CY 2025 Medicare Hospital Outpatient Prospective Payment System (HOPPS)/Ambulatory Surgery Center (ASC) Final Rule (CMS-1809-FC)

W.L. GORE and Associates

Introductory Summary and Background

On November 1, 2024, 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) 2025.

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; Indian Health Service (IHS) hospitals; and rural emergency hospitals (REHs).

2025 HOPPS/ASC Final Rule

The CY 2025 final rule is 1,734 pages in length and located in its entirety at the following link: https://www.federalregister.gov/public-inspection/2024-25521/medicare-and-medicaid-programs-hospital-outpatient-prospective-payment-and-ambulatory-surgical. 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 3,500 facilities paid under HOPPS including general acute care hospitals, children's hospitals, cancer hospitals, community mental health centers (CMHCs) and 6,100 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. Therefore, CMS has finalized to use CY 2023 claims data to set CY 2025 HOPPS and ASC payment rates.

Copyright © 2024, Revenue Cycle Coding Strategies, LLC All Rights Reserved.
CPT Only® 2024 American Medical Association All Rights Reserved

Conversion Factor

The Outpatient Department (OPD) increase factor is equal to the hospital inpatient market basket percentage increase, applicable to hospital charges. The finalized OPD fee schedule increase factor is 2.9 percent, which reflects the 3.4 percent final estimate of the hospital inpatient market basket percentage increase reduced by a 0.5 percentage point productivity adjustment. The finalized CF for CY 2025 for hospitals that meet the hospital OQR program requirements is $89.179 in the calculation for national unadjusted rates. For those hospitals that fail to meet the hospital OQR program requirements, the CF is $87.439, which is a difference of -1.730 in the CF relative to hospitals that meet the requirement.

Payment Rates

For CY 2025, CMS is finalizing an increase of 2.9 percent in HOPPS payment rates for hospitals that meet applicable quality reporting requirements under the Outpatient Department (OPD) fee schedule. This update is based on the projected inpatient hospital market basket increase of 3.4 percent minus a 0.5 percentage point adjustment for multi-factor productivity (MFP). Based on this increase, the estimated total payments to HOPPS providers for CY 2025 will be $87.7 billion. This represents a $4.7 billion increase from estimated CY 2024 HOPPS payments.

CMS is also finalizing their proposal to continue implementing a statutory 2.0 percent reduction for hospitals failing to meet the hospital outpatient quality reporting requirements set forth by the Hospital Outpatient Quality Reporting (OQR) Program.

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 (60 percent is the HOPPS labor-related portion, 40 percent is the HOPPS non-labor portion) 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 and finalized by CMS as part of the fiscal year (FY) 2025 inpatient prospective payment system (IPPS) wage index adjustments. This is because most hospitals have outpatient and inpatient services. For those hospitals which do not, CMS assigns a wage index as if they were paid under IPPS, based on their geographic location and any applicable wage index policies and adjustments. This also includes updated Office of Management and Budget (OMB) delineations, which are relative to the changes between urban and rural located hospitals.

CMS proposed for FY 2025 and subsequent years to apply a 5 percent cap on any decreases to a hospital's wage index from the previous year's wage index. The wage index for FY 2024 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 final wage index for the prior year. This low wage index hospital policy adjustment would also apply to outpatient hospitals. On October 3, 2024, an interim final action with comment period (IFC) entitled "Changes to the Fiscal Year 2025 Hospital Inpatient Prospective Payment System (IPPS) Rates Due to Court Decision" was issued in the Federal Register (CMS-1808-IFC).

This document outlined changes to the Medicare IPPS wage index values and established a traditional payment exception for low wage hospitals impacted by removal of the low wage index policy and related low wage index budget neutrality factor from standardized amount as a result of an appellate court decision. CMS believes implementing the low wage index hospital policy is a "valid exercise of the Secretary's authority to adopt

Copyright © 2024, Revenue Cycle Coding Strategies, LLC All Rights Reserved.
CPT Only® 2024 American Medical Association All Rights Reserved

adjustments" to HOPPS payments under the HOPPS statute, and the language regarding the HOPPS wage adjustment factor calculation differs from the calculation of the IPPS wage index in the Act. Therefore, CMS is finalizing to continue the low wage index hospital policy, recognizing this decision will create a deviation between FY 2025 HOPPS wage index values and FY 2025 IPPS wage index for some hospitals, but understanding its overall benefit to low wage index hospitals. CMS stated it was "merely declining to incorporate certain modifications to those values made in the IFC", and would explore options for realigning the IPPS and OPPS wage index values through future rulemaking.

