria for designation as permanently office-based. CMS is also proposing to continue to designate covered surgical procedures currently assigned a payment indicator of "P2" "P3" or "R2." Of interest are codes 92985 and 93986, which have a payment indicator of P2.

TABLE 56: PROPOSED CY 2023 PAYMENT INDICATORS FOR ASC COVERED SURGICAL PROCEDURES DESIGNATED AS TEMPORARILY OFFICE-BASED IN THE CY 2022 OPPS/ASC FINAL RULE

CY 2022 CPT/HCPCS Code	CY 2022 Long Descriptor	Final CY 2022 ASC Payment Indicator	Proposed CY 2023 ASC Payment Indicator**
93985	Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete bilateral study	P2**	P2**
93986	Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete unilateral study	P2**	P2**

**Payment indicators are based on a comparison of the final rates according to the ASC standard ratesetting methodology and the PFS final rates.

For these two codes, payment is based on their OPPS relative weight rather than MPFS nonfacility PE RVU-based amount.

Changes to the List of ASC Covered Surgical Procedures

CMS is required to review and update the ASC covered procedure list (ASC CPL) annually to determine whether procedures should be added or removed from the list. This process is often made in response to comments and concerns expressed by stakeholders. However, there are general "exclusion" criteria used in the determination for surgical procedures that:

1) Generally result in extensive blood loss;
2) Require major or prolonged invasion of body cavities;
3) Directly involve major blood vessels;
4) Are generally emergent or life threatening in nature;
5) Commonly require systemic thrombolytic therapy;
6) Are designated as requiring inpatient care under the e-CFR;
7) Can only be reported using a CPT unlisted surgical procedure code; or
8) Are otherwise excluded in the regulations.

The current policy in place is intended to ensure "*that surgical procedures added to the ASC CPL can be performed safely in the ASC setting on the typical Medicare beneficiary*." Based on this review, CMS is proposing to update the ASC CPL by adding one lymphatic procedure to the list for CY 2023.

Supervision by Nonphysician Practitioners of Hospital and CAH Diagnostic Services Furnished to Outpatients

Section 410 of the Act provides supervision requirements for diagnostic x-ray tests, diagnostic laboratory test and other diagnostic paid under the MPFS. In the Interim final rule published on May 8, 2020, CMS finalized to allow certain nonphysician practitioners (nurse practitioners, physician assistants, clinical nurse specialists and certified nurse midwives) to supervise the performance of diagnostic tests to the extent they are authorized to do so under their scope of practice and applicable State law for the duration of the PHE. In the CY 2021 MPFS final rule, CMS made the provisions permanent, adding certified registered nurse anesthetists to the list of nonphysicians practitioners permitted to provide supervision of diagnostic tests.

For consistency, CMS is proposing to clarify the definitions of "general" and "personal" supervision with the text of those definitions in the codified policy. CMS is also proposing revisions to clarify that certain nonphysician practitioners (nurse practitioners, physician assistants, clinical nurse specialists and certified nurse midwifes) may supervise the performance of diagnostic tests to the extent they are authorized to do so under their scope of practice and applicable State law. Cross references for the definitions of "general," "direct" and "personal" supervision for outpatient services provided at a nonhospital location were also proposed.

HOPPS Payment for Software as a medical Service (SaaS)

Evolving technologies are providing advancements in treatment options that could increase access to care for beneficiaries, improve outcomes and reduce overall costs to Medicare. Clinical software, including clinical decision support software, clinical risk modeling and computer aided detection (CAD) are becoming more available to providers. This machine learning or "AI" has been available for years, often performing data analysis of diagnostic images from patients.

In the HOPPS CY 2018 final rule, the Software as a medical Service (SaaS) procedure Fractional Flow Reserve Derived from Computed Tomography (FFRCT), also known by the trade name HeartFlow, became the first procedure in which separate payment was made under HOPPS through APC 1516. HeartFlow is a noninvasive diagnostic service that allows physicians to measure coronary artery disease in a patient through the use of coronary CT scans.

For CY 2023, CMS is proposing to move HeartFlow (CPT® code 0503T) from new technology APC 1511 to clinical APC 5724, as there is enough data to make an assignment to a clinical APC for this procedure.

CMS is seeking comments on a payment approach for SaaS procedures, including how these services should be distinctly recognized from the imaging test or professional service; how their costs should be identified; how these services may be available and paid for in other settings; and what specific payment approach may be used for these services under HOPPS, considering the spread of this technology may not be limited to imaging services.

Submitting Comments

Comments to CMS regarding the HOPPS proposed rule must refer to file code **CMS-1772-P** and must be received no later than **5 pm EST September 13, 2022.** Electronic and mail submissions are acceptable, electronic submissions are encouraged: http://www.regulations.gov. Follow the instructions under the "submit a comment" tab.