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

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INTRODUCTORY SUMMARY AND BACKGROUND

On November 1, 2022, the Centers for Medicare & Medicaid Services (CMS) issued the final 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 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 Final Rule

The CY 2023 final rule is located in its entirety at the following link: https://www.cms.gov/files/document/cy2023-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-final-rule.pdf.

This document in PDF form is 1,764 pages in length. The format of the information is intended to summarize the final changes so readers are encouraged to view the document in its entirety for further details.

HOPPS Payment Rates

There are approximately 9,500 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 finalized their proposal 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 finalized their proposal to increase the CY 2021 conversion factor of $84.177 by 3.8 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 final overall budget neutrality factor is 0.9998 for wage index changes (which includes a 1.0002 budget neutrality adjustment using the standard calculation, as well as a 0.9996 budget neutrality adjustment policy to cap the wage index reduction for hospitals at 5 percent on an annual basis). Thus, the final CF for CY 2023 for hospitals that meet the hospital OQR program requirements is $85.585 in the calculation for national unadjusted rates. For those hospitals that fail to meet the hospital OQR program requirements, the CF is $83.934.

HOPPS Payment Rates

For CY 2023, CMS is finalizing HOPPS payment rates for hospitals that meet applicable quality reporting requirements by 3.8 percent under the Outpatient Department (OPD) fee schedule. This update is based on the projected inpatient hospital market basket increase of 4.1 percent minus a 0.3 percentage point adjustment for multi-factor productivity (MFP). Based on this increase, the estimated total payments to HOPPS providers for CY 2023 will be $86.5 billion. This represents a $6.5 billion increase from estimated CY 2022 HOPPS payments.

CMS is also finalizing 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.

CMS finalized to use the FY 2023 IPPS post-reclassified wage index for urban and rural areas as the wage index for HOPPS to determine the wage adjustments for both the HOPPS payment rate, and the copayment rate for CY 2023. Any policies and adjustments for the FY 2023 IPPS post-reclassified wage index will be reflected in the final CY 2023 OPPS wage index beginning on January 1, 2023.

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 finalized 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 will 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 final rule update of the wage indexes (based on the FY 2023 IPPS final rule wage indexes) result in increased payments of 4.9 percent for urban hospitals and increased payments of 2.9 percent for rural hospitals under HOPPS. For nonteaching hospitals, this update would result in an increased payment of 3.1 percent; minor teaching hospitals would result in increased payments of 4.2 percent; and major teaching hospitals would experience increased payments of 6.8 percent. These wage indexes include the continued implementation of the OMB labor market area delineations based on 2010 census data.

For CY 2023, CMS finalized 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 finalizing 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.

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. The changes would have to be done in a budget neutral manner, meaning CMS would have to make decreases elsewhere under HOPPS to balance the adjustments. Therefore, 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 minus 22.5 percent would be $86.785.

For CY 2023, in light of the Supreme Court's decision in *American Hospital Association v. Becerra*, CMS finalized a general payment rate of ASP plus 6 percent for drugs and biologicals acquired through the 340B Program, consistent with its policy for separately payable drugs not acquired through the 340B program. As required by statute, CMS is implementing a minus 3.09 percent reduction to the payment rates for non-drug services to achieve budget neutrality for the 340B drug payment rate change for CY 2023.

CMS will address the remedy for 340B drug payments from 2018-2022 in future rulemaking prior to the CY 2024 HOPPS/ASC proposed rule. CMS noted that claims for 340B-acquired drugs paid after the District Court's September 28, 2022, ruling are paid at the default rate (generally ASP plus 6 percent).

More details are provided later in this summary about the 340B Drug Discount Program updates and alternate impacts to reimbursement as released by CMS to this point.