For CY 2025, CMS is finalizing their proposal 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.

CMS also finalized their proposal to use the FY 2025 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 2025. Those hospitals that are paid under the OPPS, but not under the IPPS, do not have an assigned hospital wage index under the IPPS. Therefore, non-IPPS hospitals paid under the OPPS are assigned a wage index as if they were paid under IPPS based on geographic location, including any applicable wage index policies and adjustments. CMS finalized to continue this policy for CY 2025.

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 their proposal to continue this current policy for CY 2025. 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 finalizing to continue a budget neutrality factor for the rural adjustment at 1.0000.

340B Drug Discount Program 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 final rule with comment period, CMS reexamined the appropriateness of paying the average sales price (ASP) plus 6 percent 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.

As previously mentioned, CMS is finalizing their proposal to continue to reimburse drugs and biologicals purchased under a 340B program at the default rate of ASP plus 6 percent. In previous rulemaking, CMS established specific modifiers to be utilized by hospitals reporting 340B acquired drugs and biologicals. Hospitals were instructed to report the "JG" modifier (Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes) or "TB" modifier (Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes for select entities) for informational purposes.

While the payment policy was revised for 340B acquired drugs and biologicals in CY 2023, CMS instructed hospitals to continue to use these modifiers as previously required. In CY 2024, CMS proposed and finalized to

Copyright © 2024, Revenue Cycle Coding Strategies, LLC All Rights Reserved.
CPT Only® 2024 American Medical Association All Rights Reserved

simplify the process by utilizing only the “TB” modifier to identify 340B acquired drugs and biologicals. Per this policy, hospitals would report the “TB” modifier effective January 1, 2025, even if the hospital previously reported the “JG” modifier. In addition, the “TB” modifier descriptor (Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes for select entities) would be changed effective January 1, 2024, to no longer include “…for select entities” as all entities would report this modifier after this date. The use of a single modifier (TB) is seen as a more straightforward approach, especially since both "JG" and "TB" serve the same identification purpose. The goal is to ensure accurate tracking of 340B program related drugs while reducing reporting burden for hospitals.

Due to litigation with previous 340B payment policies between the years of 2018 through 2022, CMS has published separate proposed and final rules to remedy the reduced payment amounts during these years. This final rule does not affect payment policy for 340B acquired drugs in 2024; however, CMS initially proposed changes to adjust the conversion factor beginning in CY 2025 by minus 0.5 percent annually until the estimated total offset of $7.8 billion was reached in a budget neutral manner. At the time of the proposed rule, CMS estimated this process would take 16 years; however, this estimate would be adjusted in future CY annual HOPPS rules after CY 2025. CMS believes starting the reduction in CY 2025 would allow them time to finalize and apply the methodology to calculate and publish rates, as well as allow effected parties to prepare for the new payment rates. CMS sought comments on CY 2026 as an alternative start date of this required financial offset on impacted hospitals. After consideration of the comments received, CMS finalized the start date of CY 2026 to adjust the conversion factor by minus 0.5% percent on an annual basis until the entire $7.8 million is compensated over the CMS-estimated 16 years. This final rule can be located on the CMS website: CMS-1793-F.

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 considered clinically comparable in resource utilization and associated cost. Ancillary services or items considered 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 2025, CMS finalized their proposal of 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.

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

Copyright © 2024, Revenue Cycle Coding Strategies, LLC All Rights Reserved.
CPT Only® 2024 American Medical Association All Rights Reserved

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 17: COMMENT AND FINALIZATION TIMEFRAMES FOR NEW AND REVISED HOPPS-RELATED HCPCS CODES

HOPPS Quarterly Update CR	Type of Code	Effective Date	Comments Sought	When Finalized
April 2024	HCPCS (CPT and Level II codes)	April 1, 2024	CY 2025 OPPS/ASC proposed rule	CY 2025 OPPS/ASC final rule with comment period
July 2024	HCPCS (CPT and Level II codes)	July 1, 2024	CY 2025 OPPS/ASC proposed rule	CY 2025 OPPS/ASC final rule with comment period
October 2024	HCPCS (CPT and Level II codes)	October 1, 2024	CY 2025 OPPS/ASC final rule with comment period	CY 2025 OPPS/ASC final rule with comment period
January 2025	CPT Codes	January 1, 2025	CY 2025 OPPS/ASC proposed rule	CY 2025 OPPS/ASC final rule with comment period
	Level II HCPCS Codes	January 1, 2025	CY 2025 OPPS/ASC final rule with comment period	CY 2026 OPPS/ASC final rule with comment period

For the April 2024 update, 73 new codes were established and made effective on April 1, 2024. For the July 2024 update, 127 new codes were established and made effective July 1, 2024. For the October 2024 update, 107 codes were established and made effective October 1, 2024. CMS recognized several of these new codes for April, July and October for finalized OPPS payment under APCs. For the January 2025 HCPCS update, codes will be assigned with a comment indicator of "NI" to indicate an interim status indicator, which is subject to public comment.

