CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10541	**Date: December 31, 2020**
	Change Request 12120

SUBJECT: January 2021 Update of the Hospital Outpatient Prospective Payment System (OPPS)

I. SUMMARY OF CHANGES: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the January 2021 OPPS update. The January 2021 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 Change Request (CR). This Recurring Update Notification applies to Chapter 4, section 50.7.

EFFECTIVE DATE: January 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2021

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	4/10.2/10.2.3/Comprehensive APCs
N	4/10.2/10.2.4/Reporting for Certain Outpatient Department Services (That Are Similar to Therapy Services) (“Non-Therapy Outpatient Department Services”) and Are Adjunctive to Comprehensive APC Procedures

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:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 10541	Date: December 31, 2020	Change Request: 12120

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EFFECTIVE DATE: January 1, 2021
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I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to and billing instructions for various payment policies implemented in the January 2021 OPPS update. The January 2021 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 Change Request (CR). This Recurring Update Notification applies to chapter 4, section 50.7.

The January 2021 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming January 2021 I/OCE CR.

B. Policy: 1. Covid-19 Laboratory Tests and Services Coding Update

Since February 2020, CMS has recognized several Covid-19 laboratory tests and related services. The codes are listed in Table 1, attachment A, along with their OPPS status indictors. The codes, along with their short descriptors and status indicators are also listed in the January 2021 OPPS Addendum B that is posted on the CMS website. For information on the OPPS status indicator definitions, refer to OPPS Addendum D1 of the CY 2021 OPPS/Ambulatory Surgical Center (ASC) final rule.

CMS has established one HCPCS code, U0005, effective January 1, 2021. In addition, the AMA CPT Editorial Panel established five new CPT codes, specifically, CPT codes 87636, 87637, 87811, and 0240U and 0241U effective October 6, 2020. These codes were established too late to include in the October 2020 Update, so they are included in this January 2021 Update with the effective date of October 6, 2020.

In addition, the AMA CPT Editorial Panel established CPT code 87428 effective November 10, 2020. Since it was established too late to include in the October 2020 Update, it is included in this January 2021 Update, with the effective date of November 10, 2020.

2. CPT Proprietary Laboratory Analyses (PLA) Coding Changes Effective October 6, 2020 and January 1, 2021

The AMA CPT Editorial Panel established 13 new PLA codes, specifically, CPT codes 0227U through 0239U, effective January 1, 2021. In addition, the AMA CPT Editorial Panel established two new PLA codes, specifically, CPT codes 0240U and 0241U effective October 6, 2020. Because CPT codes 0240U and 0241U were released on October 6, 2020, they were too late to include in the October 2020 OPPS update and are instead being included in the January 2021 update with an effective date of October 6, 2020. Table 2, attachment A, lists the long descriptors and status indicators for the codes.

CPT codes 0227U through 0239U have been added to the January 2021 I/OCE with an effective date of January 1, 2021 while CPT codes 0240U and 0241U have been added to the January 2021 I/OCE with an effective date of October 6, 2020. These codes, along with their short descriptors, status indicators, and payment rates (where applicable) are also listed in the January 2021 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

2021 OPPS/ASC final rule for the latest definitions.

3. Monoclonal Antibody Therapy Product and Administration Codes

On November 9, 2020, the U.S. Food and Drug Administration (FDA) issued an emergency use authorization (EUA) for the investigational monoclonal antibody therapy, bamlanivimab, for the treatment of mild to moderate COVID-19 in adults and pediatric patients with positive COVID-19 test results who are at high risk for progressing to severe COVID-19 and/or hospitalization. Bamlanivimab may only be administered in settings in which health care providers have immediate access to medications to treat a severe infusion reaction, such as anaphylaxis, and the ability to activate the emergency medical system (EMS), as necessary.

On November 21, 2020, FDA issued an EUA for two monoclonal antibodies, specifically, casirivimab and imdevimab, that are administered together for the treatment of mild to moderate COVID-19 in adults and pediatric patients (12 years of age or older) with positive results of direct SARS-CoV-2 viral testing and who are at high risk for COVID-19. This includes those who are 65 years of age or older or who have certain chronic medical conditions.

To ensure access to these monoclonal antibody treatments during the COVID-19 public health emergency (PHE), Medicare covers and pays for the infusion of monoclonal antibody therapy in accordance with Section 3713 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). That is, as a result of the circumstances of the PHE, Medicare covers and pays for the infusion of monoclonal antibody therapy in the manner in which it will pay for COVID-19 vaccines and other statutory vaccines such as influenza.

To track and pay appropriately for monoclonal antibodies used to treat COVID-19, CMS established new HCPCS codes M0239 and Q0239 effective November 9, 2020 for bamlanivimab, and new HCPCS codes M0243 and Q0243 effective November 21, 2020 for casirivimab and imdevimab. The codes have been added to the January 2021 I/OCE with their effective dates. Table 3, attachment A, lists the long descriptors for the codes. These codes, along with their short descriptors, status indicators, and payment rates (where applicable) are also listed in the January 2021 OPPS Addendum B that is posted on the CMS website.

Similar to other vaccines, Medicare will not make a separate payment to the provider for a monoclonal antibody product when that product is given to the provider for free by the government. We anticipate much of the initial volume will be supplied to providers free of charge. Medicare established HCPCS code Q0239 for bamlanivimab and HCPCS code Q0243 for casirivimab and imdevimab (administered together). If HOPDs purchase bamlanivimab or casirivimab and imdevimab, they should report HCPCS codes Q0239 or Q0243, respectively, to receive separate payment for the monoclonal antibody treatments.

Medicare will pay the provider for the administration of monoclonal antibodies regardless of whether the product is given to the provider for free. To receive separate payment for the infusion of bamlanivimab, HOPDs should report HCPCS code M0239. Similarly, to receive separate payment for the infusion of casirivimab and imdevimab, HOPDs should report HCPCS code M0243.

For more information on the Medicare Monoclonal Antibody COVID-19 Infusion Program during the Public Health Emergency, refer to the following CMS websites:

https://www.cms.gov/medicare/covid-19/monoclonal-antibody-covid-19-infusion

https://www.cms.gov/medicare/covid-19/monoclonal-antibody-covid-19-infusion#Payment

4. New Covid-19 CPT Vaccines and Administration Codes

On November 10, 2020, the AMA released six new CPT codes associated with the Pfizer and Moderna COVID-19 vaccines. Two of the six CPT codes (91300 and 91301) refer to the specific vaccine products, while the other four CPT codes (0001A, 0002A, 0011A and 0012A) describe the service to administer the

vaccines. These codes will be available for use once the applicable coronavirus vaccine product receives Emergency Use Authorization (EUA) or approval from the Food and Drug Administration. The codes have been included in the January 2021 I/OCE.

In addition, on December 17, 2020, the AMA released three new CPT codes associated with the AstraZeneca and University of Oxford COVID-19 vaccine. The codes, specifically, CPT codes 91302, 0021A, and 0022A, will be available for use once the vaccine receives Emergency Use Authorization (EUA) or approval from the Food and Drug Administration.

Table 4, attachment A, lists the long descriptors for the codes. These codes, along with their short descriptors, status indicators, and payment rates (where applicable) are also listed in the January 2021 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 2021 OPPS/ASC final rule for the latest definitions.

For more information on the payment and effective dates for the COVID-19 vaccines and their administration during the Public Health Emergency (PHE), refer to the following CMS website:

https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/covid-19-vaccines-and-monoclonal-antibodies

5. a. New Device Pass-Through Categories

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 (2), but not more than three (3) years. 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.

We are establishing three new device pass-through categories as of January 1, 2021. We are also updating the device offset from payment information for the device category described by HCPCS code C1839 (Iris prosthesis) and HCPCS code C1748 (Endoscope, single, ugi). Table 5, attachment A, provides a listing of new coding and payment information concerning the new device categories for transitional pass-through payment.

b. Device Offset from Payment:

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.

i. We have determined the device offset amounts for APC 5491 Level 1 Intraocular Procedures and APC 5492 Level 2 Intraocular Procedures that are associated with the costs of the device category described by HCPCS code C1839 (Iris prosthesis). In the January 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS) (Transmittal 4513, dated February 4, 2020), we stated that the device in the category described by HCPCS C1839 should always be billed with CPT code 66999 (Unlisted procedure, anterior segment of eye). The CPT codes listed below became effective July 1, 2020 and should be billed with C1839 instead of CPT code 66999. The device in the category described by HCPCS code C1839 should always be billed with one of the following Current Procedural Terminology (CPT) codes:

- CPT code 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, which is assigned to APC 5491 for Calendar Year (CY) 2021;

- CPT code 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, which is assigned to APC 5492 for Calendar Year (CY) 2021;
- CPT code 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, which is assigned to APC 5492 for Calendar Year (CY) 2021;

ii. We have determined the device offset amount for APC 5465 (Level 5 Neurostimulator and Related Procedures) that is associated with the cost of the device category described by HCPCS code C1825 (Generator, neurostimulator (implantable), non-rechargeable with carotid sinus baroreceptor stimulation lead(s)). The device in the category described by HCPCS code C1825 should always be billed with one of the following Current Procedural Terminology (CPT) codes:

- CPT code 0266T (Implt/rpl crtd sns dev total), which is assigned to APC 5465 for Calendar Year (CY) 2021;

iii. We have determined the device offset amounts for APC 5302 (Level 2 Upper GI Procedures) and APC 5312 (Level 2 Lower GI Procedures) that are associated with the cost of the device category described by HCPCS code C1052 (Hemostatic agent, gastrointestinal, topical). The device in the category described by HCPCS code C1052 should always be billed with one of the following Current Procedural Terminology (CPT) codes:

- CPT code 43227 (Esophagoscopy control bleed), which is assigned to APC 5302 for Calendar Year (CY) 2021;
- CPT code 43255 (Egd control bleeding any), which is assigned to APC 5302 for Calendar Year (CY) 2021;
- CPT code 44366 (Small bowel endoscopy), which is assigned to APC 5302 for Calendar Year (CY) 2021;
- CPT code 44378 (Small bowel endoscopy), which is assigned to APC 5302 for Calendar Year (CY) 2021;
- CPT code 44391 (Colonoscopy for bleeding), which is assigned to APC 5312 for Calendar Year (CY) 2021;
- CPT code 45334 (Sigmoidoscopy for bleeding), which is assigned to APC 5312 for Calendar Year (CY) 2021;
- CPT code 45382 (Colonoscopy w/control bleed), which is assigned to APC 5312 for Calendar Year (CY) 2021;

iv. We have determined the device offset amount for APC 5114 (Level 4 Musculoskeletal Procedures) that is associated with the cost of the device category described by HCPCS code C1062 (Intravertebral body fracture augmentation with implant (e.g., metal, polymer). The device in the category described by HCPCS code C1062 should always be billed with one of the following Current Procedural Terminology (CPT) codes:

- CPT code 22513 (Perq vertebral augmentation), which is assigned to APC 5114 for Calendar Year (CY) 2021;
- CPT code 22514 (Perq vertebral augmentation), which is assigned to APC 5114 for Calendar Year (CY) 2021;

v. On July 1, 2020, we determined that an offset would apply to C1748 (Endoscope, single-use, (i.e. disposable), Upper GI, imaging/illumination device (insertable)) because APC 5303 (Level 3 Upper GI Procedures) and APC 5331 (Complex GI Procedures) already contain costs associated with the device

described by C1748. C1748 should always be billed with the CPT codes listed below. The device offset is a deduction from pass-through payments for C1748. After further review, we have determined that the costs associated with C1748 are not already reflected in APCs 5303 or 5331. Therefore, we are not applying a device offset to C1748. This determination to not apply the device offset from payment will be retroactive to July 1, 2020. See 68 FR 63438-9 for further discussion about the device offset policy.

- CPT code 43260 (Ercp w/specimen collection), which is assigned to APC 5303 for Calendar Year (CY) 2021;
- CPT code 43261 (Endo cholangiopancreatograph), which is assigned to APC 5303 for Calendar Year (CY) 2021;
- CPT code 43262 (Endo cholangiopancreatograph), which is assigned to APC 5303 for Calendar Year (CY) 2021;
- CPT code 43263 (Ercp sphincter pressure meas), which is assigned to APC 5303 for Calendar Year (CY) 2021;
- CPT code 43264 (Ercp remove duct calculi), which is assigned to APC 5303 for Calendar Year (CY) 2021;
- CPT code 43265 (Ercp lithotripsy calculi), which is assigned to APC 5331 for Calendar Year (CY) 2021;
- CPT code 43274 (Ercp duct stent placement), which is assigned to APC 5331 for Calendar Year (CY) 2021;
- CPT code 43275 (Ercp remove forgn body duct), which is assigned to APC 5303 for Calendar Year (CY) 2021;
- CPT code 43276 (Ercp stent exchange w/dilate), which is assigned to APC 5331 for Calendar Year (CY) 2021;
- CPT code 43277 (Ercp ea duct/ampulla dilate), which is assigned to APC 5303 for Calendar Year (CY) 2021;
- CPT code 43278 (Ercp lesion ablate w/dilate), which is assigned to APC 5303 for Calendar Year (CY) 2021;

Also, refer to https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html for the most current device pass-through information.

c. Transitional Pass-Through Payments for Designated Devices

Certain designated new devices are assigned to APCs and identified by the I/OCE as eligible for payment based on the reasonable cost of the new device reduced by the amount included in the APC for the procedure that reflects the packaged payment for device(s) used in the procedure. The I/OCE will determine the proper payment amount for these APCs as well as the coinsurance and any applicable deductible. All related payment calculations will be returned on the same APC line and identified as a designated new device. We refer readers to Addendum P of the CY 2021 final rule with comment period for the most current OPPS HCPCS Offset file. Addendum P is available via the Internet on the CMS website.

d. Alternative Pathway for Devices That Have a Food and Drug Administration (FDA) Breakthrough Designation

For devices that have received FDA marketing authorization and a Breakthrough Device designation from the FDA, CMS provided an alternative pathway to qualify for device pass-through payment status, under which devices would not be evaluated in terms of the current substantial clinical improvement criterion for the purposes of determining device pass-through payment status. The devices would still need to meet the other criteria for pass-through status. This applies to devices that receive pass-through payment status effective on or after January 1, 2020.

