CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal: 12552	**Date: March 21, 2024**
	Change Request 13568

SUBJECT: April 2024 Update of the Hospital Outpatient Prospective Payment System (OPPS)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to describe changes to and billing instructions for various payment policies implemented in the April 2024 Outpatient Prospective Payment System (OPPS) update. The April 2024 Integrated Outpatient Code Editor (I/OCE) will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this CR. This Recurring Update Notification applies to Chapter 4, section 50.8 (Annual Updates to the OPPS Pricer for Calendar Year (CY) 2007 and Later).

EFFECTIVE DATE: April 1, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 1, 2024

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	4/Table of Contents
R	4/20.6.12/Modifier PN
N	4/61.2.2/Edit for Level 6 Intraocular Procedures APC

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 12552	Date: March 21, 2024	Change Request: 13568

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EFFECTIVE DATE: April 1, 2024
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I. GENERAL INFORMATION

A. Background: This Recurring Update Notification (RUN) provides instructions on coding changes and policy updates that are effective April 1, 2024, for the Hospital OPPS. The updates include coding and policy changes for new services, pass-through drug and devices, PLA codes and other items and services. The April 2024 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming April 2024 I/OCE CR.

B. Policy: 1. CPT Proprietary Laboratory Analyses (PLA) Coding Changes Effective April 1, 2024

The AMA CPT Editorial Panel established 11 new PLA codes, specifically, CPT codes 0439U through 0449U, effective April 1, 2024.

Table 1, attachment A, lists the long descriptors and status indicators for the codes. The codes have been added to the April 2024 I/OCE with an effective date of April 1, 2024. In addition, the codes, along with their short descriptors and status indicators, are listed in the April 2024 OPPS Addendum B that is posted on the CMS website. For more information on OPPS status indicators, refer to OPPS Addendum D1 of the Calendar Year 2024 OPPS/ASC final rule for the latest definitions.

2. OPPS Device Pass-Through

a. Clarification for New Device Pass-Through Categories Effective January 1, 2024

Section 1833(t)(6)(B) of the Social Security Act requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least two, but not more than three years. In addition, section 1833(t)(6)(B)(ii)(IV) of the Act requires that we create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

As discussed in section IV.A.2. New Device Pass-Through Applications for CY 2024 of the CY 2024 OPPS/ASC final rule with comment period, we approved four new devices for pass-through status under the OPPS, specifically, HCPCS codes C1600, C1601, C1602, and C1603. For the full discussion on the criteria used to evaluate device pass-through applications, refer to the CY 2024 OPPS/ASC final rule with comment period, which was published in the **Federal Register** on November 22, 2023. In addition, we note that HCPCS code C1604 was preliminarily approved as part of the device pass-through quarterly review process with an effective date of January 1, 2024. The device application associated with HCPCS code C1604 will be included and discussed in the CY 2025 OPPS/ASC proposed and final rules. Refer to Table 2, attachment A, for the long descriptor, status indicator, APC, and offset amount for these five HCPCS codes.

Furthermore, we are adding these five new device category codes and their pass-through expiration dates to Table 3, attachment A. Refer to Table 3 for the complete list of device category HCPCS codes and definitions used for present and previous transitional pass-through payment.

b. Addition of CPT Codes to an Existing Device Code C1602

Section 1833(t)(6)(D)(ii) of the Act requires that we deduct from pass-through payments for devices an amount that reflects the device portion of the APC payment amount. This deduction is known as the device offset, or the portion(s) of the APC amount that is associated with the cost of the pass-through device. The device offset from payment represents a deduction from pass-through payments for the applicable pass-through device.

We note that effective January 1, 2024, we are adding CPT codes 25145, 26236, 28124 to be billed with HCPCS Code C1602, in addition to the CPT codes that we listed in the "January 2024 Update of the Hospital Outpatient Prospective Payment System (OPPS)", Change Request 13488, Transmittal 12421, dated December 21, 2023.

c. Updates for Device Offset Amounts to an Existing Device Code C1600

Section 1833(t)(6)(D)(ii) of the Act requires that we deduct from pass-through payments for devices an amount that reflects the device portion of the APC payment amount. This deduction is known as the device offset, or the portion(s) of the APC amount that is associated with the cost of the pass-through device. The device offset from payment represents a deduction from pass-through payments for the applicable pass-through device.

We note that effective January 1, 2024, we are pairing CPT codes 36902, 36903, 36095, 36906 to be billed with HCPCS Code C1600, as listed in the "January 2024 Update of the Hospital Outpatient Prospective Payment System (OPPS)", Change Request 13488, Transmittal 12421, dated December 21, 2023.

We note that the device offset amount for each of the CPT codes that are paired with C1600 is being updated to $0.00, effective January 1, 2024.

3. Edit for Level 6 Intraocular Procedures APC

Effective CY 2024, the OCE will return to providers claims that report a procedure code assigned to APC 5496 (Level 6 Intraocular Procedures) – but do not report the correct device code that must be implanted during the procedure. The device code must correctly reflect the type of device that was implanted during the procedure. Table 4, attachment A, displays the procedures assigned to the Level 6 Intraocular Procedures APC as well as the appropriate device code that must be present on the claim for that procedure. Hospitals may not bypass this edit by reporting modifier "CG."

This edit does not apply if the provider reports one of the following modifiers with the procedure code:

52 – Reduced Services;

73 – Discontinued outpatient procedure prior to anesthesia administration; and

74 – Discontinued outpatient procedure after anesthesia administration.

If the claim is returned to the provider for failure to pass the edit, the provider will need to modify the claim by correcting the device code (only if the device code to be reported accurately describes the device that was implanted), or, by correcting the procedure code on the claim before resubmission.

4. New HCPCS Codes C9796 and C9797 Effective January 1, 2024

CMS established a new HCPCS code, C9796, to describe the repair of an enterocutaneous fistula in the small intestine or colon with a plug (porcine small intestine submucosa). Table 5, attachment A, lists the official long descriptor, status indicator, and APC assignment for HCPCS code C9796. This code, along with its short descriptor, status indicator, and payment rate, is also listed in the April 2024 OPPS Addendum

B that is posted on the CMS website. For information on OPPS status indicators, refer to OPPS Addendum D1 of the CY 2024 Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center (ASC) final rule for the latest definitions.

CMS established a new HCPCS code, C9797, to describe a vascular embolization or occlusion procedure with use of a pressure-generating catheter (e.g., one-way valve, intermittently occluding). As noted in the long descriptor for HCPCS code C9797 that appears in Table 5, attachment A, this code includes all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention. When reporting HCPCS code C9797, HOPDs should also report HCPCS code C1982 (Catheter, pressure-generating, one-way valve, intermittently occlusive). Note that HCPCS code C9797 describes the procedure, while HCPCS code C1982 describes the device that is used during the procedure. In addition, device HCPCS code C1982 should not be billed with either CPT Code 37242 or 37243. Refer to Table 5, attachment A, for the long descriptor, status indicator, and APC assignment for HCPCS code C9797. This code, along with its short descriptor, status indicator, and payment rate, is also listed in the April 2024 OPPS Addendum B that is posted on the CMS website. For information on OPPS status indicators, refer to OPPS Addendum D1 of the CY 2024 Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center (ASC) final rule for the latest definitions.