Significance of code G0463

CMS is finalizing their proposal 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 2025; and is finalizing to continue to be reimbursed at a payment rate of 40% of the HOPPS rate for all off-campus outpatient departments, excepted and nonexcepted. A relative weight of 1.00 is finalized to be assigned to APC 5012 (code G0463).

CMS finalized in 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 (SCHs) 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 other settings. This is due to concerns for beneficiaries and access to quality care. Therefore, to ensure access is possible, several special payment provisions for rural providers exist, and

Copyright © 2024, Revenue Cycle Coding Strategies, LLC All Rights Reserved.
CPT Only® 2024 American Medical Association All Rights Reserved

the exemption of the clinic visit payment policy is one of them. Rather than payment at 40 percent of the HOPPS rate, the clinic visit payment policy which applies a Physician Fee Schedule (PFS)-equivalent payment rate for the clinic visit service would be paid at 100 percent of the HOPPS rate. For CY 2025, CMS is finalizing their proposal to continue this policy of exempting excepted off-campus PBDs of rural SCHs from the clinic visit policy.

APC "2 Times Rule"

Law requires the median cost for the highest cost service within the APC may not be more than 2 times the median cost for the lowest cost service in the APC. The Secretary may make exceptions in unusual cases, such as low volume items and services. This is commonly referred to as the "2 times rule." To avoid a violation of the 2 times rule, APC assignment of a service may change from year to year, based on hospital cost reports and frequency of services. CMS has identified all APCs violating the 2 times rule for CY 2025 and reviewed them for possible exceptions. CMS evaluated the identified APCs using the following criteria:

- Resource homogeneity;
- Clinical homogeneity;
- Hospital outpatient setting utilization;
- Frequency of service (volume); and
- Opportunity for upcoding and code fragments.

CMS identified 28 APCs in which the 2 times rule violation was found based on CY 2023 claims data available at the time of this final rule. After applying the above criteria, CMS determined that all 23 APCs qualify for an exception to the 2 times rule. CMS notes that only APCs with criteria-based costs where the 2 times rule is a relevant concept, such as device-dependent CPT/HCPCS codes, were identified. Table 18 lists the APCs for which CMS has finalized to make an exception under the 2 times rule for CY 2025:

TABLE 18: FINAL CY 2024 APC EXCEPTIONS TO THE 2 TIMES RULE

APC	APC Group Title
5012	Clinic Visits and Related Services
5024	Level 4 Type A ED Visits
5053	Level 3 Skin Procedures
5071	Level 1 Excision/ Biopsy/ Incision and Drainage
5501	Level 1 Extraocular, Repair, and Plastic Eye 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
5572	Level 2 Imaging with Contrast
5593	Level 3 Nuclear Medicine and Related Services
5611	Level 1 Therapeutic Radiation Treatment Preparation
5613	Level 3 Therapeutic Radiation Treatment Preparation
5627	Level 7 Radiation Therapy
5674	Level 4 Pathology
5691	Level 1 Drug Administration
5692	Level 2 Drug Administration
5721	Level 1 Diagnostic Tests and Related Services
5731	Level 1 Minor Procedures

Copyright © 2024, Revenue Cycle Coding Strategies, LLC All Rights Reserved.
CPT Only® 2024 American Medical Association All Rights Reserved

5733	Level 3 Minor Procedures
5734	Level 4 Minor Procedures
5741	Level 1 Electronic Analysis of Devices
5743	Level 3 Electronic Analysis of Devices
5791	Pulmonary Treatment
5811	Manipulation Therapy
5821	Level 1 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 hospital utilization and cost. 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 at least two years, but can be less if there is enough 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.

When new technology does have claims data but there are less than 100 claims a year, this is considered low volume. To establish a payment rate for Low Volume APCs, CMS will use up to four years of claims data to establish a payment rate. CMS will calculate the cost from the claims data using the value which is the highest, arithmetic mean cost, median cost, or geometric cost over the four-year period. Typically, a procedure remains in the new technology APC until sufficient claims data is received to justify reassignment to a clinically appropriate APC.