6. New HCPCS Code Describing the Administration of Subretinal Therapies Requiring Vitrectomy

CMS is establishing a new HCPCS code, C9770, to describe a vitrectomy, mechanical, pars plana approach, with subretinal injection of a pharmacologic or biologic agent. Table 6, attachment A, lists the official long descriptor, status indicator, and APC assignment for HCPCS code C9770. For information on OPPS status indicators, please refer to OPPS Addendum D1 of the CY 2021 OPPS/ASC final rule for the latest definitions. This code, along with its short descriptor, status indicator, and payment rate, is also listed in the January 2021 Update of the OPPS Addendum B.

7. New HCPCS Code Describing Nasal Endoscopy with Cryoablation of Nasal Tissue(s) and/or Nerve(s)

CMS is establishing HCPCS code C9771 to describe the technology associated with nasal endoscopy with cryoablation of nasal tissues and/or nerves. Table 7, attachment A, lists the long descriptor, status indicator, and APC assignment for HCPCS code C9771. For more information on OPPS status indicator "J1", refer to OPPS Addendum D1 of the Calendar Year 2021 OPPS/ASC final rule for the latest definition. This code, along with the short descriptor, status indicator, and payment rate is also listed in the January 2021 Update of the OPPS Addendum B.

8. New HCPCS Codes Describing Peripheral Intravascular Lithotripsy (IVL) Procedures

For the January 2021 update, CMS is establishing four additional new HCPCS codes to describe the technology describing the IVL procedure, which has integrated lithotripsy emitters and is designed to enhance percutaneous transluminal angioplasty by enabling delivery of the calcium disrupting capability of lithotripsy prior to full balloon dilatation at low pressures. The application of lithotripsy mechanical pulse waves alters the structure of an occlusive vascular deposit (stenosis) prior to low-pressure balloon dilation of the stenosis and facilitates the passage of blood and is used for the treatment of peripheral artery disease (PAD). Specifically, CMS is establishing HCPCS code C9772, C9773, C9774, and C9775 to describe procedures utilizing IVL. We note that for the July 2020 Update, we also established HCPCS codes C9764 through C9767 to describe the IVL procedures. Table 8, attachment A, lists the long descriptors, status indicators, and APC assignments for the HCPCS codes. For more information on OPPS status indicator "J1", refer to OPPS Addendum D1 of the Calendar Year 2021 OPPS/ASC final rule for the latest definition. We note these codes, along with their short descriptors, status indicator, and payment rates are also listed in the January 1, 2021 OPPS Addendum B.

9. Comprehensive APCs (C-APCs)

a. Two New C-APCs Effective January 1, 2021

C-APCs provide a single payment for a primary service, and payment for all adjunctive services reported on the same claim is packaged into payment for the primary service. With a few exceptions, all other services reported on a hospital outpatient claim in combination with the primary service are considered to be related to the delivery of the primary service and packaged into the single payment for the primary service.

Each year, in accordance with section 1833(t)(9)(A) of the Act, we review and revise the services within each APC group and the APC assignments under the OPPS. As stated in the CY 2021 OPPS/ASC final rule with comment period, as a result of our annual review of the services and the APC assignments under the OPPS, we finalized the addition of two new C-APCs under the existing C-APC payment policy effective January 1, 2021. The new C-APCs that are effective January 1, 2021, include:

- C-APC 5378 (Level 8 Urology and Related Services) and
- C-APC 5465 (Level 5 Neurostimulator and Related Procedures).

A list of these new C-APCs is found in Table 9, attachment A. The addition of these new C-APCs increases the total number of C-APCs to 69 for CY 2021. We note that Addendum J to the CY 2021 OPPS/ASC final rule with comment period contains all of the data related to the C–APC payment policy methodology, including the list of complexity adjustments and other information for CY 2021. In addition, we note that HCPCS codes assigned to comprehensive APCs are designated with status indicator "J1" in the latest OPPS Addendum B, which can be downloaded from this CMS website, specifically, at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html.

b. C-APC Exclusion for COVID-19 Treatments

In the interim final with request for comments (IFC) entitled, ''Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency", published on November 6, 2020, CMS stated that effective for services furnished on or after the effective date of the IFC and until the end of the PHE for COVID-19, there is an exception to the OPPS C-APC policy to ensure separate payment for new COVID–19 treatments that meet certain criteria (85 FR 71158 through 71160). Under this exception, any new COVID-19 treatment that meets the two following criteria will, for the remainder of the PHE for COVID-19, always be separately paid and will not be packaged into a C-APC when it is provided on the same claim as the primary C-APC service.

First, the treatment must be a drug or biological product (which could include a blood product) authorized to treat COVID-19, as indicated in section "I. Criteria for Issuance of Authorization" of the letter of authorization for the drug or biological product, or the drug or biological product must be approved by the FDA for treating COVID-19. Second, the emergency use authorization (EUA) for the drug or biological product (which could include a blood product) must authorize the use of the product in the outpatient setting or not limit its use to the inpatient setting, or the product must be approved by the FDA to treat COVID-19 disease and not limit its use to the inpatient setting. For further information regarding the exception to the C-APC policy for COVID–19 treatments, please refer to the IFC (85 FR 71158 through 71160).

10. Changes to the Inpatient – Only List (IPO) for CY 2021

The Medicare IPO list includes procedures that are typically only provided in the inpatient setting and therefore are not paid under the OPPS. We are eliminating the IPO list over the course of a three-year period beginning in CY 2021. For CY 2021, CMS is removing 298 services from the IPO list. These changes are included in Table 10, attachment A.

11. Removal of Selected National Coverage Determinations Effective January 1, 2021

As stated in the CY 2021 Physician Fee Schedule (PFS) final rule with comment period, effective January 1, 2021, CMS removed certain National Coverage Determinations (NCD). See Table 11, attachment A, for the NCD name and manual citation.

As a result of this change, the coverage determinations for the procedures, services, and items associated with the NCDs listed above will be made by the local Medicare Administrative Contractors (MAC). In addition, we revised the status indicators for the codes listed in Table 12, attachment A, from OPPS status indicator "E1" (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to the status indicators and/or APCs listed in Table 12, attachment A.

12. Changes to some Opioid Treatment Program (OTP) ─ related codes.

The existing OTP-related HCPCS codes G2067-G2080 were established by CMS on January 1, 2020, and were not previously paid on the institutional claims. They were only paid on the professional claims. For CY 2021, we are allowing the OTP codes to be billed on the institutional claims only by certified OTP providers who are enrolled with Medicare as an OTP. Therefore, we are changing status indicators for G2068-G2080 from SI "E1" (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI

“A” (Not paid under OPPS. Paid by MACs under a fee schedule or payment system other than OPPS) so the payment can be made on the OTP fee schedule effective January 1, 2020.

HCPCS codes G2215-G2216 were established by CMS effective January 1, 2021 and are assigned to SI “A”, similar to the existing HCPCS codes, G2067-G2080. Table 13, attachment A, lists the long descriptors and the effective dates for these codes. These codes, along with their short descriptors and status indicators, are also listed in the January 2021 Update of the OPPS Addendum B.

13. Change to the Status Indicator for HCPCS code P9099

Effective January 1, 2021, the status indicator for HCPCS code P9099 has changed from SI = “E2” (Items, codes and services for which pricing information and claims data are not available. Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI = “R” (Blood and blood products that are paid under OPPS; separate APC payment) as described in Table 14, attachment A.

14. Drugs, Biologicals, and Radiopharmaceuticals

a. New CY 2021 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals Receiving Pass-Through Status

Nine (9) 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 January 1, 2021. These drugs and biologicals will receive drug pass-through status starting January 1, 2021. These HCPCS codes are listed in Table 15, attachment A.

b. Existing HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals That Will Start to Receive Pass-Through Status

There are 2 existing HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals in the outpatient setting that will start to receive pass-through status beginning on January 1, 2021. These HCPCS codes are listed in Table 16, attachment A.

c. Existing HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals with Pass-Through Status Ending on December 31, 2020

There are 8 HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals in the outpatient setting that will have their pass-through status end on December 31, 2020. These codes are listed in Table 17, attachment A.

d. Drugs and Biologicals that Will Retroactively Change from Non-Payable Status to Separately Payable Status from October 1, 2020 to December 31, 2020

The status indicator for HCPCS code J1437 (Injection, ferric derisomaltose, 10 mg) for the period of October 1, 2020 through December 31, 2020 will be changed retroactively from status indicator = “E2” to status indicator = “K” (Nonpass-through drugs and nonimplantable biologicals, including therapeutic radiopharmaceuticals that are paid under OPPS; separate APC payment). This drug/biological is reported in Table 18, attachment A.

e. Newly Established HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals as of January 1, 2021

Eighteen (18) new drug, biological, and radiopharmaceutical HCPCS codes will be established on January 1, 2021. These HCPCS codes are listed in Table 19, attachment A.

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

For CY 2021, payment for the majority of nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals that were not acquired through the 340B Program is made at a single rate of ASP + 6 percent (or ASP + 6 percent of the reference product for biosimilars). Payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals that were acquired under the 340B program is made at the single rate of ASP – 22.5 percent (or ASP - 22.5 percent of the biosimilar's ASP if a biosimilar is acquired under the 340B Program), which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2021, a single payment of ASP + 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 + 6 percent of the reference product for biosimilars). Payments for drugs and biologicals based on ASP will be updated on a quarterly basis as later quarter ASP submissions become available. Effective January 1, 2021, payment rates for many drugs and biologicals have changed from the values published in the CY 2021 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from second quarter of CY 2020. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2021 Fiscal Intermediary Standard System (FISS) release. CMS is not publishing the updated payment rates in this Change Request implementing the January 2021 update of the OPPS. However, the updated payment rates effective January 1, 2021 can be found in the January 2021 update of the OPPS Addendum A and Addendum B on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS

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

Some drugs and biologicals 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/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html

Providers may resubmit claims that were impacted by adjustments to previous quarter's payment files

h. Restatement of the payment rate for HCPCS code A9600 (Strontium Sr-89 chloride, therapeutic, per millicurie) for the period October 1, 2020 through December 31, 2020

The payment rate of HCPCS code A9600 (Strontium sr-89 chloride, therapeutic, per millicurie) for the period of October 1, 2020 through December 31, 2020 needs to be restated. This drug/biological with the new payment rate is reported in Table 20, attachment A.

15. 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. The skin substitute products are divided into two groups: 1) high cost skin substitute products and 2) low cost skin substitute products for packaging purposes. Please note that the final rule skin substitute table incorrectly assigned Q4222 (Progenamatrix, per sq cm) to the low cost group when it should have been assigned to the high cost group for January. This correction is currently reflected in all relevant January OPPS payment files and tables.

Table 21, attachment A, lists the skin substitute products and their assignment as either a high cost or a low cost skin substitute product, when applicable.

16. Reporting for Certain Outpatient Department Services (That Are Similar to Therapy Services) ("Non-Therapy Outpatient Department Services") and Are Adjunctive to Comprehensive APC Procedures

This language was originally published in the October 2016 Update of the Outpatient Perspective Payment System (OPPS) (Transmittal 3602). We are updating this language based on the removal of the regulations at 42 CFR 410.59(a)(4) and 42 CFR 410.60(a)(4) related to functional reporting for therapy services.

Non-therapy outpatient department services are services such as physical therapy, occupational therapy, and speech-language pathology provided during the perioperative period (of a Comprehensive APC (C-APC) procedure) without a certified therapy plan of care. These are not therapy services as described in section 1834(k) of the Act, regardless of whether the services are delivered by therapists or other non-therapist health care workers. Therapy services are those provided by therapists under a plan of care in accordance with section 1835(a)(2)(C) and section 1835(a)(2)(D) of the Act and are paid for under section 1834(k) of the Act, subject to annual therapy caps as applicable (78 FR 74867 and 79 FR 66800), until they were repealed by Bipartisan Budget Act of 2018, effective January 1, 2018. Because these services are outpatient department services and not therapy services, the requirement for functional reporting under the regulations at 42 CFR 410.59(a)(4) and 42 CFR 410.60(a)(4) does not apply. The functional reporting requirements were applicable until January 1, 2019 at which time the regulations at 42 CFR 410.59(a)(4) and 42 CFR 410.60(a)(4) were removed (83 FR 41786 and 83 FR 59452).

