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Calendar Year 2025 Hospital Outpatient Prospective Payment System Proposed Rule

On July 10, 2024, Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2025 Hospital Outpatient Prospective Payment System (HOPPS) proposed rule. This rule provides for a 60-day comment period ending on September 9, 2024. The finalized changes are effective January 1st, 2025.

Conversion Factor Update

CMS proposes to increase the conversion factor by 2.6 percent bringing it up to $89.379 for CY 2025. This increase is based on the proposed hospital inpatient market basket percentage increase of 3.0 percent for inpatient services paid under the hospital inpatient prospective payment system (IPPS) reduced by a proposed productivity adjustment of 0.4 percentage point. CMS proposes further to adjust the conversion factor to ensure that any revisions made to the wage index and rural adjustment are made on a budget neutral basis. CMS proposes to calculate an overall budget neutrality factor of 1.0026 for wage index changes by comparing proposed total estimated payments from simulation model using the proposed FY 2025 IPPS wage indexes to those payments using the FY 2024 IPPS wage indexes, as adopted on a calendar year basis for the OPPS. CMS further proposes to calculate an additional budget neutrality factor of 0.9982 to account for the proposed policy to cap wage index reductions for hospitals at 5 percent on an annual basis. CMS proposes to maintain the current rural adjustment policy, and therefore proposes the budget neutrality factor for the rural adjustment to be 1.0000.

CMS proposes that hospitals that fail to meet the reporting requirements of the Hospital Outpatient Quality Reporting (OQR) Program would be subject to a further reduction of 2.0 percentage points. Hospitals that fail to meet the requirements would result in a proposed conversion factor for CY 2025 of $87.636.

CMS proposes to use CY 2023 claims data to set CY 2025 OPPS and ASC rates. CMS proposes to use the most recently available cost report data from the Healthcare Cost Report Information System (HCRIS).

Estimated Impact on Hospitals

CMS estimates that OPPS expenditures, including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case mix will be approximately $88.2 billion, which is approximately $5.2 billion higher than estimated CY 2024 OPPS expenditures.

PROPOSED AMBULATORY PAYMENT CLASSIFICATION GROUP POLICIES

Imaging Ambulatory Payment Classifications

CMS does not propose any new changes to the APC structure for imaging codes. The seven payment categories remain. However, CMS has moved codes within these payment categories which would cause changed pricing for 2025. CMS is making reassignments to the codes within the series to resolve and/or prevent any violations of the two times rule.

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Proposed CY 2025 Imaging APCs

APC	APC Group Title	SI	CY 2024 Relative Weight	CY 2025 Proposed Relative Weight	CY 2024 Payment Rate	CY 2025 Proposed Payment Rate
5521	Level 1 Imaging without Contrast	S*	0.9908	0.9797	$86.58	$87.56
5522	Level 2 Imaging without Contrast	S	1.1988	1.1893	$104.75	$106.30
5523	Level 3 Imaging without Contrast	S	2.6718	2.6887	$233.47	$240.31
5524	Level 4 Imaging without Contrast	S	6.0153	6.0959	$525.63	$544.85
5571	Level 1 Imaging with Contrast	S	2.0034	1.9664	$175.06	$175.75
5572	Level 2 Imaging with Contrast	S	4.1933	4.1819	$366.42	$373.77
5573	Level 3 Imaging with Contrast	S	8.7304	8.7159	$762.88	$779.02

*Procedure or Service, Not Discounted When Multiple; Paid under OPPS; separate APC payment.

Proposed APC Exceptions to the 2 Times Rule

CMS proposes exceptions to the 2-times rule based on the following criteria: resource homogeneity; clinical homogeneity; hospital outpatient setting utilization; frequency of service (volume); and opportunity for up-coding and code fragments. Table 13, found below, lists the 23 APCs that CMS proposes to exempt from the 2 times rule for 2025 based on CY 2023 available claims data. Of note to radiology, APC 5593 – Level 3 Nuclear Medicine and Related Services is proposed to be excepted for CY 2025.