5. Clarification on the OPPS Status Indicator for the Cardiovascular Remote Interrogation Device Evaluation HCPCS Code G2066, 93297, and 93298

HCPCS codes 93297, 93298, and G2066 describe the services associated with a cardiovascular remote interrogation device evaluation. CPT codes 93297 and 93298 were effective January 1, 2009, and since its effective date, have been assigned to OPPS status indicator “M” to indicate that the codes describe physician/professional-only services. HCPCS code G2066 was effective January 1, 2020 and deleted December 31, 2023. Under the OPPS, HCPCS code G2066 was assigned to status indicator “Q1” and APC 5741 (Level 1 Electronic Analysis of Devices).

For CY 2024, under the Physician Fee Schedule (PFS), CPT codes 93297 and 93298 have been assigned to direct practice inputs, and designated with a global, technical, and professional indicators. As stated in the 2024 PFS final rule (88 FR 78914), CPT 93297 and 93298 were previously billed under HCPCS code G2066. With the deletion of the code, because HCPCS code G2066 was the code previously reported for CPT codes 93297 and 93298, and because CPT codes 93297 and 93298 were designated as having a technical component under the PFS, we have assigned these codes to separately payable status under the OPPS for CY 2024. Specifically, effective January 1, 2024, we have assigned CPT codes 93297 and 93298 to status indicator “Q1” and APC 5741, which is the same APC that was assigned to HCPCS code G2066. Table 6, attachment A, lists the long descriptors and OPPS SIs for HCPCS codes G2066, 93297, and 93298. CPT codes 93297 and 93298, along with their short descriptors, status indicators, and payment rates are also listed in the April 2024 OPPS Addendum B that is posted on the CMS website. For information on the OPPS status indicators, refer to OPPS Addendum D1 of the CY 2024 Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center (ASC) final rule for the latest definitions.

6. iDose TR (travoprost intracameral implant) for the Treatment of Glaucoma

For the July 1, 2021 update, the CPT Editorial Panel established CPT codes 0660T and 0661T to describe the service associated with the implantation, removal, and reimplantation of the iDose TR, which is a prostaglandin analog used for the reduction of intraocular pressure (IOP) in patients with open-angle glaucoma (OAG) or ocular hypertension (OHT). On December 13, 2023, the iDose TR received FDA NDA approval. Since July 1, 2021, CPT codes 0660T and 0661T have been assigned to status indicator “E1” (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to indicate that the codes are not payable under the OPPS because the drug associated with these codes has not received FDA approval. Based on the recent FDA approval, these codes are now separately payable under the OPPS. Specifically, CPT codes 0660T and 0661T have been assigned from status indicator “E1” to “J1” (Hospital Part B Services Paid Through a Comprehensive APC; Paid under OPPS) and APC 5492 (Level 2 Intraocular

Procedures) effective April 1, 2024.

Table 7, attachment A, lists the long descriptors and OPPS SI for CPT codes 0660T and 0661T. The codes, along with their short descriptors, status indicators, and payment rates are also listed in the April 2024 OPPS Addendum B that is posted on the CMS website. For information on the OPPS status indicators, refer to OPPS Addendum D1 of the CY 2024 Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center (ASC) final rule for the latest definitions.

7. APC Assignment Change for HCPCS Code C9790 (Histotripsy (i.e., non-thermal ablation via acoustic energy delivery) of malignant renal tissue, including image guidance) Retroactive to January 1, 2024

The APC Assignment for HCPCS code C9790 (Histotripsy (i.e., non-thermal ablation via acoustic energy delivery) of malignant renal tissue, including image guidance) will change from APC 1575 (New Technology - Level 38 ($10,001-$15,000)) with a payment rate of $12,500.50 to APC 1576 (New Technology - Level 39 ($15,001-$20,000)) with a payment rate of $17,500.50 retroactive to January 1, 2024.

Table 8, attachment A, lists the official descriptor, status indicator, and APC assignment for HCPCS code C9790. This code, along with its short descriptor, status indicator, and payment rate, is also listed in the April 2024 Update of Addendum B.

8. New HCPCS Code G0138 Assigned to New Technology APC 1508 Effective April 1, 2024

HCPCS code G0138 (Intravenous infusion of cipaglucosidase alfa-atga, including provider/supplier acquisition and clinical supervision of oral administration of miglustat in preparation of receipt of cipaglucosidase alfa-atga) describes the service of administration of cipaglucosidase alfa-atga (Pombiliti), which includes the intravenous administration of cipaglucosidase alfa-atga, the provider or supplier's acquisition cost of miglustat, clinical supervision, and oral administration of miglustat. Effective April 1, 2024, HCPCS code G0138 will be assigned to New Technology APC 1508 (New Technology - Level 8 ($601 - $700)) with status indicator "S" (Paid under OPPS; separate APC payment). Table 9, attachment A, lists the official descriptor, status indicator, and APC assignment for HCPCS code G0138. This code, along with its short descriptor, status indicator, and payment rate, is also listed in the April 2024 Update of Addendum B. For information on the OPPS status indicators, refer to OPPS Addendum D1 of the CY 2024 Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center (ASC) final rule for the latest definitions.

9. Payment for Intensive Cardiac Rehabilitation Services (ICR) Provided by an Off-Campus, Non-Excepted Provider Based Department (PBD) of a Hospital

In the CY 2017 OPPS/ASC final rule with comment period, in accordance with Section 1833(t)(21) of the Act, as added by section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74), CMS established the PN modifier ((signifying a service provided in a non-excepted off-campus provider-based department of a hospital) to identify and pay nonexcepted items and services billed on an institutional claim. Effective January 1, 2017, non-excepted off-campus provider-based departments of a hospital were required to report this modifier on each claim line for non-excepted items and services. The use of modifier PN triggers a payment rate under the Medicare Physician Fee Schedule (PFS) that is approximately 40 percent of the OPPS rate.

In the CY 2024 OPPS/ASC final rule with comment period (88 FR 81867), effective January 1, 2024, we excluded intensive cardiac rehabilitation services (ICR) from the 40 percent PFS Relativity Adjuster policy at the code level by modifying the claims processing of HCPCS codes G0422 (Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session) and G0423 (Intensive cardiac rehabilitation; with or without continuous ECG monitoring without exercise, per session). Under this change, 100 percent of the OPPS rate for ICR is paid irrespective of the presence of the PN modifier on the

claim. For the full discussion of this change, refer to section X.B of the CY 2024 OPPS/ASC final rule with comment period, which was published in the Federal Register in November of CY 2023.

Please note that claims for HCPCS G0422 and G0423 submitted with the PN modifier from January to April 2024 were paid at the 40 percent rate. However, upon the April IOCE release, an additional amount will be retroactively applied to these past claims so that they are paid at 100 percent of the OPPS rate.