The comprehensive APC payment policy packages payment for adjunctive items, services, and procedures into the most costly primary procedures under the OPPS at the claim level. When non-therapy outpatient department services are included on the same claim as a C-APC procedure (status indicator (SI) = J1) (see 80 FR 70326) or the specific combination of services assigned to the Observation Comprehensive APC 8011 (SI = J2), these services are considered adjunctive to the primary procedure. Payment for non-therapy outpatient department services is included as a packaged part of the payment for the C-APC procedure.

Effective for claims received on or after October 1, 2016 with dates of service on or after January 1, 2015, providers may report non-therapy outpatient department services (that are similar to therapy services) that are adjunctive to a C-APC procedure (SI = J1) or the specific combination of services assigned to the Observation Comprehensive APC 8011 (SI = J2), in one of two ways:

1. Without using the therapy CPT codes and instead reporting these non-therapy services with Revenue Code 0940 (Other Therapeutic Services); or

2. Reporting non-therapy outpatient department services that are adjunctive to J1 or J2 services with the appropriate occurrence codes, CPT codes, modifiers, and revenue codes.

17. Payment Adjustment for Certain Cancer Hospitals Beginning CY 2021

For certain cancer hospitals that receive interim monthly payments associated with the cancer hospital adjustment at 42 CFR 419.43(i), Section 16002(b) of the 21st Century Cures Act requires that, for CY 2018 and subsequent calendar years, the target Payment-to-Cost Ratio (PCR) that should be used in the calculation of the interim monthly payments and at final cost report settlement is reduced by 0.01. For CY 2021, the target PCR, after including the reduction required by Section 16002(b), is 0.89.

18. Method to Control for Unnecessary Increases in Utilization of Outpatient Services/G0463 with Modifier PO

In CY 2020, CMS finalized a policy to use our authority under section 1833(t)(2)(F) of the Act to apply an amount equal to the site-specific Physician Fee Schedule (PFS) payment rate for nonexcepted items and services furnished by a nonexcepted off-campus Provider-Based Department (PBD) (the PFS payment rate) for the clinic visit service, as described by HCPCS code G0463, when provided at an off-campus PBD excepted from section 1833(t)(21) of the Act (departments that bill the modifier “PO” on claim lines). We completed the phase-in of the policy in CY 2020.

The PFS-equivalent amount paid to nonexcepted off-campus PBDs is 40 percent of OPPS payment (that is, 60 percent less than the OPPS rate) for CY 2021. Specifically, the total 60-percent payment reduction will

apply in CY 2021. In other words, these departments will be paid 40 percent of the OPPS rate (100 percent of the OPPS rate minus the 60-percent payment reduction that applies in CY 2021) for the clinic visit service in CY 2021.

19. Changes to OPPS Pricer Logic

a. Rural Sole Community Hospitals (SCH) and Essential Access Community Hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in CY 2021. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with section 1833(t)(13)(B) of the Act, as added by section 411 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

b. New OPPS payment rates and copayment amounts will be effective January 1, 2021. All copayment amounts will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the CY 2021 inpatient deductible of $1,484. For most OPPS services, copayments are set at 20 percent of the APC payment rate.

c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2021. This threshold of 1.75 is multiplied by the total line-item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount. The payment formula is (cost-(APC paymentx1.75))/2.

d. The fixed-dollar threshold for OPPS outlier payments increases in CY 2021 relative to CY 2020. The estimated cost of a service must be greater than the APC payment amount plus $5,300 in order to qualify for outlier payments.

e. For outliers for Community Mental Health Centers (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2021. This threshold of 3.4 is multiplied by the total line-item APC payment for APC 5853 to determine eligibility for outlier payments. This multiple amount is also used to determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment formula is (cost-(APC 5853 paymentx3.4))/2.

f. Continuing our established policy for CY 2021, the OPPS Pricer will apply a reduced update ratio of 0.9805 to the payment and copayment for hospitals that fail to meet their hospital outpatient quality data reporting requirements or that fail to meet CMS validation edits. The reduced payment amount will be used to calculate outlier payments.

g. Effective January 1, 2021, CMS is adopting the Fiscal Year (FY) 2021 Inpatient Prospective Payment System (IPPS) post-reclassification wage index values with application of the CY 2021 out-commuting adjustment authorized by Section 505 of the MMA to non- IPPS (non-Inpatient Prospective Payment System) hospitals as implemented through the Pricer logic.

h. Effective January 1, 2021, for claims with APCs, which require implantable devices and have significant device offsets (greater than 30%), a device offset cap will be applied based on the credit amount listed in the “FD” (Credit Received from the Manufacturer for a Replaced Medical Device) value code. The credit amount in value code “FD” which reduces the APC payment for the applicable procedure, will be capped by the device offset amount for that APC. The offset amounts for the above referenced APCs are available on the CMS website.

20. Update the Outpatient Provider Specific File (OPSF)

For January 1, 2021, contractors shall maintain the accuracy of the provider records in the Outpatient Provider Specific File (OPSF) as changes occur in data element values.

a) Updating the OPSF for the Supplemental Wage Index and Supplemental Wage Index Flag Fields

In CY 2020, for hospitals not listed on Table 2 or without a CY 2019 OPPS wage provided through the OPPS Pricer, MACs emailed CMS for the hospital's CY 2020 wage index which included the wage index quartile and cap policies if applicable. Change Request 11707 (on the CMS website at https://www.cms.gov/files/document/r10121cp.pdf) created two new PSF fields, the Supplemental Wage Index and the Supplemental Wage Index Flag.

The Pricer needs a hospital's CY 2020 OPPS wage index (or what the CY 2020 wage index would have been if the hospital existed in CY 2020) in the supplemental wage index field in order to properly apply all wage index policies and determine a hospital's CY 2021 OPPS wage index. Therefore, for CY 2021, to accurately pay claims for providers paid through the OPPS, the Supplemental Wage Index Flag must be "1" and all OPPS providers must have a wage index in the Supplemental Wage Index field.

MACs shall ensure that no OPPS providers have a "1" or "2" in the Special Payment Indicator field and no wage index value in the Special Wage Index field with an effective date of January 1, 2021. Unless otherwise instructed by CMS, MACs must seek approval from the CMS Central Office to use a "1" or "2" in the Special Payment Indicator field and a wage index value in the Special Wage Index field.

We note that there generally are several types of assignments for the supplemental wage index that would apply under the OPPS. We note that in all of the case below the Supplemental Wage Index field would be "1" and the effective dates of such changes include for the steps outlined below would be January 1, 2021

1) If the MAC received approval from the CMS Central Office to assign an OPPS provider a special wage index in CY 2020 and the use of either "1" or "2" in the Special Payment Indicator field, MACs shall do the following

● Enter the value from the Special Wage Index for CY 2020 into the Supplemental Wage index Field.

● Enter a "1" in the Supplemental Wage Index Flag field.

● Ensure that the Special Wage Index and Special Payment Indicator fields are blank.

● Establish the record with an effective date of January 1, 2021.

2) If the MAC did not email CMS during CY 2020 for a provider's CY 2020 wage index, then the MAC shall do the following for the case that applies:

a. IPPS hospitals that are also paid under the OPPS

For these hospitals, as described in detail in the instructions in MAC Implementation File 5 at https://www.cms.gov/medicare/acute-inpatient-pps/fy-2021-ipps-final-rule-home-page the 2020 wage index should be obtained from the Table 2 associated with the FY 2021 IPPS final rule (or Correction Notice, if applicable). In other instances in which there is an IPPS value derived through the steps outlined in the "MAC Implementation File 5" instructions document, that same FY 2020 wage index value entered into the Supplemental Wage index for the IPSF shall also be entered into the Supplemental Wage Index Field and would apply into the OPPS on a calendar year basis.

In this case MACs, shall do the following:

● Enter the value from the Special Wage Index for CY 2020 (from Table 2 or through the steps outlined in MAC Implementation File 5) into the Supplemental Wage Index Field.

● Enter a "1" in the Supplemental Wage Index Flag field.

● Ensure that the Special Wage Index and Special Payment Indicator fields are blank.

● Establish the record with an effective date of January 1, 2021.

b. Non-IPPS hospitals, CMHCs, and other OPPS providers

We have made the Supplemental Wage Index assignments (based on the CY 2020 OPPS wage index) for non-IPPS hospitals, CMHCs, and other OPPS providers available on the CMS website at www.cms.gov/HospitalOutpatientPPS/ under "*Annual Policy Files*."

In this case, MACs, shall do the following:

● The CY 2020 Wage index from the Excel file available online shall be entered into the Supplemental Wage Index field.

● Enter a "1" in the Supplemental Wage Index Flag field.

● Ensure that the Special Wage Index and Special Payment Indicator fields are blank.

● Establish the record with an effective date of January 1, 2021.

c. CY 2020 Wage Index not otherwise available for Supplemental Wage Index field

Email the CMS Central Office at OutpatientPPS@cms.hhs.gov requesting the calculation of the hospital's CY 2020 wage index for assignment to the Supplemental Wage Index field. Make sure to include in your email the following: FIPS county code, the Actual Geographic Location CBSA, the Wage Index Location CBSA, the Payment CBSA, Special Payment Indicator field and the effective date in the PSF.

b) Updating the OPSF for Expiration of Transitional Outpatient Payments(TOPs)

Cancer and children's hospitals are held harmless under section 1833(t)(7)(D)(ii) of the Social Security Act and continue to receive hold harmless TOPs permanently. For CY 2021, cancer hospitals will continue to receive an additional payment adjustment.

c) Updating the OPSF for the Hospital Outpatient Quality Reporting (HOQR) Program Requirements

Effective for OPPS services furnished on or after January 1, 2009, subsection (d) hospitals that have failed to submit timely hospital outpatient quality data as required in Section 1833(t)(17)(A) of the Act will receive payment under the OPPS that reflects a 2 percentage point deduction from the annual OPPS update for failure to meet the HOQR program requirements. This reduction will not apply to hospitals not required to submit quality data or hospitals that are not paid under the OPPS.

For January 1, 2021, contractors shall maintain the accuracy of the provider records in the OPSF by updating the Hospital Quality Indicator field. CMS will release a Technical Direction Letter that lists Subsection (d) hospitals that are subject to and fail to meet the HOQR program requirements. Once this list is released, A/B Medicare Administrative Contractors (MACs) will update the OPSF by removing the '1', (that is, ensure that the Hospital Quality Indicator field is blank) for all hospitals identified on the list and will ensure that the OPSF Hospital Quality Indicator field contains '1' for all hospitals that are not on the list. CMS notes that if these hospitals are later determined to have met the HOQR program requirements, A/B MACs shall update the OPSF. For greater detail regarding updating the OPSF for the HOQR program requirements, see Transmittal 368, CR 6072, issued on August 15, 2008.

d) Updating the OPSF for Cost to Charge Ratios(CCR)

As stated in publication 100-04, Medicare Claims Processing Manual, chapter 4, section 50.1, contractors must maintain the accuracy of the data and update the OPSF as changes occur in data element values, including changes to provider cost–to-charge ratios and, when applicable, device department cost-to-charge ratios. The file of OPPS hospital upper limit CCRs and the file of Statewide CCRs are located on the CMS website at www.cms.gov/HospitalOutpatientPPS/ under "*Annual Policy Files*."

e) Updating the "County Code"Field

Prior to CY 2018, in order to include the outmigration in a hospital's wage index, we provided a separate table that assigned wage indexes for hospitals that received the outmigration adjustment. For the CY 2021 OPPS, the OPPS Pricer will continue to assign the out migration adjustment using the "County Code" field in the OPSF. Therefore, MACs shall ensure that every hospital has listed in the "County Code" field the Federal Information Processing Standards (FIPS) county code where the hospital is located to maintain the accuracy of the OPSF data fields.

f) Updating the "Wage Index Location Core-Based Statistical Areas (CBSA)"Field

We note that under historical and current OPPS wage index policy, hospitals that have wage index reclassifications for wage adjustment purposes under the IPPS would also have those wage index reclassifications applied under the OPPS on a calendar year basis. Therefore, MACs shall ensure that wage index reclassifications applied under the FY 2021 IPPS are also reflected in the OPSF on a CY 2021 OPPS basis.

g) Updating the "Payment Core-Based Statistical Areas (CBSA)"Field

In the prior layout of the OPSF, there were only two CBSA related fields: the "Actual Geographic Location CBSA" and the "Wage Index Location CBSA." These fields are used to wage adjust OPPS payment through the Pricer if there is not an assigned Special Wage Index (as has been used historically to assign the wage index for hospitals receiving the outmigration adjustment).

In Transmittal 3750, dated April 19, 2017, for Change Request 9926, we created an additional field for the "Payment CBSA," similar to the IPPS, to allow for consistency between the data in the two systems and identify when hospitals receive dual reclassifications. In the case of dual reclassifications, similar to the IPPS, the "Payment CBSA" field will be used to note the Urban to Rural Reclassification Under Section 1886(d)(8)(E) of the Act (§ 412.103). This "Payment CBSA" field is not used for wage adjustment purposes, but to identify when the 412.103 reclassification applies, because rural status is considered for rural sole community hospital adjustment eligibility. We further note that whereas the IPPS Pricer allows the Payment CBSA, even when applied as the sole CBSA field (without a Wage Index CBSA), to be used for wage adjusting payment, that field is not used for wage adjustment the OPPS.

