What's Next for the OPPS: A Look at the 2024 Final Rule

November 29, 2023

Webinar FAQ Document

1. **Question:** Where are you getting the 2024 reimbursement for new procedures?

   Answer: The Centers for Medicare & Medicaid Services (CMS) published the initial files within the addenda files from the calendar year (CY) 2024 Hospital Outpatient Prospective Payment System (OPPS) Notice of Final Rulemaking with Comment Period (NFRM) when the final rule was released.[1] The rates presented in the slides were the national unadjusted rates and will not match what each individual hospital will receive.

2. **Question:** Do you have any suggestions for device-intensive procedures where a device isn't used, the procedure doesn't qualify for the CG *Policy criteria* applied modifier, and it wasn't performed in an Ambulatory Surgery Center (ASC)?

   Answer: Consider reporting Healthcare Common Procedure Coding System (HCPCS) code C1889, *Implantable/insertable device, not otherwise classified,* which was created to recognize devices furnished during a device-intensive procedure that are not described by a specific Level II HCPCS Category C-code. Additionally, it should be noted that since 2017 any device code, when reported on a claim with a device-intensive procedure, will satisfy the edit.[2]

3. **Question:** Do you know what device code C1604, *Graft, transmural transvenous arterial bypass (implantable), with all delivery system components,* is related to?

   Answer: HCPCS code C1604, *Graft, transmural transvenous arterial bypass (implantable), with all delivery system components,* represents a device granted CMS new-technology status on September 7, 2023. It was not discussed in the CY 2024 OPPS Final Rule due to the timing of the application. Specifically, the device represents the Detour System for percutaneous transmural arterial bypass (PTAB) from Endologix. According to Endologix, "PTAB with the Detour system offers a novel approach to treating complex peripheral artery disease, enabling physicians to bypass lesions in the superficial femoral artery by using conduits routed through the femoral vein via a transmural passage to restore blood flow to the leg. This approach is effective for patients with long lesions (20-46 cm in length), those who have already undergone failed endovascular procedures, or those who may be suboptimal candidates for open surgical bypass."[3]

4. **Question:** Has CMS announced when they will pay the lump sum amount to the 340B hospitals?

   Answer: CMS has not announced a specific date for the lump sum amount to be dispersed to the 340B hospitals affected by the underpayment. However, they have stated that they will be issuing instructions to each Medicare Administrative Contractor (MAC), who will be responsible for issuing the lump sum payments to each hospital within 60 days of receiving specific instructions from CMS.[4]

5. **Question:** Do we have to use modifier TB, *Drug or biological acquired with 340b drug pricing program discount, reported for informational purposes for select entities,* on inpatient claims that have 340B drugs on them?

   Answer: In the majority of circumstances, inpatient claims do not use HCPCS codes for reporting drugs, so modifier TB would not be necessary.

   In any instance where modifier JG, *Drug or biological acquired with 340b drug pricing program discount, reported for informational purposes,* would have been reported, modifier TB may be used on or after January 1, 2024, but will be required for dates of service on or after January 1, 2025.[5]

6. **Question:** Does Vitalware® have information on the Intensive Outpatient (IOP) program?

   Answer: While Vitalware does not currently have information regarding IOP programs outside the information published in the OPPS and Medicare Physician Fee Schedule (MPFS) Final Rules, there should be additional outreach and education provided by CMS.

   Within the final rule, CMS states that IOP services are very similar to Partial Hospitalization Program (PHP) services. The IOP services are a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care that provided in a setting other than the patient's home or in an inpatient or residential setting.[6]

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[1] Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems, CMS-1786-FC, "2024 NFRM OPPS Addenda," available at: https://www.govinfo.gov/content/pkg/FR-2023-11-22/pdf/2023-24293.pdf
[2] Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems, CMS-1786-FC, page 81758, https://www.govinfo.gov/content/pkg/FR-2023-11-22/pdf/2023-24293.pdf
[3] https://evtoday.com/news/endologix-detour-system-granted-cms-new-technology-add-on-payment
[4] Medicare Program; Hospital Outpatient Prospective Payment System: Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022, CMS-1793-F, "g. Anticipated Timing of Remedy Payments," pages77163-77164, available at: https://www.govinfo.gov/content/pkg/FR-2023-11-08/pdf/2023-24407.pdf
[5] Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems, CMS-1786-FC, "c. CY 2024 Proposed 340B Drug Payment Policy," page 81771, available at: https://www.govinfo.gov/content/pkg/FR-2023-11-22/pdf/2023-24293.pdf
[6] Medicare Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems, CMS-1786-FC, "B. Intensive Outpatient Program Services," page 81812, available at: https://www.govinfo.gov/content/pkg/FR-2023-11-22/pdf/2023-24293.pdf

7. **Question:** Can IOP be billed/paid by regular Hospital Outpatient Departments?