10. Drugs, Biologicals, and Radiopharmaceuticals

a. New CY 2024 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals Receiving Pass-Through Status Effective April 1, 2024

Five (5) new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available starting on April 1, 2024. These drugs and biologicals will receive drug pass-through status starting April 1, 2024. These HCPCS codes are listed in Table 10, attachment A.

b. Existing HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals with Pass-Through Status Ending on March 31, 2024

There are three (3) HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals in the outpatient setting that will have their pass-through status end on March 31, 2024. These codes are listed in Table 11, attachment A. Therefore, effective April 1, 2024, the status indicator for these codes is changing from “G” to “K”. For more information on OPPS status indicators, refer to OPPS Addendum D1 of the Calendar Year 2024 OPPS/ASC final rule for the latest definition. These codes, along with their short descriptors and status indicators are also listed in the January April 2024 Update of the OPPS Addendum B.

c. Newly Established HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals as of April 1, 2024

Thirty-nine (39) new drug, biological, and radiopharmaceutical HCPCS codes will be established on April 1, 2024. These HCPCS codes are listed in Table 12, attachment A.

d. HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals Deleted as of March 31, 2024

Eleven (11) drug, biological, and radiopharmaceutical HCPCS codes will be deleted on March 31, 2024. These HCPCS codes are listed in Table 13, attachment A.

e. HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals Changing to a Non-Payable Status on April 1, 2024

One (1) drug, biological, and radiopharmaceutical HCPCS code will be changing to a non-payable status on April 1, 2024. This HCPCS code is listed in Table 14, attachment A.

f. HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals with Descriptor Changes as of April 1, 2024

Seven (7) drug, biological, and radiopharmaceutical HCPCS codes have a descriptor change as of April 1, 2024. These HCPCS codes are listed in Table 15, attachment A.

g. Vaccine that Will Retroactively Change from Non-Payable Status to Payable Status Effective November 9, 2023, in the April 2024 I/OCE Update

The status indicator for CPT code 90589 (Chikungunya virus vaccine, live attenuated, for intramuscular use), effective November 9, 2023, will be changed retroactively from status indicator = “E1” to status

indicator = “M” in the April 2024 I/OCE Update. This drug/biological is reported in Table 16, attachment A.

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

For CY 2024, payment for the majority of nonpass-through drugs, biologicals, and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent (or ASP plus 6 or 8 percent of the reference product for biosimilars. In CY 2024, a single payment of ASP plus 6 percent for pass-through drugs, biologicals, and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items (or ASP plus 6 or 8 percent of the reference product for biosimilars). Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Effective April 1, 2024, payment rates for many drugs and biologicals have changed from the values published in the CY 2024 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from third quarter of CY 2023. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the April 2024 Fiscal Intermediary Standard System (FISS) release. CMS is not publishing the updated payment rates in this Change Request implementing the April 2024 update of the OPPS. However, the updated payment rates effective April 1, 2024, can be found in the April 2024 update of the OPPS Addendum A and Addendum B on the CMS website at https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient

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

Some drugs and biologicals paid based on ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the CMS website on the first date of the quarter at https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/restated-drug-biological-payment-rates

Providers may resubmit claims that were affected by adjustments to a previous quarter’s payment files.

11. Skin Substitutes

The payment for skin substitute products that do not qualify for pass-through status will be packaged into the payment for the associated skin substitute application procedure. For payment packaging purposes, the skin substitute products are divided into two groups: 1) high cost skin substitute products and 2) low cost skin substitute products. New skin substitute HCPCS codes are assigned into the low-cost skin substitute group unless CMS has pricing data that demonstrates that the cost of the product is above either the mean unit cost of $47 or the per day cost of $807 for CY 2024.

a. New Skin Substitute Products as of April 1, 2024

There are five (5) new skin substitute HCPCS codes that will be active as of April 1, 2024. These codes are listed in Table 17, attachment A.

b. Skin Substitute Product Codes Deleted Effective March 31, 2024

One (1) skin substitute product code has been deleted as of March 31, 2024. This code is reported in Table 18, attachment A

12. Coverage Determinations

As a reminder, the fact that a drug, device, procedure, or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program but indicates only how the product, procedure, or service may be paid if covered by the program. Medicare Administrative Contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage.

For example, MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13568.1	Medicare contractors shall adjust, as appropriate, claims brought to their attention with any retroactive changes that were received prior to implementation of the April 2024 OPPS I/OCE.	X		X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13568.2	Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.	X		X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 1

Attachment A − Tables for the Policy Section

Table 1. ─ PLA Coding Changes Effective April 1, 2024

CPT Code	Long Descriptor	OPPS SI
0439U	Cardiology (coronary heart disease [CHD]), DNA, analysis of 5 single-nucleotide polymorphisms (SNPs) (rs11716050 [LOC105376934], rs6560711 [WDR37], rs3735222 [SCIN/LOC107986769], rs6820447 [intergenic], and rs9638144 [ESYT2]) and 3 DNA methylation markers (cg00300879 [transcription start site {TSS200} of CNKSR1], cg09552548 [intergenic], and cg14789911 [body of SPATC1L]), qPCR and digital PCR, whole blood, algorithm reported as a 4-tiered risk score for a 3-year risk of symptomatic CHD	A
0440U	Cardiology (coronary heart disease [CHD]), DNA, analysis of 10 single-nucleotide polymorphisms (SNPs) (rs710987 [LINC010019], rs1333048 [CDKN2B-AS1], rs12129789 [KCND3], rs942317 [KTN1-AS1], rs1441433 [PPP3CA], rs2869675 [PREX1], rs4639796 [ZBTB41], rs4376434 [LINC00972], rs12714414 [TMEM18], and rs7585056 [TMEM18]) and 6 DNA methylation markers (cg03725309 [SARS1], cg12586707 [CXCL1, cg04988978 [MPO], cg17901584 [DHCR24-DT], cg21161138 [AHRR], and cg12655112 [EHD4]), qPCR and digital PCR, whole blood, algorithm reported as detected or not detected for CHD	A
0441U	Infectious disease (bacterial, fungal, or viral infection), semiquantitative biomechanical assessment (via deformability cytometry), whole blood, with algorithmic analysis and result reported as an index	Q4
0442U	Infectious disease (respiratory infection), Myxovirus resistance protein A (MxA) and C-reactive protein (CRP), fingerstick whole blood specimen, each biomarker reported as present or absent	Q4
0443U	Neurofilament light chain (NfL), ultra-sensitive immunoassay, serum or cerebrospinal fluid	Q4

0444U	Oncology (solid organ neoplasia), targeted genomic sequence analysis panel of 361 genes, interrogation for gene fusions, translocations, or other rearrangements, using DNA from formalin-fixed paraffin-embedded (FFPE) tumor tissue, report of clinically significant variant(s)	A
0445U	β-amyloid (Abeta42) and phospho tau (181P) (pTau181), electrochemiluminescent immunoassay (ECLIA), cerebral spinal fluid, ratio reported as positive or negative for amyloid pathology	Q4
0446U	Autoimmune diseases (systemic lupus erythematosus [SLE]), analysis of 10 cytokine soluble mediator biomarkers by immunoassay, plasma, individual components reported with an algorithmic risk score for current disease activity	Q4
0447U	Autoimmune diseases (systemic lupus erythematosus [SLE]), analysis of 11 cytokine soluble mediator biomarkers by immunoassay, plasma, individual components reported with an algorithmic prognostic risk score for developing a clinical flare	Q4
0448U	Oncology (lung and colon cancer), DNA, qualitative, nextgeneration sequencing detection of single-nucleotide variants and deletions in EGFR and KRAS genes, formalin-fixed paraffinembedded (FFPE) solid tumor samples, reported as presence or absence of targeted mutation(s), with recommended therapeutic options	A
0449U	Carrier screening for severe inherited conditions (eg, cystic fibrosis, spinal muscular atrophy, beta hemoglobinopathies [including sickle cell disease], alpha thalassemia), regardless of race or self-identified ancestry, genomic sequence analysis panel, must include analysis of 5 genes (CFTR, SMN1, HBB, HBA1, HBA2)	E1