21. Wage Index Policies in the CY 2021 OPPS

In the FY 2021 IPPS and CY 2021 IPPS we made the following changes to the wage index: increased the wage index values for hospitals with a wage index value below the 25th percentile wage index value of 0.8469 across all hospitals, and applied a 5 percent cap for CY 2021 on any wage index values that decreased relative to CY 2020 (implemented through the Supplemental Wage Index in the OPSF).

22.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	
12120 - 04.1	Medicare contractors shall install the January 2021 OPPS Pricer.	X		X		X				
12120 - 04.2	Medicare contractors shall adjust, as appropriate, claims brought to their attention with any retroactive changes that were received prior to implementation of the January 2021 Pricer.	X		X						
12120 - 04.3	As specified in chapter 4, section 50.1, of the Claims Processing Manual, Medicare contractors shall maintain the accuracy of the data and update the OPSF file as changes occur in data element values. For CY 2021, this includes all changes to the OPSF identified in Section 20 of this Change Request.	X		X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12120 - 04.4	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information	X		X		

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.					

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

Pre-Implementation Contact(s): Marina Kushnirova, marina.kushnirova@cms.hhs.gov

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

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

Table of Contents
(Rev.10541; Issued: 12-31-2020)

10.2.3 - Comprehensive APCs

(Rev. 10541; Issued: 12-31-20; Effective: 01-01-21; Implementation: 01-04-21)

Comprehensive APCs provide a single payment for a primary service, and payment for all adjunctive services reported on the same claim is packaged into payment for the primary service. With few exceptions, all other services reported on a hospital outpatient claim in combination with the primary service are considered to be related to the delivery of the primary service and packaged into the single payment for the primary service.

HCPCS codes assigned to comprehensive APCs are designated with status indicator J1, See Addendum B at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS for the list of HCPCS codes designated with status indicator J1.

Claims reporting at least one J1 procedure code will package the following items and services that are not typically packaged under the OPPS:

- major OPPS procedure codes (status indicators P, S, T, V)
- lower ranked comprehensive procedure codes (status indicator J1)
- non-pass-through drugs and biologicals (status indicator K)
- blood products (status indicator R)
- DME (status indicator Y)
- therapy services (HCPCS codes with status indicator A reported on therapy revenue centers)

The following services are excluded from comprehensive APC packaging:

- ambulance services
- brachytherapy sources (status indicator U)
- diagnostic and mammography screenings
- physical therapy, speech-language pathology and occupational therapy services reported on a separate facility claim for recurring services
- pass-through drugs, biologicals, and devices (status indicators G or H)
- preventive services defined in 42 CFR410.2
- self-administered drugs (SADs) - drugs that are usually self-administered and do not function as supplies in the provision of the comprehensive service
- services assigned to OPPS status indicator F (certain CRNA services, Hepatitis B vaccines and corneal tissue acquisition)
- services assigned to OPPS status indicator L (influenza and pneumococcal pneumonia vaccines)
- certain Part B inpatient services – Ancillary Part B inpatient services payable under Part B when the primary J1 service for the claim is not a payable Medicare Part B inpatient service (for example, exhausted Medicare Part A benefits, beneficiaries with Part B only)
- services assigned to a New Technology APC
- *For the remainder of the PHE for COVID-19, new COVID-19 treatments that meet the following criteria: 1) The treatment must be a drug or biological product (which could include a blood product) authorized to treat COVID-19, as indicated in section "I. Criteria for Issuance of Authorization" of the letter of authorization for the drug or biological product, or the drug or biological product must be approved by the FDA for treating COVID-19 2) The emergency use authorization (EUA) for the drug or biological product (which could include a blood product) must authorize the use of the product in the outpatient setting or not limit its use to the inpatient setting, or the product must be approved by the FDA to treat COVID-19 disease and not limit its use to the inpatient setting.*

The single payment for a comprehensive claim is based on the rate associated with either the J1 service or the specific combination of J2 services. When multiple J1 services are reported on the same claim, the single payment is based on the rate associated with the highest ranking J1 service. When certain pairs of J1 services (or in certain cases a J1 service and an add-on code) are reported on the same claim, the claim is eligible for a complexity adjustment, which provides a single payment for the claim based on the rate of the next higher comprehensive APC within the same clinical family. When a J1 service and a J2 service are reported on the same claim, the single payment is based on the rate associated with the J1 service, and the combination of the J1 and J2 services on the claim does not make the claim eligible for a complexity adjustment. Note that complexity adjustments will not be applied to discontinued services (reported with mod -73 or -74).

10.2.4. Reporting for Certain Outpatient Department Services (That Are Similar to Therapy Services) ("Non-Therapy Outpatient Department Services") and Are Adjunctive to Comprehensive APC Procedures

(Rev. 10541; Issued: 12-31-20; Effective: 01-01-21; Implementation: 01-04-21)

This language was originally published in the October 2016 Update of the Outpatient Perspective Payment System (OPPS) (Transmittal R3602CP). We are updating this language based on the removal of the regulations at 42 CFR 410.59(a)(4) and 42 CFR 410.60(a)(4) related to functional reporting for therapy services.

Non-therapy outpatient department services are services such as physical therapy, occupational therapy, and speech-language pathology provided during the perioperative period (of a Comprehensive APC (C-APC) procedure) without a certified therapy plan of care. These are not therapy services as described in section 1834(k) of the Act, regardless of whether the services are delivered by therapists or other non-therapist health care workers. Therapy services are those provided by therapists under a plan of care in accordance with section 1835(a)(2)(C) and section 1835(a)(2)(D) of the Act and are paid for under section 1834(k) of the Act, subject to annual therapy caps as applicable (78 FR 74867 and 79 FR 66800), until they were repealed by Bipartisan Budget Act of 2018, effective January 1, 2018. Because these services are outpatient department services and not therapy services, the requirement for functional reporting under the regulations at 42 CFR 410.59(a)(4) and 42 CFR 410.60(a)(4) does not apply. The functional reporting requirements were applicable until January 1, 2019 at which time the regulations at 42 CFR 410.59(a)(4) and 42 CFR 410.60(a)(4) were removed (83 FR 41786 and 83 FR 59452).

The comprehensive APC payment policy packages payment for adjunctive items, services, and procedures into the most costly primary procedures under the OPPS at the claim level. When non-therapy outpatient department services are included on the same claim as a C-APC procedure (status indicator (SI) = J1) (see 80 FR 70326) or the specific combination of services assigned to the Observation Comprehensive APC 8011 (SI = J2), these services are considered adjunctive to the primary procedure. Payment for non-therapy outpatient department services is included as a packaged part of the payment for the C-APC procedure.

Effective for claims received on or after October 1, 2016 with dates of service on or after January 1, 2015, providers may report non-therapy outpatient department services (that are similar to therapy services) that are adjunctive to a C-APC procedure (SI = J1) or the specific combination of services assigned to the Observation Comprehensive APC 8011 (SI = J2), in one of two ways:

1. Without using the therapy CPT codes and instead reporting these non-therapy services with Revenue Code 0940 (Other Therapeutic Services); or

2. Reporting non-therapy outpatient department services that are adjunctive to J1 or J2 services with the appropriate occurrence codes, CPT codes, modifiers, and revenue codes.

Attachment A − Tables for the Policy Section

Table 1. ─ Covid-19 Laboratory Tests and Services

HCPCS Code	Long Descriptor	ata	OPPS SI	OPPS APC
U0001	CDC 2019 Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel	02/04/2020	A	N/A
U0002	2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC	02/04/2020	A	N/A
U0003	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R	04/14/2020	A	N/A
U0004	2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R	04/14/2020	A	N/A
U0005	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique, CDC or non-CDC, making use of high throughput technologies, completed within 2 calendar days from date of specimen collection (List separately in addition to either HCPCS code U0003 or U0004) as described by CMS-2020-01-R2.	01/01/21	A	N/A
C9803	Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), any specimen source	03/01/2020	Q1	5731
G2023	Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source	03/01/2020	B	N/A
G2024	Specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) from an	03/01/2020	B	N/A

HCPCS Code	Long Descriptor	ata	OPPS SI	OPPS APC
	individual in a SNF or by a laboratory on behalf of a HHA, any specimen source			
86328	Immunoassay for infectious agent antibody, qualitative or semiquantitative, single step method (eg, reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])	04/10/2020	A	N/A
86408	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); screen	08/10/2020	A	N/A
86409	Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); titer	08/10/2020	A	N/A
86413	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) antibody, quantitative	09/08/2020	A	N/A
86769	Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])	04/10/2020	A	N/A
87426	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; severe acute respiratory syndrome coronavirus (eg, SARS-CoV, SARS-CoV-2 [COVID-19])	06/25/2020	A	N/A
87428	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; severe acute respiratory syndrome coronavirus (eg, SARS-CoV, SARS-CoV-2 [COVID-19]) and influenza virus types A and B	11/10/2020	A	N/A
87635	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique	03/13/2020	A	N/A

HCPCS Code	Long Descriptor	ata	OPPS SI	OPPS APC
87636	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) and influenza virus types A and B, multiplex amplified probe technique	10/06/2020	A	N/A
87637	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), influenza virus types A and B, and respiratory syncytial virus, multiplex amplified probe technique	10/06/2020	A	N/A
87811	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])	10/06/2020	A	N/A
0202U	Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected	05/20/2020	A	N/A
0223U	Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected	06/25/2020	A	N/A
0224U	Antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), includes titer(s), when performed	06/25/2020	A	N/A
0225U	Infectious disease (bacterial or viral respiratory tract infection) pathogen-specific DNA and RNA, 21 targets, including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), amplified probe technique, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected	08/10/2020	A	N/A

HCPCS Code	Long Descriptor	ata	OPPS SI	OPPS APC
0226U	Surrogate viral neutralization test (sVNT), severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), ELISA, plasma, serum	08/10/2020	A	N/A
0240U	Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 3 targets (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A, influenza B), upper respiratory specimen, each pathogen reported as detected or not detected	10/06/2020	A	N/A
0241U	Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 4 targets (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A, influenza B, respiratory syncytial virus [RSV]), upper respiratory specimen, each pathogen reported as detected or not detected	10/06/2020	A	N/A

Table 2. – PLA Coding Changes Effective October 6, 2020 and January 1, 2021

CPT Code	Long Descriptor	OPPS SI
0227U	Drug assay, presumptive, 30 or more drugs or metabolites, urine, liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring (MRM), with drug or metabolite description, includes sample validation	Q4
0228U	Oncology (prostate), multianalyte molecular profile by photometric detection of macromolecules adsorbed on nanosponge array slides with machine learning, utilizing first morning voided urine, algorithm reported as likelihood of prostate cancer	Q4
0229U	BCAT1 (Branched chain amino acid transaminase 1) or IKZF1 (IKAROS family zinc finger 1) (eg, colorectal cancer) promoter methylation analysis	A
0230U	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation), full sequence analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions, and variants in non-uniquely mappable regions	A
0231U	CACNA1A (calcium voltage-gated channel subunit alpha 1A) (eg, spinocerebellar ataxia), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) gene expansions, mobile element insertions, and variants in non-uniquely mappable regions	A

CPT Code	Long Descriptor	OPPS SI
0232U	CSTB (cystatin B) (eg, progressive myoclonic epilepsy type 1A, Unverricht-Lundborg disease), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions, and variants in non-uniquely mappable regions	A
0233U	FXN (frataxin) (eg, Friedreich ataxia), gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions, and variants in non-uniquely mappable regions	A
0234U	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-uniquely mappable regions	A
0235U	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-uniquely mappable regions	A
0236U	SMN1 (survival of motor neuron 1, telomeric) and SMN2 (survival of motor neuron 2, centromeric) (eg, spinal muscular atrophy) full gene analysis, including small sequence changes in exonic and intronic regions, duplications and deletions, and mobile element insertions	A
0237U	Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia), genomic sequence analysis panel including ANK2, CASQ2, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, RYR2, and SCN5A, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-uniquely mappable regions	A
0238U	Oncology (Lynch syndrome), genomic DNA sequence analysis of MLH1, MSH2, MSH6, PMS2, and EPCAM, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-uniquely mappable regions	A
0239U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free DNA, analysis of 311 or more genes, interrogation for sequence variants, including substitutions, insertions, deletions, select rearrangements, and copy number variations	A
0240U	Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 3 targets (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A, influenza B), upper respiratory specimen, each pathogen reported as detected or not detected	A
0241U	Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 4 targets (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2], influenza A, influenza B, respiratory syncytial virus [RSV]), upper respiratory specimen, each pathogen reported as detected or not detected	A

Table 3. ─ Monoclonal Antibody Treatment Bamlanivimab Product and Administration Codes

CPT Code	Type	Long Descriptor
M0239	Administration/ Infusion Code	Intravenous infusion, bamlanivimab-xxxx, includes infusion and post administration monitoring
Q0239	Product Code	Injection, bamlanivimab-xxxx, 700 mg
M0243	Administration/ Infusion Code	Intravenous infusion, casirivimab and imdevimab includes infusion and post administration monitoring
Q0243	Product Code	Injection, casirivimab and imdevimab, 2400 mg