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 finalized 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 9: 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

Here's a summary of the quarterly updates:

- April 2022 update – 48 new HCPCS codes were established and made effective April 1, 2022.
- July 2022 update – 63 new HCPCS codes were established and made effective July 1, 2022.
- October 2022 update – as is their current practice, CMS is soliciting comments on the new CPT® and HCPCS codes which will allow them to finalize the status indicators and the APC assignments in the CY 2024 HOPPS\ASC final rule with comment period. These HCPCS codes were released through the October 2022 HOPPS quarterly update change request (CR) and the CPT® codes will be released through the AMA website.
- January 2023 update – CMS is soliciting comments on the new HCPCS codes that will be effective January 1, 2023, which will allow them to finalize the status indicators and the APC assignments. Because most HCPCS codes are not released until November, they are not included in the HOPPS/ASC proposed rules. Therefore, CMS finalized to include these new codes effective January 1, 2023, in Addendum B of the CY 2023 HOPPS/ASC final rule. These codes will be incorporated in the January 2023 HOPPS quarterly update CR, and finalized in the CY 2024 HOPPS/ASC final rule with comment period.

Significance of code G0463

CMS finalized their intent 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 finalized to continue to be reimbursed a payment rate of 40% of the HOPPS rate for all off-campus outpatient departments, excepted and nonexcepted. The rate for G0463 in 2023 is $120.86.

CMS also finalized 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. Thus, 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."

CMS identified 25 APCs in which the 2 times rule violation was found based on updated CY 2021 claims data available. Of these 25 APCs, 22 were identified in the proposed rule and 3 are newly identified APCs. 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 finalized to make an exception for CY 2023:

TABLE 10: FINAL CY 2023 APC EXCEPTIONS TO THE 2 TIMES RULE

CY 2023 APC	CY 2023 APC Title
5012	Clinic Visits and Related Services
5071	Level 1 Excision/ Biopsy/ Incision and Drainage
5301	Level 1 Upper GI Procedures
5341	Abdominal/Peritoneal/Biliary and Related Procedures
5361	Level 1 Laparoscopy and Related Services
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
5723	Level 3 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
5821	Level 1 Health and Behavior Services
5822	Level 2 Health and Behavior Services
5823	Level 3 Health and Behavior Services

New Technology APCs

When new technology is assigned a billing code the establishment of a payment rate by CMS can be difficult because there is no claims data to determine utilization and cost by the hospital. Due to this, CMS created New Technology APCs which are similar to pass-through payments for new drugs, biologicals, radiopharmaceuticals and devices. The new technology is assigned to a temporary APC until claims data is available (typically this is a minimum of two years, but can be less if there is sufficient data available sooner). Once there is sufficient data, the new technology is moved to a clinically appropriate APC.

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.

For CY 2023, CMS will 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 finalized to use CY 2021 claims data information to determine device offset percentages and assign device-intensive status. CMS is also finalizing 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, a 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 making any changes to these policies regarding payment for no cost/full credit and partial credit devices.

A full listing of the final CY 2023 device-intensive procedures can be found in Addendum P of the CY 2023 HOPPS/ASC final rule:
https://www.cms.gov/httpswwwcmsgovmedicaremedicare-fee-service-paymenthospitaloutpatientppshospital-outpatient/cms-1772-fc.

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 on the claims data for payment rate setting.

There are currently 11 device categories eligible for pass-through payment. For CY 2023, CMS received 8 applications for device pass-through payments. Based on review of the current criteria and public comments, CMS determined 4 devices are eligible for pass-through payments, and is therefore approving these 4 devices in CY 2023. For HOPPS device pass-through applications received on or after January 1, 2023, CMS is finalizing to begin to publicly post online the completed application forms and related materials that were received 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/ASC final 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; and
- 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 CMS 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/ASC 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 proposed to remove 10 services from the IPO list (integumentary and musculoskeletal) for CY 2023. Based on review of comments received, CMS finalized their proposal with modification to remove 11 services rather than 10 service.

In addition, CMS is finalizing to add 8 services to the IPO list that were newly created by the AMA CPT® Editorial Panel for CY 2023. The table below contains the list of services to be added back to the IPO list. Of interest are the new hernia repair codes which now include insertion of mesh when performed (49596, 49616-49618, 49621-49622). After clinical review, CMS determined they require a hospital inpatient admission, and as such, will received a status indicator of "C" for CY 2023:

Addendum E.- HCPCS Codes That Would Be Paid Only as Inpatient Procedures for CY 2023			
HCPCS Code	**Short Descriptor**	**Comment Indicator**	**Status Indicator**
49596	Rpr aa hrn 1st > 10 ncr/strn	NC*	C

49616	Rpr aa hrn rcr 3-10 ncr/strn	NC*	C
49617	Rpr aa hrn rcr > 10 rdc	NC*	C
49618	Rpr aa hrn rcr > 10 rdc	NC*	C
49621	Rpr parastomal hernia rdc	NC*	C
49622	Rpr parastomal hrna ncr/strn	NC*	C

*NC = New code for CY 2023

The full list of IPO services is provided by CMS on their website in Addendum E of the CY 2023 HOPPS/ASC final rule: https://www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatientppshospital-outpatient-regulations-and-notices/cms-1772-fc.