Table 2. -- Device Pass-Through Category HCPCS Codes and Associated Device Offset Amounts

HCPCS Code	Long Descriptor	SI	APC	CY 2024 Device Offset Amount(s)
C1600	Catheter, transluminal intravascular lesion preparation device, bladed, sheathed (insertable)	H	2041	CPT code 36902 $0.00
C1601	Endoscope, single-use (i.e. disposable), pulmonary, imaging/illumination device (insertable)	H	2042	CPT code 31626 $652.77
C1602	Orthopedic/device/drug matrix/absorbable bone void filler, antimicrobial-eluting (implantable)	H	2043	CPT code 24134 $647.55
C1603	Retrieval device, insertable, laser (used to retrieve intravascular inferior vena cava filter)	H	2044	CPT code 37193 $782.64
C1604	Graft, transmural transvenous arterial bypass (implantable), with all delivery system components	H	2045	CPT code 0505T $4947.41

Device category HCPCS code C1602 should always be billed with at least one of the following CPT codes:

HCPCS Code	Long Descriptor	SI	APC	CY 2024 Device Offset Amount
21510	Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), thorax	C	NA	NA
23035	Incision, bone cortex (eg, osteomyelitis or bone abscess), shoulder area	J1	5112	$0.00
23170	Sequestrectomy (eg, for osteomyelitis or bone abscess), clavicle	J1	5113	$779.03
23172	Sequestrectomy (eg, for osteomyelitis or bone abscess), scapula	J1	NA	NA
23174	Sequestrectomy (eg, for osteomyelitis or bone abscess), humeral head to surgical neck	J1	5114	$0.00
23180	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), clavicle	J1	5114	$0.00
23182	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), scapula	J1	5114	$411.71
23184	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), proximal humerus	J1	5114	$0.00
23935	Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), humerus or elbow	J1	5113	$97.15

24134	Sequestrectomy (eg, for osteomyelitis or bone abscess), shaft or distal humerus	J1	5114	$647.55
24136	Sequestrectomy (eg, for osteomyelitis or bone abscess), radial head or neck	J1	5113	$0.00
24138	Sequestrectomy (eg, for osteomyelitis or bone abscess), olecranon process	J1	5114	$165.64
24140	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), humerus	J1	5113	$143.72
24145	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), radial head or neck	J1	5114	$0.00
24147	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), olecranon process	J1	5113	$66.31
25035	Incision, deep, bone cortex, forearm and/or wrist (eg, osteomyelitis or bone abscess)	J1	5114	$805.01
25150	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis); ulna	J1	5113	$18.20
25151	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis); radius	J1	5113	$101.46
26230	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis); metacarpal	J1	5113	$64.76
26992	Incision, bone cortex, pelvis and/or hip joint (eg, osteomyelitis or bone abscess)	C	NA	NA
27070	Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (eg, osteomyelitis or bone abscess); superficial	C	NA	NA
27071	Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (eg, osteomyelitis or bone abscess); deep (subfascial or intramuscular)	C	NA	NA
27303	Incision, deep, with opening of bone cortex, femur or knee (eg, osteomyelitis or bone abscess)	C	NA	NA
27360	Partial excision (craterization, saucerization, or diaphysectomy) bone, femur, proximal tibia and/or fibula (eg, osteomyelitis or bone abscess)	J1	5113	$169.00
27607	Incision (eg, osteomyelitis or bone abscess), leg or ankle	J1	5113	$557.28

27640	Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); tibia	J1	5113	$329.37
27641	Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); fibula	J1	5113	$72.78
28005	Incision, bone cortex (eg, osteomyelitis or bone abscess), foot	J1	5113	$214.65
28120	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus	J1	5113	$218.35
28122	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus	J1	5113	$104.86
25145*	Sequestrectomy (eg, for osteomyelitis or bone abscess), forearm and/or wrist	J1	5113	$0.00
26236*	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis); distal phalanx of finger	J1	5112	$7.20
28124*	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); phalanx of toe	J1	5113	$54.28

*We note we are adding CPT codes 25145, 26236, 28124 to be billed with HCPCS Code C1602 effective January 1, 2024.

Device category HCPCS code C1600 should always be billed with at least one of the following CPT codes:

HCPCS Code	Long Descriptor	SI	APC	Device Offset Amount
36902	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transluminal balloon angioplasty, peripheral dialysis segment,	J1	5192	$0.00

	including all imaging and radiological supervision and interpretation necessary to perform the angioplasty			
36903	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment	J1	5193	$0.00
36905	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	J1	5193	$0.00
36906	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all	J1	5194	$0.00

	angioplasty within the peripheral dialysis circuit			

Table 3. -- List of Device Category HCPCS Codes and Definitions Used for Present and Previous Pass-Through Payment ***

	HCPCS Codes	Category Long Descriptor	Date First Populated	Pass-Through Expiration Date***
1.	C1883*	Adaptor/extension, pacing lead or neurostimulator lead (implantable)	8/1/2000	12/31/2002
2.	C1765*	Adhesion barrier	10/01/00 – 3/31/2001; 7/1/2001	12/31/2003
3.	C1713*	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)	8/1/2000	12/31/2002
4.	L8690	Auditory osseointegrated device, includes all internal and external components	1/1/2007	12/31/2008
5.	**C1832**	**Autograft suspension, including cell processing and application, and all system components**	**1/1/2022**	**12/31/2024**
6.	C1715	Brachytherapy needle	8/1/2000	12/31/2002
7.	C1716#	Brachytherapy source, non-stranded, Gold-198, per source	10/1/2000	12/31/2002
8.	C1717#	Brachytherapy source, non-stranded, high dose rate Iridium-192, per source	1/1/2001	12/31/2002
9.	C1718#	Brachytherapy source, Iodine 125, per source	8/1/2000	12/31/2002
10.	C1719#	Brachytherapy source, non-stranded, non-high dose rate Iridium-192, per source	10/1/2000	12/31/2002
11.	C1720#	Brachytherapy source, Palladium 103, per source	8/1/2000	12/31/2002
12.	C2616#	Brachytherapy source, non-stranded, Yttrium-90, per source	1/1/2001	12/31/2002
13.	C2632	Brachytherapy solution, iodine – 125, per mCi	1/1/2003	12/31/2004
14.	C1721	Cardioverter-defibrillator, dual chamber (implantable)	8/1/2000	12/31/2002
15.	C1882*	Cardioverter-defibrillator, other than single or dual chamber (implantable)	8/1/2000	12/31/2002
16.	C1722	Cardioverter-defibrillator, single chamber (implantable)	8/1/2000	12/31/2002
17.	C1888*	Catheter, ablation, non-cardiac, endovascular (implantable)	7/1/2002	12/31/2004
18.	C1726*	Catheter, balloon dilatation, non-vascular	8/1/2000	12/31/2002
19.	C1727*	Catheter, balloon tissue dissector, non-vascular (insertable)	8/1/2000	12/31/2002
20.	C1728	Catheter, brachytherapy seed administration	1/1/2001	12/31/2002
21.	C1729*	Catheter, drainage	10/1/2000	12/31/2002