Table 4. ─ New Covid-19 CPT Vaccines Product and Administration Codes

CPT Code	Type	Labeler	Long Descriptor
91300	Vaccine/ Product Code	Pfizer	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted, for intramuscular use
0001A	Administration/ Immunization Code	Pfizer	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; first dose
0002A	Administration/ Immunization Code	Pfizer	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; second dose
91301	Vaccine/ Product Code	Moderna	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage, for intramuscular use
0011A	Administration/ Immunization Code	Moderna	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; first dose
0012A	Administration/ Immunization Code	Moderna	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])

			vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; second dose
91302	Vaccine/ Product Code	AstraZeneca/ University of Oxford	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, $5x10^{10}$ viral particles/0.5mL dosage, for intramuscular use
0021A	Administration/ Immunization Code	AstraZeneca/ University of Oxford	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, $5x10^{10}$ viral particles/0.5mL dosage; first dose
0022A	Administration/ Immunization Code	AstraZeneca/ University of Oxford	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, $5x10^{10}$ viral particles/0.5mL dosage; second dose

Table 5. — New Device Pass-Through Codes Effective January 1, 2021

HCPCS Code	Effective Date	SI	APC	Short Descriptor	Long Descriptor	Device Offset Amount(s)
C1839	1/01/2020	H	2028	Iris prosthesis	Iris prosthesis	• 0616T - $644.54 • 0617T - $1,214.50 • 0618T - $1,214.50
C1825	01/01/2021	H	2030	Gen, neuro, carot sinus baro	Generator, neurostimulator (implantable), non-rechargeable with carotid sinus baroreceptor stimulation lead(s)	• CPT code 0266T – $28,190.18
C1052	01/01/2021	H	2031	Hemostatic agent, gi, topic	Hemostatic agent, gastrointestinal, topical	• CPT code 43227 - $0.00 • CPT code 43255 - $41.93 • CPT code 44366 - $20.96 • CPT code 44378 - $45.66 • CPT code 44391 - $0.00

						• CPT code 45334 - $30.80 • CPT code 45382 - $38.57
C1062	01/01/2021	H	2032	Intravertebral fx aug impl	Intravertebral body fracture augmentation with implant (e.g., metal, polymer)	• CPT code 22513 - $1308.12 • CPT code 22514 - $1333.18
C1748	07/01/2020	H	2029	Endoscope, single, ugi	Endoscope, single-use (i.e. disposable), upper gi, imaging/illumination device (insertable)	• CPT code 43260 – $0.00 • CPT code 43261 – $0.00 • CPT code 43262 – $0.00 • CPT code 43263 – $0.00 • CPT code 43264 – $0.00 • CPT code 43265 – $0.00 • CPT code 43274 – $0.00 • CPT code 43276 – $0.00 • CPT code 43277 – $0.00 • CPT code 43278 – $0.00

Table 6. — New HCPCS Code Describing the Administration of Subretinal Therapies Requiring Vitrectomy Effective January 1, 2021

HCPCS Code	Short Descriptor	Long Descriptor	SI	APC
C9770	Vitrec/mech pars, subret inj	Vitrectomy, mechanical, pars plana approach, with subretinal injection of pharmacologic/biologic agent	T	1561

Table 7. — New Nasal Endoscopy with Cryoablation of Nasal Tissues and/or Nerves HCPCS Code Effective January 1, 2021

HCPCS Code	Short Descriptor	Long Descriptor	SI	APC
C9771	Nsl/sins cryo post nasal tis	Nasal/sinus endoscopy, cryoablation nasal tissue(s) and/or nerve(s), unilateral or bilateral	J1	5164

Table 8. — New HCPCS Codes Describing Peripheral Intravascular Lithotripsy (IVL) Procedures Effective January 1, 2021

HCPCS Code	Short Descriptor	Long Descriptor	SI	APC
C9772	Revasc lithotrip tibi/perone	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies), with intravascular lithotripsy, includes angioplasty within the same vessel (s), when performed	J1	5193
C9773	Revasc lithotr-stent tib/per	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed	J1	5194
C9774	Revasc lithotr-ather tib/per	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel (s), when performed	J1	5194
C9775	Revasc lith-sten-ath tib/per	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel (s), when performed	J1	5194

Table 9. — New Comprehensive APCs for CY 2021

CY 2021 APC	CY 2021 APC Descriptor
5378	Level 8 Urology and Related Services
5465	Level 5 Neurostimulator and Related Procedures

Table 10. – Changes to the IPO List for CY 2021

CY 2021 CPT Code	CY 2021 Long Descriptor	Final Action	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
00192	Anesthesia for procedures on facial bones or skull; radical surgery (including prognathism)	Remove from the IPO	N	N/A

CY 2021 CPT Code	CY 2021 Long Descriptor	Final Action	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
00474	Anesthesia for partial rib resection; radical procedures (eg, pectus excavatum)	Remove from the IPO	N	N/A
00604	Anesthesia for procedures on cervical spine and cord; procedures with patient in the sitting position	Remove from the IPO	N	N/A
00904	Anesthesia for; radical perineal procedure	Remove from the IPO	N	N/A
0095T	Removal of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (list separately in addition to code for primary procedure)	Remove from the IPO	N	N/A
0098T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (list separately in addition to code for primary procedure)	Remove from the IPO	N	N/A
01140	Anesthesia for interpelviabdominal (hindquarter) amputation	Remove from the IPO	N	N/A
01150	Anesthesia for radical procedures for tumor of pelvis, except hindquarter amputation	Remove from the IPO	N	N/A
01212	Anesthesia for open procedures involving hip joint; hip disarticulation	Remove from the IPO	N	N/A
01232	Anesthesia for open procedures involving upper two-thirds of femur; amputation	Remove from the IPO	N	N/A
01234	Anesthesia for open procedures involving upper two-thirds of femur; radical resection	Remove from the IPO	N	N/A
01274	Anesthesia for procedures involving arteries of upper leg, including bypass graft; femoral artery embolectomy	Remove from the IPO	N	N/A
01404	Anesthesia for open or surgical arthroscopic procedures on knee joint; disarticulation at knee	Remove from the IPO	N	N/A
01486	Anesthesia for open procedures on bones of lower leg, ankle, and foot; total ankle replacement	Remove from the IPO	N	N/A

CY 2021 CPT Code	CY 2021 Long Descriptor	Final Action	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
0163T	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), each additional interspace, lumbar (list separately in addition to code for primary procedure)	Remove from the IPO	N	N/A
01634	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; shoulder disarticulation	Remove from the IPO	N	N/A
01636	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; interthoracoscapular (forequarter) amputation	Remove from the IPO	N	N/A
01638	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; total shoulder replacement	Remove from the IPO	N	N/A
0164T	Removal of total disc arthroplasty, (artificial disc), anterior approach, each additional interspace, lumbar (list separately in addition to code for primary procedure)	Remove from the IPO	N	N/A
0165T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, lumbar (list separately in addition to code for primary procedure)	Remove from the IPO	N	N/A
01756	Anesthesia for open or surgical arthroscopic procedures of the elbow; radical procedures	Remove from the IPO	N	N/A
0202T	Posterior vertebral joint(s) arthroplasty (eg, facet joint[s] replacement), including facetectomy, laminectomy, foraminotomy, and vertebral column fixation, injection of bone cement, when performed, including fluoroscopy, single level, lumbar spine	Remove from the IPO	J1	5115

CY 2021 CPT Code	CY 2021 Long Descriptor	Final Action	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
0219T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; cervical	Remove from the IPO	J1	5115
0220T	Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; thoracic	Remove from the IPO	J1	5115
20661	Application of halo, including removal; cranial	Remove from the IPO	Q1	5113
20664	Application of halo, including removal, cranial, 6 or more pins placed, for thin skull osteology (eg, pediatric patients, hydrocephalus, osteogenesis imperfecta)	Remove from the IPO	Q1	5113
20802	Replantation, arm (includes surgical neck of humerus through elbow joint), complete amputation	Remove from the IPO	J1	5116
20805	Replantation, forearm (includes radius and ulna to radial carpal joint), complete amputation	Remove from the IPO	J1	5116
20808	Replantation, hand (includes hand through metacarpophalangeal joints), complete amputation	Remove from the IPO	J1	5116
20816	Replantation, digit, excluding thumb (includes metacarpophalangeal joint to insertion of flexor sublimis tendon), complete amputation	Remove from the IPO	J1	5114
20824	Replantation, thumb (includes carpometacarpal joint to mp joint), complete amputation	Remove from the IPO	J1	5114
20827	Replantation, thumb (includes distal tip to mp joint), complete amputation	Remove from the IPO	J1	5114
20838	Replantation, foot, complete amputation	Remove from the IPO	J1	5116
20955	Bone graft with microvascular anastomosis; fibula	Remove from the IPO	J1	5114

CY 2021 CPT Code	CY 2021 Long Descriptor	Final Action	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
20956	Bone graft with microvascular anastomosis; iliac crest	Remove from the IPO	J1	5114
20957	Bone graft with microvascular anastomosis; metatarsal	Remove from the IPO	J1	5114
20962	Bone graft with microvascular anastomosis; other than fibula, iliac crest, or metatarsal	Remove from the IPO	J1	5114
20969	Free osteocutaneous flap with microvascular anastomosis; other than iliac crest, metatarsal, or great toe	Remove from the IPO	J1	5114
20970	Free osteocutaneous flap with microvascular anastomosis; iliac crest	Remove from the IPO	J1	5114
21045	Excision of malignant tumor of mandible; radical resection	Remove from the IPO	J1	5165
21141	Reconstruction midface, lefort i; single piece, segment movement in any direction (eg, for long face syndrome), without bone graft	Remove from the IPO	J1	5165
21142	Reconstruction midface, lefort i; 2 pieces, segment movement in any direction, without bone graft	Remove from the IPO	J1	5165
21143	Reconstruction midface, lefort i; 3 or more pieces, segment movement in any direction, without bone graft	Remove from the IPO	J1	5165
21145	Reconstruction midface, lefort i; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)	Remove from the IPO	J1	5165
21146	Reconstruction midface, lefort i; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)	Remove from the IPO	J1	5165
21147	Reconstruction midface, lefort i; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)	Remove from the IPO	J1	5165

CY 2021 CPT Code	CY 2021 Long Descriptor	Final Action	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
21151	Reconstruction midface, lefort ii; any direction, requiring bone grafts (includes obtaining autografts)	Remove from the IPO	J1	5165
21154	Reconstruction midface, lefort iii (extracranial), any type, requiring bone grafts (includes obtaining autografts); without lefort i	Remove from the IPO	J1	5165
21155	Reconstruction midface, lefort iii (extracranial), any type, requiring bone grafts (includes obtaining autografts); with lefort i	Remove from the IPO	J1	5165
21159	Reconstruction midface, lefort iii (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); without lefort i	Remove from the IPO	J1	5165
21160	Reconstruction midface, lefort iii (extra and intracranial) with forehead advancement (eg, mono bloc), requiring bone grafts (includes obtaining autografts); with lefort i	Remove from the IPO	J1	5165
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)	Remove from the IPO	J1	5165
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)	Remove from the IPO	J1	5165
21182	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm	Remove from the IPO	J1	5165
21183	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 40 sq cm but less than 80 sq cm	Remove from the IPO	J1	5165

CY 2021 CPT Code	CY 2021 Long Descriptor	Final Action	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
21184	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (eg, fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 80 sq cm	Remove from the IPO	J1	5165
21188	Reconstruction midface, osteotomies (other than lefort type) and bone grafts (includes obtaining autografts)	Remove from the IPO	J1	5165
21194	Reconstruction of mandibular rami, horizontal, vertical, c, or l osteotomy; with bone graft (includes obtaining graft)	Remove from the IPO	J1	5165
21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation	Remove from the IPO	J1	5165
21247	Reconstruction of mandibular condyle with bone and cartilage autografts (includes obtaining grafts) (eg, for hemifacial microsomia)	Remove from the IPO	J1	5165
21255	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)	Remove from the IPO	J1	5165
21268	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; combined intra- and extracranial approach	Remove from the IPO	J1	5165
21343	Open treatment of depressed frontal sinus fracture	Remove from the IPO	J1	5165
21344	Open treatment of complicated (eg, comminuted or involving posterior wall) frontal sinus fracture, via coronal or multiple approaches	Remove from the IPO	J1	5165
21347	Open treatment of nasomaxillary complex fracture (lefort ii type); requiring multiple open approaches	Remove from the IPO	J1	5165
21348	Open treatment of nasomaxillary complex fracture (lefort ii type); with bone grafting (includes obtaining graft)	Remove from the IPO	J1	5165
21366	Open treatment of complicated (eg, comminuted or involving cranial nerve foramina) fracture(s) of malar area,	Remove from the IPO	J1	5165

CY 2021 CPT Code	CY 2021 Long Descriptor	Final Action	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
	including zygomatic arch and malar tripod; with bone grafting (includes obtaining graft)			
21422	Open treatment of palatal or maxillary fracture (lefort i type);	Remove from the IPO	J1	5165
21423	Open treatment of palatal or maxillary fracture (lefort i type); complicated (comminuted or involving cranial nerve foramina), multiple approaches	Remove from the IPO	J1	5165
21431	Closed treatment of craniofacial separation (lefort iii type) using interdental wire fixation of denture or splint	Remove from the IPO	J1	5165
21432	Open treatment of craniofacial separation (lefort iii type); with wiring and/or internal fixation	Remove from the IPO	J1	5165
21433	Open treatment of craniofacial separation (lefort iii type); complicated (eg, comminuted or involving cranial nerve foramina), multiple surgical approaches	Remove from the IPO	J1	5165
21435	Open treatment of craniofacial separation (lefort iii type); complicated, utilizing internal and/or external fixation techniques (eg, head cap, halo device, and/or intermaxillary fixation)	Remove from the IPO	J1	5165
21436	Open treatment of craniofacial separation (lefort iii type); complicated, multiple surgical approaches, internal fixation, with bone grafting (includes obtaining graft)	Remove from the IPO	J1	5165
21510	Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), thorax	Remove from the IPO	J1	5114
21602	Excision of chest wall tumor involving rib(s), with plastic reconstruction; without mediastinal lymphadenectomy	Remove from the IPO	J1	5114
21603	Excision of chest wall tumor involving rib(s), with plastic reconstruction; with mediastinal lymphadenectomy	Remove from the IPO	J1	5114
21615	Excision first and/or cervical rib;	Remove from the IPO	J1	5114