Ambulatory Surgery Center (ASC) Payment Rates

Ambulatory Surgery Center (ASC) payments for CY 2019 through 2023, CMS has updated their policy for using a market basket update to calculate rates. For CY 2023, CMS is finalizing to adopt a policy to update the ASC payment system using the hospital market basket update. Based on this methodology, CMS finalized to increase payment rates under the ASC payment system by 2.8 percent for ASCs that meet the quality reporting requirements under the ASCQR Program. This increase is based on a hospital market basket percentage increase of 4.1 percent reduced by a productivity adjustment of a 0.3 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 finalized to adjust the conversion factor (CF) by the final wage index budget neutrality factor of 1.0008 in addition to the hospital market basket update of 2.8 percent, which results in a final CY 2023 ASC CF of $51.854 for ASCs meeting the ASCQR program. For those ASCs who do not meet the ASCQR program, the final CF is $50.855.

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 finalizing 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 finalizing their proposal 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 78: CY 2023 PAYMENT INDICATORS FOR ASC COVERED SURGICAL PROCEDURES DESIGNATED AS TEMPORARILY OFFICE-BASED

CY 2022 CPT/HCPCS Code	CY 2022 Long Descriptor	Final CY 2022 ASC Payment Indicator	Final 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 CPT® 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 proposed to update the ASC CPL by adding one lymphatic procedure to the list for CY 2023. CMS is finalizing this proposal with modification to add four procedures to the ASC CPL.

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 procedures 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 finalizing to replace cross references at § 410.27(a)(1)(iv)(A) and (B) and § 410.28(e) to the definitions of "general" and "personal supervision" at § 410.32(b)(3)(i) and (iii) with the text of those definitions, in order to clarify the definitions of "general" and "personal" supervision with the text of those definitions in the codified policy.

CMS is also finalizing their 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.

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.

Since that time, there have been other SaaS procedures developed, CPT® codes developed for their reporting, and reimbursed by Medicare. Some of these codes are add-on codes, and by HOPPS packaging rules, payment for add-on codes is typically packaged into the primary procedure. Add-on codes are performed in addition to the primary procedure and are never reported as a stand-alone code. Procedures described by add-on codes represent *"an extension or continuation of a primary procedure, which means they are ancillary, supportive, dependent, or adjunctive to a primary service."*

Applications informed CMS that the services described by these add-on codes should also be paid separately because the technologies are new and have significant associated costs. CMS agreed, and therefore proposed not to recognize the select CPT® add-on codes that describe SaaS procedures under the OPPS and instead establish HCPCS codes, specifically C-codes, to describe the add-on codes as standalone services that would be billed with the associated imaging service.

Based on review and consideration of comments received, CMS is finalizing their proposal with modification. Specifically, CMS is recognizing SaaS CPT® add-on codes and paying separately for them. However, CMS is not establishing C codes to describe the add-on codes as standalone services that would be billed with the associated imaging service. CMS believes establishing a duplicative set of codes in place of CPT® add-on codes is unnecessary and would be a burden for hospitals. Subsequently, CMS is finalizing a policy that SaaS add-on codes are not among the *"certain services described by add-on codes"* for which payment is packaged with the related procedures or services under current policy. The SaaS CPT® add-on codes will be assigned to identical APCs and have the same status indicator assignments as their standalone codes.

Submitting Comments

Comments to CMS regarding the HOPPS final rule must refer to file code **CMS-1772-FC** and must be received no later than **5 pm EST January 1, 2023.** Electronic and mail submissions are acceptable, electronic submissions are encouraged: http://www.regulations.gov. Follow the instructions under the "submit a comment" tab.