22.	C1730*	Catheter, electrophysiology, diagnostic, other than 3D mapping (19 or fewer electrodes)	8/1/2000	12/31/2002
23.	C1731*	Catheter, electrophysiology, diagnostic, other than 3d mapping (20 or more electrodes)	8/1/2000	12/31/2002
24.	C1732*	Catheter, electrophysiology, diagnostic/ablation, 3D or vector mapping	8/1/2000	12/31/2002
25.	C1733*	Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, other than cool-tip	8/1/2000	12/31/2002
26.	C2630*	Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, cool-tip	10/1/2000	12/31/2002
27.	C1886	Catheter, extravascular tissue ablation, any modality (insertable)	01/1/2012	12/31/2013
28.	C1887*	Catheter, guiding (may include infusion/perfusion capability)	8/1/2000	12/31/2002
29.	C1750	Catheter, hemodialysis/peritoneal, long-term	8/1/2000	12/31/2002
30.	C1752	Catheter, hemodialysis/peritoneal, short-term	8/1/2000	12/31/2002
31.	C1751	Catheter, infusion, inserted peripherally, centrally or midline (other than hemodialysis)	8/1/2000	12/31/2002
32.	C1759	Catheter, intracardiac echocardiography	8/1/2000	12/31/2002
33.	C1754	Catheter, intradiscal	10/1/2000	12/31/2002
34.	C1755	Catheter, intraspinal	8/1/2000	12/31/2002
35.	C1753	Catheter, intravascular ultrasound	8/1/2000	12/31/2002
36.	C2628	Catheter, occlusion	10/1/2000	12/31/2002
37.	C1756	Catheter, pacing, transesophageal	10/1/2000	12/31/2002
38.	C2627	Catheter, suprapubic/cystoscopic	10/1/2000	12/31/2002
39.	C1757	Catheter, thrombectomy/embolectomy	8/1/2000	12/31/2002
40.	C2623	Catheter, transluminal angioplasty, drug-coated, non-laser	4/1/2015	12/31/2017
41.	C1885*	Catheter, transluminal angioplasty, laser	10/1/2000	12/31/2002
42.	C1725*	Catheter, transluminal angioplasty, non-laser (may include guidance, infusion/perfusion capability)	8/1/2000	12/31/2002
43.	C1714	Catheter, transluminal atherectomy, directional	8/1/2000	12/31/2002
44.	C1724	Catheter, transluminal atherectomy, rotational	8/1/2000	12/31/2002
45.	**C1761**	**Catheter, transluminal intravascular lithotripsy, coronary**	**7/1/2021**	**6/30/2024**
46.	C1760*	Closure device, vascular (implantable/insertable)	8/1/2000	12/31/2002
47.	L8614	Cochlear implant system	8/1/2000	12/31/2002
48.	C1762*	Connective tissue, human (includes fascia lata)	8/1/2000	12/31/2002
49.	C1763*	Connective tissue, non-human (includes synthetic)	10/1/2000	12/31/2002
50.	C1881	Dialysis access system (implantable)	8/1/2000	12/31/2002
51.	C1884*	Embolization protective system	1/01/2003	12/31/2004
52.	C1749	Endoscope, retrograde imaging/illumination colonoscope device (implantable)	10/1/2010	12/31/2012
53.	C1748	Endoscope, single-use (i.e. disposable), Upper GI, imaging/illumination device (insertable)	7/1/2020	6/30/2023

54.	C1764	Event recorder, cardiac (implantable)	8/1/2000	12/31/2002
55.	C1822	Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system	1/1/2016	12/31/2017
56.	C1767**	Generator, neurostimulator (implantable), non-rechargeable	8/1/2000	12/31/2002
57.	C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system	1/1/2006	12/31/2007
58.	C1825	Generator, neurostimulator (implantable), non-rechargeable with carotid sinus baroreceptor stimulation lead(s)	1/1/2021	12/31/2023
59.	C1823	Generator, neurostimulator (implantable), nonrechargeable , with transvenous sensing and stimulation leads	1/1/2019	12/31/2022
60.	C1768	Graft, vascular	1/1/2001	12/31/2002
61.	C1769	Guide wire	8/1/2000	12/31/2002
62.	C1052	Hemostatic agent, gastrointestinal, topical	1/1/2021	12/31/2023
63.	C1770	Imaging coil, magnetic resonance (insertable)	1/1/2001	12/31/2002
64.	C2624	Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components	1/1/2015	12/31/2016
65.	C1891	Infusion pump, non-programmable, permanent (implantable)	8/1/2000	12/31/2002
66.	C2626*	Infusion pump, non-programmable, temporary (implantable)	1/1/2001	12/31/2002
67.	C1772	Infusion pump, programmable (implantable)	10/1/2000	12/31/2002
68.	C1818*	Integrated keratoprosthesis	7/1/2003	12/31/2005
69.	C1821	Interspinous process distraction device (implantable)	1/1/2007	12/31/2008
70.	C1062	Intravertebral body fracture augmentation with implant (e.g., metal, polymer)	1/1/2021	12/31/2023
71.	C1893	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, other than peel-away	10/1/2000	12/31/2002
72.	C1892*	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, peel-away	1/1/2001	12/31/2002
73.	C1766	Introducer/sheath, guiding, intracardiac electrophysiological, steerable, other than peel-away	1/1/2001	12/31/2002
74.	C1894	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, non-laser	8/1/2000	12/31/2002
75.	C2629	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, laser	1/1/2001	12/31/2002
76.	C1776*	Joint device (implantable)	10/1/2000	12/31/2002
77.	C1895	Lead, cardioverter-defibrillator, endocardial dual coil (implantable)	8/1/2000	12/31/2002
78.	C1777	Lead, cardioverter-defibrillator, endocardial single coil (implantable)	8/1/2000	12/31/2002