   Answer: Yes, IOP services may be furnished in hospital outpatient departments, community mental health centers (CMHCs), Rural Health Centers (RHCs) and Federally Qualified Health Centers (FQHCs). Additionally, payment made be made for intensive outpatient services provided by opioid treatment programs (OTP) under the existing OTP benefit.[7]

8. **Question:** Is modifier 95 needed for all of the services when provided remotely? Is the 95 valid for Hospital Billing as well as Professional Billing? Are any other modifiers or indicators needed for Remote billing?

   Answer: There has been some confusion regarding the use of modifiers for telehealth services. CMS has stated they will be sending out additional clarification; however, a date for publication of the information was not mentioned.

   In the OPPS Final Rule, CMS referred a commenter to the CY 2024 PFS Final Rule.[8]

   In the CY 2024 Medicare Physician Fee Schedule (MPFS) Final Rule, CMS states that institutional providers of therapy services should append modifier 95 when providing outpatient therapy services, diabetes self-management training (DMST), and medical nutrition therapy (MNT) when furnished via telehealth by qualified employed staff of hospital outpatient departments.[9]

9. **Question:** Can you provide information about G0023, Principal Illness Navigation services, in hospital settings? The OPPS final rule mentions them in relation to PHP/IOP, but could G0023 also be reported by hospital nurse navigators in areas like oncology or cardiology?

   Answer: The Principal Illness Navigation (PIN), social determinants of health (SDOH) risk assessment and community health integration (CHI) services were discussed in more detail within the CY 2024 MPFS Final Rule, and CMS refers commenters to the MPFS document for additional information.[10]

   In the CY 2024 MPFS Final Rule, PIN services must be provided by certified or trained auxiliary personnel under the direction of the billing practitioner. The auxiliary personnel may be a patient navigator, oncology nurse, and many others. The provider must be

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[7] Medicare Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems, CMS-1786-FC, "B. Intensive Outpatient Program Services," page 81543, available at: https://www.govinfo.gov/content/pkg/FR-2023-11-22/pdf/2023-24293.pdf

[8] Medicare Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems, CMS-1786-FC, "D. Remote Services," page 81873, available at: https://www.govinfo.gov/content/pkg/FR-2023-11-22/pdf/2023-24293.pdf

[9] Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies, CMS-1784-F, "b. Proposal to Extend Billing Flexibilities for Certain Remotely Furnished Services Through the End of CY 2024 and Comment Solicitation," pages 191-194, available at: https://public-inspection.federalregister.gov/2023-24184.pdf

[10] Medicare Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems, CMS-1786-FC, "b. Discharge and Transition Planning," pages 81823-81825, available at: https://www.govinfo.gov/content/pkg/FR-2023-11-22/pdf/2023-24293.pdf

authorized to provide the services according to your state's laws. The long description of the HCPCS code describes the services that may be provided by the PIN provider.[11]

An additional resource you may wish to check is the microsite created by the American Medical Association (AMA) dedicated to the Cancer Moonshot. The site has coding guidance as well as links to additional references.[12]

10. **Question:** Can you speak to the modifier requirements for audio/video and audio only, as well as supervision through remote supervision.

    Answer: There are no specific modifier requirements for supervision through remote or audio/visual technology. Other telehealth-related modifiers may be dependent upon your provider type, such as Critical Access Hospital (CAH) or geographic location, such as Alaska (AK) or Hawaii (HI).

    Modifiers include:

    95 *Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System*

    GT *Via interactive audio and video telecommunication systems*

    GQ *Via asynchronous telecommunications system*[13]

11. **Question:** Would a modifier be required when reporting hemophilia clotting factor drugs acquired under the 340B program on an inpatient bill?

    Answer: No. A modifier is required for all drugs that are separately payable Part B drugs, other than vaccines, that were purchased through 340B Program or the Prime Vendor Program.[14] Hemophilia clotting factors may be reported for inpatients using the appropriate ICD-10-PCS code, which would not utilize a modifi

[11] Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies, CMS-1784-F, "ii. Proposed Principal Illness Navigation (PIN) Services," pages 363-399, available at: https://public-inspection.federalregister.gov/2023-24184.pdf

[12] AMA, "Reporting CPT codes for oncology navigation services: The Cancer Moonshot," available at: https://www.ama-assn.org/practice-management/cpt/reporting-cpt-codes-oncology-navigation-services-cancer-moonshot

[13] Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies, CMS-1784-F, "b. Proposal to Extend Billing Flexibilities for Certain Remotely Furnished Services Through the End of CY 2024 and Comment Solicitation," page 195, available at: https://public-inspection.federalregister.gov/2023-24184.pdf

[14] "Billing 340B Modifiers Under the Hospitals Outpatient Prospective Payment System (OPPS), page 2, available at https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/billing-340b-modifiers-under-hospital-opps.pdf