Consistent with current policy, for CY 2025, CMS is finalizing 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.

CMS' final payment rates for New Technology APCs 1491 to 1599 and 1901 to 1908 are located in Addendum A to this final rule, available on the CMS website: https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1809-fc.

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:

- Procedure must involve implantable device assigned to a CPT® or HCPCS code;
- Device must be surgically inserted or implanted (either permanently or temporarily);

Copyright © 2024, Revenue Cycle Coding Strategies, LLC All Rights Reserved.
CPT Only® 2024 American Medical Association All Rights Reserved

- 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 finalized proposal to use CY 2023 claims data for CY 2025 HOPPS and ASC ratesetting, CMS is finalizing their proposal to use CY 2023 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 facility 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 receives a credit for a replaced device that is 50 percent or greater than the cost of the device. For CY 2025, CMS is not proposing any changes to these policies regarding payment for no cost/full credit and partial credit devices.

A complete list of the device-intensive procedures is provided in Addendum P of the CY 2025 HOPPS final rule: https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1809-fc.

Pass-Through 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.

Currently, there are 13 device categories eligible for pass-through payment. In addition, CMS received 14 new completed and timely device pass-through payment applications for CY 2025. Ten of these have received Breakthrough Device designation from the FDA, and FDA marketing authorization for the indication for which they have a Breakthrough Device designation; therefore, these devices were eligible to apply under the alternative pathway. Three applications were approved during the quarterly review process. CMS solicited public comment on these applications based on current criteria and made final determinations on these applications. CMS has publicly posted online the completed application forms and related materials that are received from HOPPS device pass-through applicants on or after January 2, 2023, excluding certain copyrighted or other materials that applicants indicate cannot otherwise be released to the public: https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/pass-through-payment-status-new-technology-ambulatory-payment-classification-apc.

Copyright © 2024, Revenue Cycle Coding Strategies, LLC All Rights Reserved.
CPT Only® 2024 American Medical Association All Rights Reserved

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."*

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. 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 us for addition to the ASC list.

For CY 2025, CMS received several requests recommending specific services be removed from the IPO list. CMS found sufficient evidence to support that code 22848 meets the criteria for removal. Therefore, CMS finalized to remove 22848 from the IPO list for CY 2025 and reassigned the status indicator to "N" (Items and Services Packaged into APC Rates).

In addition, CMS is finalizing their proposal to add 3 services to the IPO list that were newly created by the AMA CPT® Editorial Panel for CY 2025. These new services are described by CPT® codes 0894T, 0895T and 0896T, which will be effective on January 1,2025. After clinical review of these services, CMS found that they require a hospital inpatient admission or stay; therefore, CMS believes these services are not appropriate for payment under HOPPS. CMS finalized to assign these services to status indicator "C'' (Inpatient Only) for CY 2025. The full list of IPO services is provided in Addendum E on the CMS website: https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/pass-through-payment-status-new-technology-ambulatory-payment-classification-apc.

Ambulatory Surgery Center (ASC) Payment Rates

For Ambulatory Surgery Center (ASC) payments CY 2019 through 2023, CMS has updated their policy for using the hospital inpatient market basket update to calculate rates. This current methodology was extended for an additional two years, CY 2024 and CY 2025, due to the impact of the COVID-19 PHE on healthcare utilization. Therefore, CMS is finalizing to increase payment rates under the ASC payment system by 2.9 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 3.4 percent reduced by a productivity adjustment of 0.5 percent. Based on this increase, the estimated total payments to ASCs for CY 2024 will be $7.4 billion. This represents a $308 million increase from estimated CY 2022 ASC Medicare payments.

Copyright © 2024, Revenue Cycle Coding Strategies, LLC All Rights Reserved.
CPT Only® 2024 American Medical Association All Rights Reserved

In addition, CMS finalized to adjust the conversion factor (CF) by the wage index budget neutrality factor of 0.9969, in addition to the projected hospital market basket update of 3.4 percent, reduced by a productivity adjustment of 0.5 percent, which results in a CY 2025 ASC CF of $53.895 for ASCs meeting the ASCQR program. For those ASCs who do not meet the ASCQR program, the finalized CF is $53.828.

For CY 2025, CMS is finalizing their proposal to continue the special payment policy and methodology for the ASC complexity-adjusted C-APCs. The full list of finalized ASC complexity adjustment codes for CY 2025 can be found in the ASC addenda and supplemental policy file on the CMS website: https://www.cms.gov/medicare/medicare-fee-for-service-payment/ascpayment/asc-regulations-and-notices.