79.	C1896	Lead, cardioverter-defibrillator, other than endocardial single or dual coil (implantable)	8/1/2000	12/31/2002
80.	C1900*	Lead, left ventricular coronary venous system	7/1/2002	12/31/2004
81.	C1778	Lead, neurostimulator (implantable)	8/1/2000	12/31/2002
82.	C1897	Lead, neurostimulator test kit (implantable)	8/1/2000	12/31/2002
83.	C1898	Lead, pacemaker, other than transvenous VDD single pass	8/1/2000	12/31/2002
84.	C1779*	Lead, pacemaker, transvenous VDD single pass	8/1/2000	12/31/2002
85.	C1899	Lead, pacemaker/cardioverter-defibrillator combination (implantable)	1/1/2001	12/31/2002
86.	C1780*	Lens, intraocular (new technology)	8/1/2000	12/31/2002
87.	C1840	Lens, intraocular (telescopic)	10/1/2011	12/31/2013
88.	C2613	Lung biopsy plug with delivery system	7/1/2015	12/31/2017
89.	C1878*	Material for vocal cord medialization, synthetic (implantable)	10/1/2000	12/31/2002
90.	C1781*	Mesh (implantable)	8/1/2000	12/31/2002
91.	**C1833**	**Monitor, cardiac, including intracardiac lead and all system components (implantable)**	**1/1/2022**	**12/31/2024**
92.	C1782*	Morcellator	8/1/2000	12/31/2002
93.	C1784*	Ocular device, intraoperative, detached retina	1/1/2001	12/31/2002
94.	C1783	Ocular implant, aqueous drainage assist device	7/1/2002	12/31/2004
95.	C2619	Pacemaker, dual chamber, non rate-responsive (implantable)	8/1/2000	12/31/2002
96.	C1785	Pacemaker, dual chamber, rate-responsive (implantable)	8/1/2000	12/31/2002
97.	C2621*	Pacemaker, other than single or dual chamber (implantable)	1/1/2001	12/31/2002
98.	C2620	Pacemaker, single chamber, non rate-responsive (implantable)	8/1/2000	12/31/2002
99.	C1786	Pacemaker, single chamber, rate-responsive (implantable)	8/1/2000	12/31/2002
100.	C1787*	Patient programmer, neurostimulator	8/1/2000	12/31/2002
101.	**C1831**	**Interbody cage, anterior, lateral or posterior, personalized (implantable)**	**10/1/2021**	**9/30/2024**
102.	C1788	Port, indwelling (implantable)	8/1/2000	12/31/2002
103.	C1830	Powered bone marrow biopsy needle	10/1/2011	12/31/2013
104.	C2618	Probe, cryoablation	4/1/2001	12/31/2003
105.	C2614	Probe, percutaneous lumbar discectomy	1/1/2003	12/31/2004
106.	C1789	Prosthesis, breast (implantable)	10/1/2000	12/31/2002
107.	C1813	Prosthesis, penile, inflatable	8/1/2000	12/31/2002
108.	C2622	Prosthesis, penile, non-inflatable	10/1/2001	12/31/2002
109.	C1815	Prosthesis, urinary sphincter (implantable)	10/1/2000	12/31/2002
110.	C1816	Receiver and/or transmitter, neurostimulator (implantable)	8/1/2000	12/31/2002
111.	C1771*	Repair device, urinary, incontinence, with sling graft	10/1/2000	12/31/2002

112.	C2631*	Repair device, urinary, incontinence, without sling graft	8/1/2000	12/31/2002
113.	C1841	Retinal prosthesis, includes all internal and external components	10/1/2013	12/31/2015
114.	C1814*	Retinal tamponade device, silicone oil	4/1/2003	12/31/2005
115.	C1773*	Retrieval device, insertable	1/1/2001	12/31/2002
116.	C2615*	Sealant, pulmonary, liquid (implantable)	1/1/2001	12/31/2002
117.	C1817*	Septal defect implant system, intracardiac	8/1/2000	12/31/2002
118.	C1874*	Stent, coated/covered, with delivery system	8/1/2000	12/31/2002
119.	C1875*	Stent, coated/covered, without delivery system	8/1/2000	12/31/2002
120.	C1876*	Stent, non-coated/non-covered, with delivery system	8/1/2000	12/31/2002
121.	C1877	Stent, non-coated/non-covered, without delivery system	8/1/2000	12/31/2002
122.	C2625*	Stent, non-coronary, temporary, with delivery system	10/1/2000	12/31/2002
123.	C2617*	Stent, non-coronary, temporary, without delivery system	10/1/2000	12/31/2002
124.	C1819	Tissue localization excision device	1/1/2004	12/31/2005
125.	C1879*	Tissue marker (implantable)	8/1/2000	12/31/2002
126.	C1880	Vena cava filter	1/1/2001	12/31/2002
127.	**C1826**	**Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system**	**1/1/2023**	**12/31/2025**
128.	**C1827**	**Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller**	**1/1/2023**	**12/31/2025**
129.	**C1747**	**Endoscope, single-use (i.e. disposable), urinary tract, imaging/illumination device (insertable)**	**1/1/2023**	**12/31/2025**
130.	C1824^	Generator, cardiac contractility modulation (implantable)	1/1/2020	12/31/2023
131.	C1982^	Catheter, pressure-generating, one-way valve, intermittently occlusive	1/1/2020	12/31/2023
132.	C1839^	Iris prosthesis	1/1/2020	12/31/2023
133.	C1734^	Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue-to bone (implantable)	1/1/2020	12/31/2023
134.	C2596^	Probe, image-guided, robotic, waterjet ablation	1/1/2020	12/31/2023
135.	**C1600**	**Catheter, transluminal intravascular lesion preparation device, bladed, sheathed (insertable)**	**01/01/2024**	**12/31/2026**
136.	**C1601**	**Endoscope, single-use (i.e. disposable), pulmonary, imaging/illumination device (insertable)**	**01/01/2024**	**12/31/2026**
137.	**C1602**	**Orthopedic/device/drug matrix/absorbable bone void filler, antimicrobial-eluting (implantable)**	**01/01/2024**	**12/31/2026**
138.	**C1603**	**Retrieval device, insertable, laser (used to retrieve intravascular inferior vena cava filter)**	**01/01/2024**	**12/31/2026**
139.	**C1604**	**Graft, transmural transvenous arterial bypass (implantable), with all delivery system components**	**01/01/2024**	**12/31/2026**

BOLD codes are still actively receiving pass-through payment.

Italicized codes have received preliminary approval for pass-through payment.

*** Refer to the definition below for further information on this device category code.**

**** Effective 1/1/06 C1767 descriptor was changed for succeeding claims. See CR 4250, Jan. 3, 2006 for details.**

***** Although the pass-through payment status for device category codes has expired, these codes are still active and hospitals are still required to report the device category C-codes (except the brachytherapy source codes, which are separately paid under the OPPS) on claims when such devices are used in conjunction with procedures billed and paid under the OPPS.**

^Sec. 4141. Extension of Pass-Through Status Under the Medicare Program for Certain Devices Impacted by COVID-19 of the Consolidated Appropriations Act, 2023 has extended pass-through status for a 1-year period beginning on January 1, 2023.

