



# 2020 – 2024 CMS OPPTS (Outpatient Prospective Payment System) Reimbursement Changes

## **outpatient facility payments for nerve graft and Connector-Assisted Repair® procedures increased $\geq$ 20% in 2020 and has been sustained through 2024**

Medicare sets payment rates based on the costs of services provided. Prior to 2020, all nerve repairs (direct, conduits, or grafts) fell into the level 2 nerve repair Ambulatory Payment Classification (APC) 5432. In 2020 most direct repair procedures were moved to APC 5431, leading to a 21% rate increase for nerve repair with conduit or grafts (allograft and autograft) in the Hospital Outpatient setting. From 2020 through 2024 Hospital Outpatient payment rates were sustained at this level with an incremental 15% increase during those 4 years.

In 2020 the Ambulatory Surgery Center (ASC) allograft procedures (CPT 64912) received device intensive status allowing the payment rate to be set by CPT (vs. APC). This resulted in a rate increase of 78%. Conduit procedures (CPT 64910) maintained device intensive status with a 20% payment increase. In 2020 through 2024 allograft (CPT 64912) and conduit (CPT 64910) retained device intensive status and both CPT codes saw payment increases of 34% and 37% respectively during those 4 years.

## **outpatient facility payments for most direct repair procedures decreased approximately 60% in 2020 and has been sustained through 2024**

In 2020, select direct repair procedures (digital, sciatic, and brachial plexus) were moved to the lower paying APC 5431 and Outpatient Hospital and ASCs saw a respective 62% and 59% reduction in payment for these select direct repairs.

From 2021 to 2024, rates for direct digital and brachial plexus nerve repair saw a modest 5%-11% increase over those 3 years. In 2022, direct sciatic nerve repair received device intensive status with a larger payment increase but continues to trail payments for graft and conduit procedures.

## **coding procedures correctly is important in establishing appropriate payment**

Medicare sets payments based on costs of services provided for a procedure and proper coding ensures future payments can be properly adjusted to accurately reflect costs.

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