CY 2021 CPT Code	CY 2021 Long Descriptor	Final Action	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
21616	Excision first and/or cervical rib; with sympathectomy	Remove from the IPO	J1	5114
21620	Ostectomy of sternum, partial	Remove from the IPO	J1	5114
21627	Sternal debridement	Remove from the IPO	J1	5114
21630	Radical resection of sternum;	Remove from the IPO	J1	5114
21632	Radical resection of sternum; with mediastinal lymphadenectomy	Remove from the IPO	J1	5114
21705	Division of scalenus anticus; with resection of cervical rib	Remove from the IPO	J1	5114
21740	Reconstructive repair of pectus excavatum or carinatum; open	Remove from the IPO	J1	5114
21750	Closure of median sternotomy separation with or without debridement (separate procedure)	Remove from the IPO	J1	5114
21825	Open treatment of sternum fracture with or without skeletal fixation	Remove from the IPO	J1	5114
22010	Incision and drainage, open, of deep abscess (subfascial), posterior spine; cervical, thoracic, or cervicothoracic	Remove from the IPO	J1	5114
22015	Incision and drainage, open, of deep abscess (subfascial), posterior spine; lumbar, sacral, or lumbosacral	Remove from the IPO	J1	5114
22110	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; cervical	Remove from the IPO	J1	5114
22112	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; thoracic	Remove from the IPO	J1	5114

CY 2021 CPT Code	CY 2021 Long Descriptor	Final Action	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
22114	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; lumbar	Remove from the IPO	J1	5114
22116	Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; each additional vertebral segment (list separately in addition to code for primary procedure)	Remove from the IPO	N	N/A
22206	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); thoracic	Remove from the IPO	J1	5114
22207	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); lumbar	Remove from the IPO	J1	5114
22208	Osteotomy of spine, posterior or posterolateral approach, 3 columns, 1 vertebral segment (eg, pedicle/vertebral body subtraction); each additional vertebral segment (list separately in addition to code for primary procedure)	Remove from the IPO	N	N/A
22210	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervical	Remove from the IPO	J1	5114
22212	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; thoracic	Remove from the IPO	J1	5114
22214	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar	Remove from the IPO	J1	5114
22216	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; each additional vertebral segment (list separately in addition to primary procedure)	Remove from the IPO	N	N/A
22220	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; cervical	Remove from the IPO	J1	5114

CY 2021 CPT Code	CY 2021 Long Descriptor	Final Action	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
22222	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; thoracic	Remove from the IPO	J1	5114
22224	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; lumbar	Remove from the IPO	J1	5114
22226	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; each additional vertebral segment (list separately in addition to code for primary procedure)	Remove from the IPO	N	N/A
22318	Open treatment and/or reduction of odontoid fracture(s) and or dislocation(s) (including os odontoideum), anterior approach, including placement of internal fixation; without grafting	Remove from the IPO	J1	5115
22319	Open treatment and/or reduction of odontoid fracture(s) and or dislocation(s) (including os odontoideum), anterior approach, including placement of internal fixation; with grafting	Remove from the IPO	J1	5115
22325	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; lumbar	Remove from the IPO	J1	5115
22326	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; cervical	Remove from the IPO	J1	5115
22327	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; thoracic	Remove from the IPO	J1	5115
22328	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; each additional fractured vertebra or dislocated segment (list separately in addition to code for primary procedure)	Remove from the IPO	N	N/A

CY 2021 CPT Code	CY 2021 Long Descriptor	Final Action	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
22532	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic	Remove from the IPO	J1	5116
22533	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	Remove from the IPO	J1	5116
22534	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (list separately in addition to code for primary procedure)	Remove from the IPO	N	N/A
22548	Arthrodesis, anterior transoral or extraoral technique, clivus-c1-c2 (atlas-axis), with or without excision of odontoid process	Remove from the IPO	J1	5116
22556	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic	Remove from the IPO	J1	5116
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	Remove from the IPO	J1	5116
22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, l5-s1 interspace	Remove from the IPO	J1	5116
22590	Arthrodesis, posterior technique, craniocervical (occiput-c2)	Remove from the IPO	J1	5116
22595	Arthrodesis, posterior technique, atlas-axis (c1-c2)	Remove from the IPO	J1	5116
22600	Arthrodesis, posterior or posterolateral technique, single level; cervical below c2 segment	Remove from the IPO	J1	5116
22610	Arthrodesis, posterior or posterolateral technique, single level; thoracic (with lateral transverse technique, when performed)	Remove from the IPO	J1	5116

CY 2021 CPT Code	CY 2021 Long Descriptor	Final Action	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar	Remove from the IPO	J1	5116
22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (list separately in addition to code for primary procedure)	Remove from the IPO	N	N/A
22800	Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments	Remove from the IPO	J1	5116
22802	Arthrodesis, posterior, for spinal deformity, with or without cast; 7 to 12 vertebral segments	Remove from the IPO	J1	5116
22804	Arthrodesis, posterior, for spinal deformity, with or without cast; 13 or more vertebral segments	Remove from the IPO	J1	5116
22808	Arthrodesis, anterior, for spinal deformity, with or without cast; 2 to 3 vertebral segments	Remove from the IPO	J1	5116
22810	Arthrodesis, anterior, for spinal deformity, with or without cast; 4 to 7 vertebral segments	Remove from the IPO	J1	5116
22812	Arthrodesis, anterior, for spinal deformity, with or without cast; 8 or more vertebral segments	Remove from the IPO	J1	5116
22818	Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); single or 2 segments	Remove from the IPO	J1	5116
22819	Kyphectomy, circumferential exposure of spine and resection of vertebral segment(s) (including body and posterior elements); 3 or more segments	Remove from the IPO	J1	5116
22830	Exploration of spinal fusion	Remove from the IPO	J1	5115
22841	Internal spinal fixation by wiring of spinous processes (list separately in addition to code for primary procedure)	Remove from the IPO	N	N/A

CY 2021 CPT Code	CY 2021 Long Descriptor	Final Action	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
22843	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments (list separately in addition to code for primary procedure)	Remove from the IPO	N	N/A
22844	Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments (list separately in addition to code for primary procedure)	Remove from the IPO	N	N/A
22846	Anterior instrumentation; 4 to 7 vertebral segments (list separately in addition to code for primary procedure)	Remove from the IPO	N	N/A
22847	Anterior instrumentation; 8 or more vertebral segments (list separately in addition to code for primary procedure)	Remove from the IPO	N	N/A
22848	Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum (list separately in addition to code for primary procedure)	Remove from the IPO	N	N/A
22849	Reinsertion of spinal fixation device	Remove from the IPO	J1	5116
22850	Removal of posterior nonsegmental instrumentation (eg, harrington rod)	Remove from the IPO	J1	5115
22852	Removal of posterior segmental instrumentation	Remove from the IPO	J1	5115
22855	Removal of anterior instrumentation	Remove from the IPO	J1	5115
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar	Remove from the IPO	J1	5116
22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	Remove from the IPO	J1	5116
22862	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	Remove from the IPO	J1	5116

CY 2021 CPT Code	CY 2021 Long Descriptor	Final Action	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
22864	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	Remove from the IPO	J1	5115
22865	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	Remove from the IPO	J1	5115
23200	Radical resection of tumor; clavicle	Remove from the IPO	J1	5114
23210	Radical resection of tumor; scapula	Remove from the IPO	J1	5114
23220	Radical resection of tumor, proximal humerus	Remove from the IPO	J1	5114
23335	Removal of prosthesis, includes debridement and synovectomy when performed; humeral and glenoid components (eg, total shoulder)	Remove from the IPO	J1	5073
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))	Remove from the IPO	J1	5115
23474	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component	Remove from the IPO	J1	5115
23900	Interthoracoscapular amputation (forequarter)	Remove from the IPO	J1	5115
23920	Disarticulation of shoulder;	Remove from the IPO	J1	5115
24900	Amputation, arm through humerus; with primary closure	Remove from the IPO	J1	5115
24920	Amputation, arm through humerus; open, circular (guillotine)	Remove from the IPO	J1	5115
24930	Amputation, arm through humerus; re-amputation	Remove from the IPO	J1	5114

CY 2021 CPT Code	CY 2021 Long Descriptor	Final Action	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
24931	Amputation, arm through humerus; with implant	Remove from the IPO	J1	5115
24940	Cineplasty, upper extremity, complete procedure	Remove from the IPO	J1	5115
25900	Amputation, forearm, through radius and ulna;	Remove from the IPO	J1	5115
25905	Amputation, forearm, through radius and ulna; open, circular (guillotine)	Remove from the IPO	J1	5115
25915	Krukenberg procedure	Remove from the IPO	J1	5114
25920	Disarticulation through wrist;	Remove from the IPO	J1	5114
25924	Disarticulation through wrist; re-amputation	Remove from the IPO	J1	5114
25927	Transmetacarpal amputation;	Remove from the IPO	J1	5113
26551	Transfer, toe-to-hand with microvascular anastomosis; great toe wrap-around with bone graft	Remove from the IPO	J1	5114
26553	Transfer, toe-to-hand with microvascular anastomosis; other than great toe, single	Remove from the IPO	J1	5114
26554	Transfer, toe-to-hand with microvascular anastomosis; other than great toe, double	Remove from the IPO	J1	5114
26556	Transfer, free toe joint, with microvascular anastomosis	Remove from the IPO	J1	5114
26992	Incision, bone cortex, pelvis and/or hip joint (eg, osteomyelitis or bone abscess)	Remove from the IPO	J1	5114
27005	Tenotomy, hip flexor(s), open (separate procedure)	Remove from the IPO	J1	5114

CY 2021 CPT Code	CY 2021 Long Descriptor	Final Action	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
27025	Fasciotomy, hip or thigh, any type	Remove from the IPO	J1	5114
27030	Arthrotomy, hip, with drainage (eg, infection)	Remove from the IPO	J1	5114
27036	Capsulectomy or capsulotomy, hip, with or without excision of heterotopic bone, with release of hip flexor muscles (ie, gluteus medius, gluteus minimus, tensor fascia latae, rectus femoris, sartorius, iliopsoas)	Remove from the IPO	J1	5114
27054	Arthrotomy with synovectomy, hip joint	Remove from the IPO	J1	5113
27070	Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (eg, osteomyelitis or bone abscess); superficial	Remove from the IPO	J1	5114
27071	Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (eg, osteomyelitis or bone abscess); deep (subfascial or intramuscular)	Remove from the IPO	J1	5114
27075	Radical resection of tumor; wing of ilium, 1 pubic or ischial ramus or symphysis pubis	Remove from the IPO	J1	5114
27076	Radical resection of tumor; ilium, including acetabulum, both pubic rami, or ischium and acetabulum	Remove from the IPO	J1	5114
27077	Radical resection of tumor; innominate bone, total	Remove from the IPO	J1	5115
27078	Radical resection of tumor; ischial tuberosity and greater trochanter of femur	Remove from the IPO	J1	5115
27090	Removal of hip prosthesis; (separate procedure)	Remove from the IPO	J1	5073

CY 2021 CPT Code	CY 2021 Long Descriptor	Final Action	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
27091	Removal of hip prosthesis; complicated, including total hip prosthesis, methylmethacrylate with or without insertion of spacer	Remove from the IPO	J1	5073
27120	Acetabuloplasty; (eg, whitman, colonna, haygroves, or cup type)	Remove from the IPO	J1	5115
27122	Acetabuloplasty; resection, femoral head (eg, girdlestone procedure)	Remove from the IPO	J1	5115
27125	Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty)	Remove from the IPO	J1	5115
27132	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft	Remove from the IPO	J1	5115
27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft	Remove from the IPO	J1	5115
27137	Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft	Remove from the IPO	J1	5115
27138	Revision of total hip arthroplasty; femoral component only, with or without allograft	Remove from the IPO	J1	5115
27140	Osteotomy and transfer of greater trochanter of femur (separate procedure)	Remove from the IPO	J1	5115
27146	Osteotomy, iliac, acetabular or innominate bone;	Remove from the IPO	J1	5114
27147	Osteotomy, iliac, acetabular or innominate bone; with open reduction of hip	Remove from the IPO	J1	5114
27151	Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy	Remove from the IPO	J1	5114
27156	Osteotomy, iliac, acetabular or innominate bone; with femoral osteotomy and with open reduction of hip	Remove from the IPO	J1	5114