Table 4. -- Procedures Assigned to the Level 6 Intraocular Procedures APC and the Appropriate Device Code that Must be Present on the Claim for that Procedure

APC 5496 CPT Codes	Long Descriptor	Device HCPCS Code to Report with CPT code	Long Descriptor
0308T	Insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis	C1840	Lens, intraocular (telescopic)
0616T	Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; without removal of crystalline lens or intraocular lens, without insertion of intraocular lens	C1839	Iris prosthesis
0617T	Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; with removal of crystalline lens and insertion of intraocular lens	C1839	Iris prosthesis
0618T	Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; with secondary intraocular lens placement or intraocular lens exchange	C1839	Iris prosthesis

Table 5. — OPPS APC and SI for HCPCS Codes C9796 and C9797

HCPCS Code	Long Descriptor	CY 2024 OPPS SI	CY 2024 OPPS APC	CY 2024 OPPS APC Group Title
C9796	Repair of enterocutaneous fistula small intestine or colon (excluding anorectal fistula) with plug (e.g., porcine small intestine submucosa [SIS])	J1	5313	Level 3 Lower GI Procedures
C9797	Vascular embolization or occlusion procedure with use of a pressure-generating catheter (e.g., one-way valve, intermittently occluding), inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction	J1	5194	Level 4 Endovascular Procedures

Table 6. — OPPS APC and SI for HCPCS Codes G2066, 93297, and 93298

HCPCS Code	Long Descriptor	CY 2024 OPPS SI	CY 2024 OPPS APC	CY 2024 OPPS APC Group Title
G2066	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system, implantable loop recorder system, or subcutaneous cardiac rhythm monitor system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	N/A Code Deleted Dec 31, 2023		
93297	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified health care professional	Q1	5741	Level 1 Electronic Analysis of Devices

93298	Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional	Q1	5741	Level 1 Electronic Analysis of Devices

Table 7. — OPPS APC and SI for CPT Codes 0660T and 0661T

HCPCS Code	Long Descriptor	April 2024 OPPS SI	April 2024 OPPS APC	CY 2024 OPPS APC Group Title
0660T	Implantation of anterior segment intraocular nonbiodegradable drug-eluting system, internal approach	J1	5492	Level 2 Intraocular Procedures
0661T	Removal and reimplantation of anterior segment intraocular nonbiodegradable drug-eluting implant	J1	5492	Level 2 Intraocular Procedures

Table 8. ─ APC Assignment Change for HCPCS Code C9790 (Histotripsy (i.e., non-thermal ablation via acoustic energy delivery) of malignant renal tissue, including image guidance) Retroactive to January 1, 2024

HCPCS Code	Short Descriptor	Long Descriptor	SI	Old APC	New APC
C9790	Kidney histotripsy w/image	Histotripsy (ie, non-thermal ablation via acoustic energy delivery) of malignant renal tissue, including image guidance	S	1575	1576

Table 9. - OPPS Long Descriptor, APC and SI for HCPCS Code G0138

HCPCS Code	Long Descriptor	April 2024 OPPS SI	April 2024 OPPS APC	CY 2024 OPPS APC Group Title
G0138	Intravenous infusion of cipaglucosidase alfa-atga, including provider/supplier acquisition and clinical supervision of oral administration of miglustat in preparation of receipt of cipaglucosidase alfa-atga	S	1508	New Technology - Level 8 ($601 - $700)

Table 10. ─ New CY 2024 HCPCS Codes Effective April 1, 2024, for Certain Drugs, Biologicals, and Radiopharmaceuticals Receiving Pass-Through Status

CY 2024 HCPCS Code	CY 2024 Long Descriptor	CY 2024 SI	CY 2024 APC
C9166	Injection, secukinumab, intravenous, 1 mg	G	0725
C9167	Injection, apadamtase alfa, 10 units	G	0727
C9168	Injection, mirikizumab-mrkz, 1 mg	G	0728
J2277	Injection, motixafortide, 0.25 mg	G	0729
J9248	Injection, melphalan (hepzato), 1 mg	G	0730

Table 11. ─ HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals with Pass-Through Status Ending Effective March 31, 2024

CY 2024 HCPCS Code	CY 2024 Long Descriptor	January 2024 SI	April 2024 SI	April 2024 APC
J0224	Injection, lumasiran, 0.5mg	G	K	9407
J7212	Factor viia (antihemophilic factor, recombinant)-jncw (sevenfact), 1 microgram	G	K	9395
Q5122	Injection, pegfilgrastim-apgf (nyvepria), biosimilar, 0.5 mg	G	K	9406

Table 12. ─ Newly Established HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals as of April 1, 2024

New HCPCS Code	Old HCPCS Code	Long Descriptor	SI	APC
A2026		Restrata minimatrix, 5 mg	N	N/A
C9166		Injection, secukinumab, intravenous, 1 mg	G	0725
C9167		Injection, apadamtase alfa, 10 units	G	0727
C9168		Injection, mirikizumab-mrkz, 1 mg	G	0728
J0177	C9161	Injection, aflibercept hd, 1 mg	G	0704
J0209		Injection, sodium thiosulfate (hope), 100 mg	N	N/A

J0577		Injection, buprenorphine extended-release (brixadi), less than or equal to 7 days of therapy	G	0732
J0578		Injection, buprenorphine extended release (brixadi), greater than 7 days and up to 28 days of therapy	G	0733
J0589	C9160	Injection, daxibotulinumtoxina-lanm, 1 unit	G	0703
J0650		Injection, levothyroxine sodium, not otherwise specified, 10 mcg	N	N/A
J0651		Injection, levothyroxine sodium (fresenius kabi) not therapeutically equivalent to J0650, 10 mcg	K	0734
J0652		Injection, levothyroxine sodium (hikma) not therapeutically equivalent to J0650, 10 mcg	K	0735
J1010		Injection, methylprednisolone acetate, 1 mg	N	N/A
J1202		Miglustat, oral, 65 mg	E1	N/A
J1203		Injection, cipaglucosidase alfa-atga, 5 mg	K	0737
J1323	C9165	Injection, elranatamab-bcmm, 1 mg	G	0708
J1434		Injection, fosaprepitant (focinvez), 1 mg	E2	N/A
J2277		Injection, motixafortide, 0.25 mg	G	0729
J2782	C9162	Injection, avacincaptad pegol, 0.1 mg	G	0705
J2801		Injection, risperidone (rykindo), 0.5 mg	K	0739
J2919		Injection, methylprednisolone sodium succinate, 5 mg	N	N/A
J3055	C9163	Injection, talquetamab-tgvs, 0.25 mg	G	0706
J3424		Injection, hydroxocobalamin, intravenous, 25 mg	K	0740
J7165	C9159	Injection, prothrombin complex concentrate, human-lans, per i.u. of factor ix activity	G	0702
J7354	C9164	Cantharidin for topical administration, 0.7%, single unit dose applicator (3.2 mg)	G	0707
J9073		Injection, cyclophosphamide (ingenus), 5 mg	K	0741
J9074		Injection, cyclophosphamide (sandoz), 5 mg	E2	N/A
J9075		Injection, cyclophosphamide, not otherwise specified, 5 mg	K	0743
J9248		Injection, melphalan (hepzato), 1 mg	G	0730
J9249		Injection, melphalan (apotex), 1 mg	E2	N/A
J9376		Injection, pozelimab-bbfg, 1 mg	E2	N/A
Q4305		American amnion ac tri-layer, per square centimeter	N	N/A
Q4306		American amnion ac, per square centimeter	N	N/A
Q4307		American amnion, per square centimeter	N	N/A
Q4308		Sanopellis, per square centimeter	N	N/A
Q4309		Via matrix, per square centimeter	N	N/A
Q4310		Procenta, per 100 mg	N	N/A
Q5133		Injection, tocilizumab-bavi (tofidence), biosimilar, 1 mg	E2	N/A
Q5134		Injection, natalizumab-sztn (tyruko), biosimilar, 1 mg	E2	N/A

Table 13. ─ HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals Deleted as of March 31, 2024