ASC Adjustment Codes Designated as Device-Intensive Procedures

Under the current policy, the ASC adjustment codes retain the device portion of the primary procedure (also called the "device offset amount") and not the device offset percentage. The process for calculating the device offset percentage is two-fold: 1) the device portion of the combined procedure is set equal to the device portion of the primary procedure, and then the device offset percentage is calculated by dividing the device portion by the ASC complexity adjustment code's APC rate; and 2) the ASC payment ratesetting methodology is applied to the non-device portion of the ASC complexity adjustment code's APC rate.

Device offset percentages represent the cost portion of the procedure's total cost and are determined using the most recent claims data for a given procedure. However, for newer procedures that meet the criteria (as listed in the "Device-Intensive Procedures" section above) and do not have claims data, CMS uses other means to determine the device offset percentage, such as claims data from a predecessor code, or claims data from a "clinically related or similar" HCPCS code. CMS defines clinically related or similar procedures as those which have few or no clinical differences and use the same devices. In the event the ASC adjustment code does not have a predecessor code or a clinically related or similar code, CMS assigns a default device offset percentage of 31.

For CY 2025 and subsequent years, CMS proposed to modify the default device offset percentage methodology for new device-intensive procedures. Specifically, for all new covered surgical HCPCS codes that meet criteria and do not have claims data, a default device offset percentage of either 31 percent or device offset percentage of that procedure's APC, whichever is greater. Based on comments received, CMS is finalizing their proposal to this policy.

Surgical Procedures Designated as Temporarily or Permanently Office-Based

CMS annually reviews and updates the covered procedures for which ASC payment is made, including those procedures which may be eligible 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, specifically 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.

Copyright © 2024, Revenue Cycle Coding Strategies, LLC All Rights Reserved.
CPT Only® 2024 American Medical Association All Rights Reserved

- 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 their proposal to use the CY 2023 data for ASC ratesetting. As a result, CMS has identified 3 surgical procedures that meet criteria for designation as permanently office-based (codes 0447T, 21127 and 67516); and 3 new surgical procedure codes that meet criteria for designation as temporarily office-based (codes 0581T, 0588T, 0864T, 15013, 53866, 64598, 65785, 67229, C8002, G0564 and G0565). CMS is also finalizing their proposal to continue to assign permanent covered surgical procedures currently assigned a payment indicator of "G2" and temporary covered surgical procedures with a payment indicator or "P2" "P3" or "R2."

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 done 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 finalizing to update the ASC CPL by adding 21 procedures, including 19 dental procedures to the list for CY 2025.

Changes to the Review Timeframes for the Hospital Outpatient Department (OPD) Prior Authorization Process

The CMS Interoperability and Prior Authorization final rule (89 FR 8758) creates and adjusts prior authorization timeframes for plans such as Medicare Advantage, Children's Health Insurance Program (CHIP) Fee-for-service (FFS), Medicaid managed care and CHIP managed care. Payers that are required to submit prior authorization determinations must do so as quickly as the "enrollee's health condition requires or as the beneficiary's health condition requires but no later than 72 hours for expedited (that is, urgent) requests and 7 calendar days for standard (that is, non-urgent) requests."

IN CY 2020, CMS finalized a nationwide prior authorization process and requirements for specific OPD services. As part of the process, OPD providers must provide the Medicare Administrative Contractor (MAC) with a prior authorization request for any of the listed procedures requiring a prior authorization. Currently, CMS requires prior authorization for blepharoplasty, rhinoplasty, botulinum toxin injections, panniculectomy, vein ablation, cervical fusion with disc removal, implanted spinal neurostimulators and facet joint interventions.

It should be noted that Medicare FFS is not a payer that requires prior preauthorization under the CMS Interoperability and Prior Authorization final rule. Therefore, CMS finalized their proposal to align the timeframe for determinations of standard review requests for all impacted providers under this final rule. Specifically, CMS

Copyright © 2024, Revenue Cycle Coding Strategies, LLC All Rights Reserved.
CPT Only® 2024 American Medical Association All Rights Reserved

finalized to change the current completion timeframe for Medicare FFS standard requests from 10-business days to 7-business days. The goal of this change in policy is to align the timeframes across the prior authorization programs and shorten the wait time for beneficiaries to have access to care.

Copyright © 2024, Revenue Cycle Coding Strategies, LLC All Rights Reserved.
CPT Only® 2024 American Medical Association All Rights Reserved