CY 2021 CPT Code	CY 2021 Long Descriptor	Final Action	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
27158	Osteotomy, pelvis, bilateral (eg, congenital malformation)	Remove from the IPO	J1	5114
27161	Osteotomy, femoral neck (separate procedure)	Remove from the IPO	J1	5114
27165	Osteotomy, intertrochanteric or subtrochanteric including internal or external fixation and/or cast	Remove from the IPO	J1	5114
27170	Bone graft, femoral head, neck, intertrochanteric or subtrochanteric area (includes obtaining bone graft)	Remove from the IPO	J1	5114
27175	Treatment of slipped femoral epiphysis; by traction, without reduction	Remove from the IPO	J1	5114
27176	Treatment of slipped femoral epiphysis; by single or multiple pinning, in situ	Remove from the IPO	J1	5115
27177	Open treatment of slipped femoral epiphysis; single or multiple pinning or bone graft (includes obtaining graft)	Remove from the IPO	J1	5114
27178	Open treatment of slipped femoral epiphysis; closed manipulation with single or multiple pinning	Remove from the IPO	J1	5114
27181	Open treatment of slipped femoral epiphysis; osteotomy and internal fixation	Remove from the IPO	J1	5114
27185	Epiphyseal arrest by epiphysiodesis or stapling, greater trochanter of femur	Remove from the IPO	J1	5114
27187	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, femoral neck and proximal femur	Remove from the IPO	J1	5114
27222	Closed treatment of acetabulum (hip socket) fracture(s); with manipulation, with or without skeletal traction	Remove from the IPO	J1	5111
27226	Open treatment of posterior or anterior acetabular wall fracture, with internal fixation	Remove from the IPO	J1	5114

CY 2021 CPT Code	CY 2021 Long Descriptor	Final Action	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
27227	Open treatment of acetabular fracture(s) involving anterior or posterior (one) column, or a fracture running transversely across the acetabulum, with internal fixation	Remove from the IPO	J1	5114
27228	Open treatment of acetabular fracture(s) involving anterior and posterior (two) columns, includes t-fracture and both column fracture with complete articular detachment, or single column or transverse fracture with associated acetabular wall fracture, with internal fixation	Remove from the IPO	J1	5114
27232	Closed treatment of femoral fracture, proximal end, neck; with manipulation, with or without skeletal traction	Remove from the IPO	J1	5112
27236	Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement	Remove from the IPO	J1	5114
27240	Closed treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with manipulation, with or without skin or skeletal traction	Remove from the IPO	J1	5112
27244	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage	Remove from the IPO	J1	5114
27245	Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage	Remove from the IPO	J1	5114
27248	Open treatment of greater trochanteric fracture, includes internal fixation, when performed	Remove from the IPO	J1	5114
27253	Open treatment of hip dislocation, traumatic, without internal fixation	Remove from the IPO	J1	5113
27254	Open treatment of hip dislocation, traumatic, with acetabular wall and femoral head fracture, with or without internal or external fixation	Remove from the IPO	J1	5113

CY 2021 CPT Code	CY 2021 Long Descriptor	Final Action	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
27258	Open treatment of spontaneous hip dislocation (developmental, including congenital or pathological), replacement of femoral head in acetabulum (including tenotomy, etc);	Remove from the IPO	J1	5113
27259	Open treatment of spontaneous hip dislocation (developmental, including congenital or pathological), replacement of femoral head in acetabulum (including tenotomy, etc); with femoral shaft shortening	Remove from the IPO	J1	5113
27268	Closed treatment of femoral fracture, proximal end, head; with manipulation	Remove from the IPO	J1	5113
27269	Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed	Remove from the IPO	J1	5112
27280	Arthrodesis, open, sacroiliac joint, including obtaining bone graft, including instrumentation, when performed	Remove from the IPO	J1	5116
27282	Arthrodesis, symphysis pubis (including obtaining graft)	Remove from the IPO	J1	5115
27284	Arthrodesis, hip joint (including obtaining graft);	Remove from the IPO	J1	5116
27286	Arthrodesis, hip joint (including obtaining graft); with subtrochanteric osteotomy	Remove from the IPO	J1	5116
27290	Interpelviabdominal amputation (hindquarter amputation)	Remove from the IPO	J1	5116
27295	Detachment of hip joint	Remove from the IPO	J1	5116
27303	Incision, deep, with opening of bone cortex, femur or knee (eg, osteomyelitis or bone abscess)	Remove from the IPO	J1	5114
27365	Radical resection of tumor, femur or knee	Remove from the IPO	J1	5114

CY 2021 CPT Code	CY 2021 Long Descriptor	Final Action	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
27445	Arthroplasty, knee, hinge prosthesis (eg, walldius type)	Remove from the IPO	J1	5115
27448	Osteotomy, femur, shaft or supracondylar; without fixation	Remove from the IPO	J1	5114
27450	Osteotomy, femur, shaft or supracondylar; with fixation	Remove from the IPO	J1	5114
27454	Osteotomy, multiple, with realignment on intramedullary rod, femoral shaft (eg, sofield type procedure)	Remove from the IPO	J1	5114
27455	Osteotomy, proximal tibia, including fibular excision or osteotomy (includes correction of genu varus [bowleg] or genu valgus [knock-knee]); before epiphyseal closure	Remove from the IPO	J1	5114
27457	Osteotomy, proximal tibia, including fibular excision or osteotomy (includes correction of genu varus [bowleg] or genu valgus [knock-knee]); after epiphyseal closure	Remove from the IPO	J1	5114
27465	Osteoplasty, femur; shortening (excluding 64876)	Remove from the IPO	J1	5114
27466	Osteoplasty, femur; lengthening	Remove from the IPO	J1	5114
27468	Osteoplasty, femur; combined, lengthening and shortening with femoral segment transfer	Remove from the IPO	J1	5114
27470	Repair, nonunion or malunion, femur, distal to head and neck; without graft (eg, compression technique)	Remove from the IPO	J1	5114
27472	Repair, nonunion or malunion, femur, distal to head and neck; with iliac or other autogenous bone graft (includes obtaining graft)	Remove from the IPO	J1	5114
27486	Repair, nonunion or malunion, femur, distal to head and neck; with iliac or other autogenous bone graft (includes obtaining graft)	Remove from the IPO	J1	5115

CY 2021 CPT Code	CY 2021 Long Descriptor	Final Action	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
27487	Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component	Remove from the IPO	J1	5115
27488	Removal of prosthesis, including total knee prosthesis, methylmethacrylate with or without insertion of spacer, knee	Remove from the IPO	J1	5114
27495	Prophylactic treatment (nailing, pinning, plating, or wiring) with or without methylmethacrylate, femur	Remove from the IPO	J1	5114
27506	Open treatment of femoral shaft fracture, with or without external fixation, with insertion of intramedullary implant, with or without cerclage and/or locking screws	Remove from the IPO	J1	5114
27507	Open treatment of femoral shaft fracture with plate/screws, with or without cerclage	Remove from the IPO	J1	5114
27511	Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, includes internal fixation, when performed	Remove from the IPO	J1	5114
27513	Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, includes internal fixation, when performed	Remove from the IPO	J1	5114
27514	Open treatment of femoral fracture, distal end, medial or lateral condyle, includes internal fixation, when performed	Remove from the IPO	J1	5114
27519	Open treatment of femoral fracture, distal end, medial or lateral condyle, includes internal fixation, when performed	Remove from the IPO	J1	5114
27535	Open treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation, when performed	Remove from the IPO	J1	5114
27536	Open treatment of tibial fracture, proximal (plateau); bicondylar, with or without internal fixation	Remove from the IPO	J1	5114
27540	Open treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, includes internal fixation, when performed	Remove from the IPO	J1	5114
27556	Open treatment of knee dislocation, includes internal fixation, when performed; without	Remove from the IPO	J1	5114

CY 2021 CPT Code	CY 2021 Long Descriptor	Final Action	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
	primary ligamentous repair or augmentation/reconstruction			
27557	Open treatment of knee dislocation, includes internal fixation, when performed; with primary ligamentous repair	Remove from the IPO	J1	5114
27558	Open treatment of knee dislocation, includes internal fixation, when performed; with primary ligamentous repair	Remove from the IPO	J1	5114
27580	Arthrodesis, knee, any technique	Remove from the IPO	J1	5115
27590	Amputation, thigh, through femur, any level;	Remove from the IPO	J1	5116
27591	Amputation, thigh, through femur, any level; immediate fitting technique including first cast	Remove from the IPO	J1	5116
27592	Amputation, thigh, through femur, any level; open, circular (guillotine)	Remove from the IPO	J1	5116
27596	Amputation, thigh, through femur, any level; re-amputation	Remove from the IPO	J1	5114
27598	Disarticulation at knee	Remove from the IPO	J1	5115
27645	Radical resection of tumor; tibia	Remove from the IPO	J1	5114
27646	Radical resection of tumor; fibula	Remove from the IPO	J1	5114
27702	Arthroplasty, ankle; with implant (total ankle)	Remove from the IPO	J1	5115
27703	Arthroplasty, ankle; revision, total ankle	Remove from the IPO	J1	5115
27712	Osteotomy; multiple, with realignment on intramedullary rod (eg, sofield type procedure)	Remove from the IPO	J1	5115

CY 2021 CPT Code	CY 2021 Long Descriptor	Final Action	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
27715	Osteoplasty, tibia and fibula, lengthening or shortening	Remove from the IPO	J1	5115
27724	Repair of nonunion or malunion, tibia; with iliac or other autograft (includes obtaining graft)	Remove from the IPO	J1	5114
27725	Repair of nonunion or malunion, tibia; by synostosis, with fibula, any method	Remove from the IPO	J1	5114
27727	Repair of congenital pseudarthrosis, tibia	Remove from the IPO	J1	5114
27880	Amputation, leg, through tibia and fibula;	Remove from the IPO	J1	5116
27881	Amputation, leg, through tibia and fibula; with immediate fitting technique including application of first cast	Remove from the IPO	J1	5114
27882	Amputation, leg, through tibia and fibula; open, circular (guillotine)	Remove from the IPO	J1	5114
27886	Amputation, leg, through tibia and fibula; re-amputation	Remove from the IPO	J1	5114
27888	Amputation, ankle, through malleoli of tibia and fibula (eg, syme, pirogoff type procedures), with plastic closure and resection of nerves	Remove from the IPO	J1	5115
28800	Amputation, foot; midtarsal (eg, chopart type procedure)	Remove from the IPO	J1	5113
G0412	Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s), unilateral or bilateral for pelvic bone fracture patterns which do not disrupt the pelvic ring includes internal fixation, when performed	Remove from the IPO	J1	5114
G0414	Open treatment of anterior pelvic bone fracture and/or dislocation for fracture patterns which disrupt the pelvic ring, unilateral or bilateral, includes internal fixation when performed (includes pubic symphysis and/or superior/inferior rami)	Remove from the IPO	J1	5115

CY 2021 CPT Code	CY 2021 Long Descriptor	Final Action	CY 2021 OPPS Status Indicator	CY 2021 OPPS APC Assignment
G0415	Open treatment of posterior pelvic bone fracture and/or dislocation, for fracture patterns which disrupt the pelvic ring, unilateral or bilateral, includes internal fixation, when performed (includes ilium, sacroiliac joint and/or sacrum)	Remove from the IPO	J1	5115

Table 11. – Elimination of Selected National Coverage Determinations (NCDs) Effective January 1, 2021

NCD Manual Citation	Name of NCD
20.5	Extracorporeal Immunoadsorption (ECI) Using Protein A Columns
30.4	Electrosleep Therapy
100.9	Implantation of Gastroesophageal Reflux Device
110.19	Abarelix for the Treatment of Prostate Cancer
220.2.1	Mangenetic Resonance Spectroscopy
220.6.16	FDG PET for Inflammation and Infection

Table 12. – Revised OPPS SI and/or APCs for Designated NCDs

HCPCS Code	Long Descriptor	OPPS SI	OPPS APC
76390	Magnetic resonance spectroscopy	S	5521
0609T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); acquisition of single voxel data, per disc, on biomarkers (ie, lactic acid, carbohydrate, alanine, laal, propionic acid, proteoglycan, and collagen) in at least 3 discs	Q3	5523
0610T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); transmission of biomarker data for software analysis	N	N/A
0611T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); postprocessing for algorithmic analysis of biomarker data for determination of relative chemical differences between discs	S	5523
0612T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); interpretation and report	M	N/A
G0235	Pet imaging, any site, not otherwise specified	S	5591

Table 13. – Long Descriptors and Effective Dates for the OTP ─ related HCPCS codes

HCPCS Code	Long Descriptor	Effective Date
G2067	Medication assisted treatment, methadone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a medicare-enrolled opioid treatment program)	1/1/2020
G2068	Medication assisted treatment, buprenorphine (oral); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program)	1/1/2020
G2069	Medication assisted treatment, buprenorphine (injectable); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program)	1/1/2020
G2070	Medication assisted treatment, buprenorphine (implant insertion); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program)	1/1/2020
G2071	Medication assisted treatment, buprenorphine (implant removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program)	1/1/2020
G2072	Medication assisted treatment, buprenorphine (implant insertion and removal); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program)	1/1/2020
G2073	Medication assisted treatment, naltrexone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program)	1/1/2020