CY 2024 HCPCS Code	Long Descriptor	CY 2024 SI	APC
J0576	Injection, buprenorphine extended-release (brixadi), 1 mg	D	N/A
J1020	Injection, methylprednisolone acetate, 20 mg	D	N/A
J1030	Injection, methylprednisolone acetate, 40 mg	D	N/A
J1040	Injection, methylprednisolone acetate, 80 mg	D	N/A
J1840	Injection, kanamycin sulfate, up to 500 mg	D	N/A
J1850	Injection, kanamycin sulfate, up to 75 mg	D	N/A
J2920	Injection, methylprednisolone sodium succinate, up to 40 mg	D	N/A
J2930	Injection, methylprednisolone sodium succinate, up to 125 mg	D	N/A
J9070	Cyclophosphamide, 100 mg	D	N/A
J9250	Methotrexate sodium, 5 mg	D	N/A
Q4244	Procenta, per 200 mg	D	N/A

Table 14. ─ HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals Changing to a Non-Payable Status on April 1, 2024

CY 2024 HCPCS Code	Long Descriptor	January 2024 SI	January 2024 APC	April 2024 SI	April 2024 APC
J9019	Injection, asparaginase (erwinaze), 1,000 iu	K	9289	E2	N/A

Table 15. ─ HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals with Descriptor Changes as of April 1, 2024

CY 2024 HCPCS Code	January 2024 Long Descriptor	April 2024 Long Descriptor
J0208	Injection, sodium thiosulfate, 100 mg	Injection, sodium thiosulfate (pedmark), 100 mg
J0612	Injection, calcium gluconate (fresenius kabi), per 10 mg	Injection, calcium gluconate, not otherwise specified, 10 mg

CY 2024 HCPCS Code	January 2024 Long Descriptor	April 2024 Long Descriptor
J0613	Injection, calcium gluconate (wg critical care), per 10 mg	Injection, calcium gluconate (wg critical care) not therapeutically equivalent to J0612, 10 mg
J3380	Injection, vedolizumab, 1 mg	Injection, vedolizumab, intravenous, 1 mg
J3425	Injection, hydroxocobalamin, 10 mcg	Injection, hydroxocobalamin, intramuscular, 10 mcg
J7516	Cyclosporin, parenteral, 250 mg	Injection, cyclosporine, 250 mg
J9260	Methotrexate sodium, 50 mg	Injection, methotrexate sodium, 50 mg

Table 16. ─ Vaccine that Will Retroactively Change from Non-Payable Status to Payable Status Effective November 9, 2023, in the April 2024 I/OCE Update

HCPCS Code	Long Descriptor	Old SI	New SI	Effective Date
90589	Chikungunya virus vaccine, live attenuated, for intramuscular use	E1	M	11/09/2023

Table 17. ─ New Skin Substitute Products Low Cost Group/High Cost Group Assignment Effective April 1, 2024

CY 2024 HCPCS Code	Short Descriptor	CY 2024 SI	Low/High Cost Skin Substitute
Q4305	Amer am ac tri-lay per sq cm	N	Low
Q4306	Americ amnion ac per sq cm	N	Low
Q4307	American amnion, per sq cm	N	Low
Q4308	Sanopellis, per sq cm	N	Low
Q4309	Via matrix, per sq cm	N	Low

Table 18. ─ Skin Substitute Product Codes Deleted Effective March 31, 2024

CY 2024 HCPCS Code	Long Descriptor	January CY 2024 SI	April CY 2024 SI
Q4244	Procenta, per 200 mg	N	D

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

Transmittals for Chapter 4

61.2.2 – Edit for Level 6 Intraocular Procedures APC

20.6.12 - Modifier PN

(Rev.12552; Issued:03-21-24; Effective:04-01-24; Implementation:04-01-24)

PN: Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital

A. General

In accordance with Section 1833(t)(21) of the Act, as added by section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74), CMS established modifier PN to identify and pay nonexcepted items and services billed on an institutional claim. Effective January 1, 2017, non-excepted off-campus provider-based departments of a hospital are required to report this modifier on each claim line for non-excepted items and services. The use of modifier PN will trigger a payment rate under the Medicare Physician Fee Schedule (PFS). This modifier must be reported with each nonexcepted item and service including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services. Nonexcepted items and services are described in the regulations at 42 CFR 419.48.

Off-campus provider-based departments should not report both the PO and PN modifiers on the same claim line. However, if services reported on a claim reflect items and services furnished from both an excepted and a nonexcepted off-campus PBD of the hospital, the PO modifier should be used on the excepted claim lines and the PN modifier should be used on the nonexcepted claim lines.

Neither the PO nor the PN modifier is to be reported by the following hospital departments:

- A dedicated emergency department as defined in existing regulations at 42 CFR 489.24(b);
- A PBD that is "on the campus," or within 250 yards, of the hospital or a remote location of the hospital as defined under 42 CFR 413.65.

B. Effect on Payment

Payment for nonexcepted items and services furnished at nonexcepted off-campus provider-based departments reported with modifier PN will result in a payment rate under the PFS effective January 1, 2017. The PN modifier is required to be reported on each claim line with each nonexcepted item and service including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services.

C. Payment for Intensive Cardiac Rehabilitation (ICR) Services

Effective January 1, 2024, ICR services furnished by a nonexcepted off-campus provider-based department are excluded from the 40 percent PFS Relativity Adjuster policy. This exclusion has been implemented at the code level. Specifically, the claims processing of HCPCS codes G0422 (Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session) and G0423 (Intensive cardiac rehabilitation; with or without continuous ECG

monitoring without exercise, per session) have been modified so that 100 percent of the OPPS rate for Cardiac Rehabilitation (CR) is paid irrespective of the presence of the PN modifier on the claim.

61.2.2 – Edit for Level 6 Intraocular Procedures APC

(Rev.12552; Issued:03-21-24; Effective:04-01-24; Implementation:04-01-24)

Effective CY 2024, the OCE will return to providers claims that report a procedure code assigned to APC 5496 – Level 6 Intraocular Procedures – but do not report the correct device code that must be implanted during the procedure. The device code must correctly reflect the type of device that was implanted during the procedure. The table below displays the procedures assigned to the Level 6 Intraocular Procedures APC as well as the appropriate device code that must be present on the claim for that procedure. Hospitals may not bypass this edit by reporting modifier "CG."

APC 5496 CPT Codes	***Long Descriptor***	***Device HCPCS Code to Report with CPT code***	***Long Descriptor***
0308T	*Insertion of ocular telescope prosthesis including removal of crystalline lens or intraocular lens prosthesis*	*C1840*	*Lens, intraocular (telescopic)*
0616T	*Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; without removal of crystalline lens or intraocular lens, without insertion of intraocular lens*	*C1839*	*Iris prosthesis*
0617T	*Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; with removal of crystalline lens and insertion of intraocular lens*	*C1839*	*Iris prosthesis*
0618T	*Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; with secondary intraocular lens*	*C1839*	*Iris prosthesis*

	placement or intraocular lens exchange		

This edit does not apply if the provider reports one of the following modifiers with the procedure code:

52 – Reduced Services;

73 – Discontinued outpatient procedure prior to anesthesia administration; and

74 – Discontinued outpatient procedure after anesthesia administration.

If the claim is returned to the provider for failure to pass the edit, the provider will need to modify the claim by correcting the device code (only if the device code to be reported accurately describes the device that was implanted), or, by correcting the procedure code on the claim before resubmission.