HCPCS Code	Long Descriptor	Effective Date
G2074	Medication assisted treatment, weekly bundle not including the drug, including substance use counseling, individual and group therapy, and toxicology testing if performed (provision of the services by a medicare-enrolled opioid treatment program)	1/1/2020
G2075	Medication assisted treatment, medication not otherwise specified; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a medicare-enrolled opioid treatment program)	1/1/2020
G2076	Intake activities, including initial medical examination that is a complete, fully documented physical evaluation and initial assessment by a program physician or a primary care physician, or an authorized healthcare professional under the supervision of a program physician qualified personnel that includes preparation of a treatment plan that includes the patient's short-term goals and the tasks the patient must perform to complete the short-term goals; the patient's requirements for education, vocational rehabilitation, and employment; and the medical, psycho- social, economic, legal, or other supportive services that a patient needs, conducted by qualified personnel (provision of the services by a medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure	1/1/2020
G2077	Periodic assessment; assessing periodically by qualified personnel to determine the most appropriate combination of services and treatment (provision of the services by a medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure	1/1/2020
G2078	Take-home supply of methadone; up to 7 additional day supply (provision of the services by a medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure	1/1/2020
G2079	Take-home supply of buprenorphine (oral); up to 7 additional day supply (provision of the services by a medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure	1/1/2020

HCPCS Code	Long Descriptor	Effective Date
G2080	Each additional 30 minutes of counseling in a week of medication assisted treatment, (provision of the services by a medicare-enrolled opioid treatment program); list separately in addition to code for primary procedure	1/1/2020
G2215	Take-home supply of nasal naloxone (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to code for primary procedure	01/01/2021
G2216	Take-home supply of injectable naloxone (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to code for primary procedure	01/01/2021

Table 14. – Change to the Status Indicator for HCPCS code P9099 Effective January 1, 2021

HCPCS Code	Short Descriptor	Long Descriptor	Old 2020 APC	Old 2020 SI	New 2021 SI	New 2021 APC
P9099	Blood component/product noc	Blood component or product not otherwise classified	N/A	E2	R	9537

Table 15. ─ New CY 2021 HCPCS Codes Effective January 1, 2021 for Certain Drugs, Biologicals, and Radiopharmaceuticals Receiving Pass-Through Status

CY 2021 HCPCS Code	CY 2021 Long Descriptor	CY 2021 SI	CY 2021 APC
C9068	Copper Cu-64, dotatate, diagnostic, 1 millicurie	G	9383
C9069	Injection, belantamab mafodontin-blmf, 0.5 mg	G	9384
C9070	Injection, tafasitamab-cxix, 2 mg	G	9385
C9071	Injection, viltolarsen, 10 mg	G	9386
C9072	Injection, immune globulin (asceniv), 500 mg	G	9392
C9073	Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	G	9391

CY 2021 HCPCS Code	CY 2021 Long Descriptor	CY 2021 SI	CY 2021 APC
J0693	Injection, cefiderocol, 5 mg	G	9380
J9223	Injection, lurbinectedin, 0.1 mg	G	9389
J9316	Injection, pertuzumab, trastuzumab, and hyaluronidase-zzxf, per 10 mg	G	9390

Table 16. — Existing HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals Receiving Pass-Through Status Effective January 1, 2021

CY 2021 HCPCS Code	CY 2021 Long Descriptor	October 2020 SI	January 2021 SI	CY 2021 APC
J1437	Injection, ferric derisomaltose, 10 mg	K	G	9388
J9198	Gemcitabine hydrochloride, (infugem), 100 mg	N	G	9387

Table 17. — HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals with Pass-Through Status Ending Effective December 31, 2020

CY 2021 HCPCS Code	CY 2021 Long Descriptor	October 2021 SI	January 2021 SI	January 2021 APC
J0567	Injection, cerliponase alfa, 1 mg	G	N	N/A
J0599	Injection, c-1 esterase inhibitor (human), (haegarda), 10 units	G	K	9015
J1628	Injection, guselkumab, 1 mg	G	K	9029
J3316	Injection, triptorelin, extended-release, 3.75 mg	G	K	9016
J7345	Aminolevulinic acid hcl for topical administration, 10% gel, 10 mg	G	K	9301
J9153	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine	G	K	9302
J9203	Injection, gemtuzumab ozogamicin, 0.1 mg	G	K	9495
J9229	Injection, inotuzumab ozogamicin, 0.1 mg	G	K	9028

Table 18. – Drugs and Biologicals that Will Retroactively Change from Non-Payable Status to Separately Payable Status from October 1, 2020 to December 31, 2020

HCPCS Code	Long Descriptor	Old SI	New SI	APC	Effective Date
J1437	Injection, ferric derisomaltose, 10 mg	E2	K	9388	10/01/2020

Table 19. – Newly Established HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals as of January 1, 2021

New HCPCS Code	Old HCPCS Code	Long Descriptor	SI	APC
90377	N/A	Rabies immune globulin, heat- and solvent/detergent-treated (RIg-HT S/D), human, for intramuscular and/or subcutaneous use	E2	N/A
A9591	C9060	Fluoroestradiol F 18, diagnostic, 1 millicurie	G	9370
C9068	N/A	Copper Cu-64, dotatate, diagnostic, 1 millicurie	G	9383
C9069	N/A	Injection, belantamab mafodontin-blmf, 0.5 mg	G	9384
C9070	N/A	Injection, tafasitamab-cxix, 2 mg	G	9385
C9071	N/A	Injection, viltolarsen, 10 mg	G	9386
C9072	N/A	Injection, immune globulin (asceniv), 500 mg	G	9392
C9073	N/A	Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	G	9391
J0693	N/A	Injection, cefiderocol, 5 mg	G	9380
J1823	N/A	Injection, inebilizumab-cdon, 1 mg	K	9394
J7212	N/A	Factor viia (antihemophilic factor, recombinant)-jncw (sevenfact), 1 microgram	K	9395
J7352	N/A	Afamelanotide implant, 1 mg	K	9396
J9144	C9062	Injection, daratumumab, 10 mg and hyaluronidase-fihj	G	9378
J9223	N/A	Injection, lurbinectedin, 0.1 mg	G	9389
J9281	C9064	Mitomycin pyelocalyceal instillation, 1 mg	G	9374
J9316	N/A	Injection, pertuzumab, trastuzumab, and hyaluronidase-zzxf, per 10 mg	G	9390
J9317	C9066	Injection, sacituzumab govitecan-hziy, 2.5 mg	G	9376
Q5122	N/A	Injection, pegfilgrastim-apgf, biosimilar, (nyvepria), 0.5 mg	E2	N/A

Table 20. ─ Restatement of the payment rate for HCPCS code A9600 (Strontium sr-89 chloride, therapeutic, per millicurie) for the period October 1, 2020 through December 31, 2020

HCPCS Code	Long Descriptor	Original Payment Rate	New Payment Rate	Effective Date
A9600	Strontium sr-89 chloride, therapeutic, per millicurie	$2,045.702	$3,975.000	10/01/2020 – 12/31/2020

Table 21. — Skin Substitute Assignments to High Cost and Low Cost Groups for CY 2021

CY 2021 HCPCS Code	CY 2021 Short Descriptor	CY 2020 High/Low Cost Assignment	Final CY 2021 High/Low Cost Assignment
C1849	Skin substitute, synthetic	High	High
C9363	Integra meshed bil wound mat	High	High*
Q4100	Skin substitute, nos	Low	Low
Q4101	Apligraf	High	High
Q4102	Oasis wound matrix	Low	Low
Q4103	Oasis burn matrix	High	High*
Q4104	Integra bmwd	High	High
Q4105	Integra drt or omnigraft	High	High
Q4106	Dermagraft	High	High
Q4107	Graftjacket	High	High
Q4108	Integra matrix	High	High*
Q4110	Primatrix	High	High*
Q4111	Gammagraft	Low	Low
Q4115	Alloskin	Low	Low
Q4116	Alloderm	High	High
Q4117	Hyalomatrix	Low	Low
Q4121	Theraskin	High	High*
Q4122	Dermacell, awm, porous sq cm	High	High
Q4123	Alloskin	High	High
Q4124	Oasis tri-layer wound matrix	Low	Low
Q4126	Memoderm/derma/tranz/integup	High	High
Q4127	Talymed	High	High*
Q4128	Flexhd/allopatchhd/matrixhd	High	High
Q4132	Grafix core, grafixpl core	High	High
Q4133	Grafix stravix prime pl sqcm	High	High
Q4134	Hmatrix	Low	Low

CY 2021 HCPCS Code	CY 2021 Short Descriptor	CY 2020 High/Low Cost Assignment	Final CY 2021 High/Low Cost Assignment
Q4135	Mediskin	Low	Low
Q4136	Ezderm	Low	Low
Q4137	Amnioexcel biodexcel, 1 sq cm	High	High
Q4138	Biodfence dryflex, 1cm	High	High
Q4140	Biodfence 1cm	High	High
Q4141	Alloskin ac, 1cm	High	High*
Q4143	Repriza, 1cm	High	High
Q4146	Tensix, 1cm	High	High
Q4147	Architect ecm px fx 1 sq cm	High	High
Q4148	Neox neox rt or clarix cord	High	High
Q4150	Allowrap ds or dry 1 sq cm	High	High
Q4151	Amnioband, guardian 1 sq cm	High	High
Q4152	Dermapure 1 square cm	High	High
Q4153	Dermavest, plurivest sq cm	High	High
Q4154	Biovance 1 square cm	High	High
Q4156	Neox 100 or clarix 100	High	High
Q4157	Revitalon 1 square cm	High	High*
Q4158	Kerecis omega3, per sq cm	High	High*
Q4159	Affinity 1 square cm	High	High
Q4160	Nushield 1 square cm	High	High
Q4161	Bio-connekt per square cm	High	High
Q4163	Woundex, bioskin, per sq cm	High	High
Q4164	Helicoll, per square cm	High	High
Q4165	Keramatrix, kerasorb sq cm	Low	Low
Q4166	Cytal, per square centimeter	Low	Low
Q4167	Truskin, per square centimeter	Low	High
Q4169	Artacent wound, per sq cm	High	High
Q4170	Cygnus, per sq cm	Low	Low
Q4173	Palingen or palingen xplus	High	High
Q4175	Miroderm	High	High
Q4176	Neopatch, per sq centimeter	High	High
Q4178	Floweramniopatch, per sq cm	High	High
Q4179	Flowerderm, per sq cm	High	High
Q4180	Revita, per sq cm	High	High
Q4181	Amnio wound, per square cm	High	High
Q4182	Transcyte, per sq centimeter	Low	High
Q4183	Surgigraft, 1 sq cm	High	High
Q4184	Cellesta or duo per sq cm	High	High*
Q4186	Epifix 1 sq cm	High	High
Q4187	Epicord 1 sq cm	High	High
Q4188	Amnioarmor 1 sq cm	Low	High

CY 2021 HCPCS Code	CY 2021 Short Descriptor	CY 2020 High/Low Cost Assignment	Final CY 2021 High/Low Cost Assignment
Q4190	Artacent ac 1 sq cm	Low	High
Q4191	Restorigin 1 sq cm	Low	Low
Q4193	Coll-e-derm 1 sq cm	Low	High
Q4194	Novachor 1 sq cm	High	High*
Q4195	Puraply 1 sq cm	High	High
Q4196	Puraply am 1 sq cm	High	High
Q4197	Puraply xt 1 sq cm	High	High
Q4198	Genesis amnio membrane 1 sqcm	Low	High
Q4200	Skin te 1 sq cm	Low	High
Q4201	Matrion 1 sq cm	Low	Low
Q4203	Derma-gide, 1 sq cm	High	High*
Q4204	Xwrap 1 sq cm	Low	Low
Q4205	Membrane graft or wrap sq cm	High	High
Q4208	Novafix per sq cm	High	High
Q4209	Surgraft per sq cm	Low	High
Q4210	Axolotl graf dualgraf sq cm	Low	Low
Q4211	Amnion bio or axobio sq cm	Low	High
Q4214	Cellesta cord per sq cm	Low	Low
Q4216	Artacent cord per sq cm	Low	Low
Q4217	Woundfix biowound plus xplus	Low	Low
Q4218	Surgicord per sq cm	Low	Low
Q4219	Surgigraft dual per sq cm	Low	High
Q4220	Bellacell hd, surederm sq cm	Low	Low
Q4221	Amniowrap2 per sq cm	Low	Low
Q4222	Progenamatrix, per sq cm	Low	High
Q4226	Myown harv prep proc sq cm	High	High
Q4227	Amniocore per sq cm	Low	High
Q4228	Bionextpatch, per sq cm	Low	Low
Q4229	Cogenex amnio memb per sq cm	Low	Low
Q4232	Corplex, per sq cm	Low	High
Q4234	Xcellerate, per sq cm	High	High
Q4235	Amniorepair or altiply sq cm	Low	Low
Q4236	Carepatch per sq cm	Low	Low
Q4237	Cryo-cord, per sq cm	Low	High
Q4238	Derm-maxx, per sq cm	Low	High
Q4239	Amnio-maxx or lite per sq cm	Low	High
Q4247	Amniotext patch, per sq cm	Low	Low
Q4248	Dermacyte amn mem allo sq cm	Low	Low
Q4249	Amniply, per sq cm	Low	High

CY 2021 HCPCS Code	CY 2021 Short Descriptor	CY 2020 High/Low Cost Assignment	Final CY 2021 High/Low Cost Assignment
Q4250	AmnioAMP-MP per sq cm	Low	Low
Q4254	Novafix dl per sq cm	Low	Low
Q4255	Reguard, topical use per sq	Low	Low

* These products do not exceed either the proposed MUC or PDC threshold for CY 2021, but are assigned to the high cost group because they were assigned to the high cost group in CY 2020.