Table 13: Proposed CY 2025 APC Exceptions to the 2 Times Rule

APC	APC Group Title
5012	Clinic Visits and Related Services
5053	Level 3 Skin Procedures
5071	Level 1 Excision/ Biopsy/ Incision and Drainage
5521	Level 1 Imaging without Contrast
5522	Level 2 Imaging without Contrast
5523	Level 3 Imaging without Contrast
5524	Level 4 Imaging without Contrast
5572	Level 2 Imaging with Contrast
5593	Level 3 Nuclear Medicine and Related Services
5611	Level 1 Therapeutic Radiation Treatment Preparation
5627	Level 7 Radiation Therapy
5691	Level 1 Drug Administration
5692	Level 2 Drug Administration
5721	Level 1 Diagnostic Tests and Related Services
5731	Level 1 Minor Procedures
5733	Level 3 Minor Procedures

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5734	Level 4 Minor Procedures
5741	Level 1 Electronic Analysis of Devices
5743	Level 3 Electronic Analysis of Devices
5791	Pulmonary Treatment
5811	Manipulation Therapy
5821	Level 1 Health and Behavior Services
5823	Level 3 Health and Behavior Services

Comprehensive APCs
CMS conducted their annual review of Comprehensive APCs and proposes no changes to the current number of 72 C-APCs. Table 2 in the proposed rule lists all C-APCs for CY 2025, all of which were established in past rules.

<u>Changes to New-Technology APCs</u>
Cardiac Positron Emission Tomography (PET)/Computed Tomography (CT) Studies
Effective January 1, 2020, CMS assigned three CPT codes (78431- 78433) describing services associated with cardiac PET/CT studies to New Technology APCs (APCs 1522, 1523, and 1523, respectively). For CY 2025, CMS proposes to use CY 2023 claims data to determine the rates. The proposed APC placements are detailed in Table 18 of the proposed rule.

CPT code 78431 had over 26,000 single frequency claims in CY 2023 with a geometric mean of approximately $2350, which falls within the cost band for the currently assigned APC 1522 (New Technology Level 22 with payment of $2250.50). CMS proposes for CPT 78431 to remain in its current APC for CY 2025.

CPT code 78432 had only 19 single frequency claims in CY 2023. This is below the 100 claims per year threshold, so CMS proposes to apply the universal low volume APC policy by using the highest rate of the geometric mean cost, arithmetic mean cost, or median cost based on up to 4 years of claims data. Using available claims data from CYs 2021 through 2023, CMS found that the arithmetic mean cost was the highest at $1923, which is an amount above the cost band for APC 1520 (New Technology Level 20 with payment of $1850.50) where this code is currently assigned. Therefore, CMS proposes to reassign CPT code 78432 to APC 1521 (New Technology Level 21 with payment of $1950.50) for CY 2025.

CPT code 78433 had over 1400 single frequency claims in CY 2023. The geometric mean was approximately $2010, which is an amount above the cost band for APC 1521 (New Technology Level 21 with payment of $1950.50) to which it is currently assigned. Therefore, CMS proposes to reassign code 78433 to APC 1522 (New Technology Level 22 with payment rate $2250.50).

Table 18: Final CY 2024 and Proposed CY 2025 OPPS New Technology APC and Payment Rates for Cardiac PET/CT CPT Codes 78431, 78432, and 78433

CPT Code	Long Descriptor	Final CY 2024 APC	Final CY 2024 Payment Rate	Proposed CY 2025 APC	Proposed CY 2025 Payment Rate
78431	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan	1522	$2250.50	1522	$2250.50
78432	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability);	1520	$1850.50	1521	$1950.50
78433	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability); with concurrently acquired computed tomography transmission scan	1521	$1950.50	1522	$2250.50

Brachytherapy

Universal Low Volume APC Policy for Clinical and Brachytherapy APCs

Beginning with the CY 2022 HOPPS final rule, CMS adopted and implemented a universal Low Volume APC policy for CY 2022 and subsequent calendar. This policy states when a clinical or brachytherapy APC has fewer than 100 single claims that can be used for ratesetting, under the low volume APC payment adjustment policy CMS determines the APC cost as the greatest of the

geometric mean cost, arithmetic mean cost, or median cost based on up to 4 years of claims data. For CY 2025, CMS proposes to designate six brachytherapy APCs as low volume APCs. Table 35 in the proposed rule lists the proposed low volume APCs using comprehensive (OPPS) ratesetting methodology for CY 2025.

Cost Statistics for Proposed Low Volume APCs Using Comprehensive (OPPS) Ratesetting Methodology for CY 2025

APC	APC Description	CY 2023 Claims Available for Rate Setting	Geometric Mean Cost without Low Volume APC Designation	Proposed Median Cost	Proposed Arithmetic Mean Cost	Proposed Geometric Mean Cost	Proposed CY 2025 APC Payment Rate
2632	Iodine I-125 sodium iodide	0	---*	$28.66	$203.41	$56.11	**$203.41**
2635	Brachytx, non-str, HA, P-103	13	$100.85	$34.04	$70.03	$59.18	**$70.03**
2636	Brachy linear, non-str, P-103	1	$3694.19	$22.17	$53.57	$32.24	**$53.57**
2642	Brachytx, stranded, C-131	90	$109.15	$86.65	$108.99	$88.76	**$108.99**
2645	Brachytx, non-str, gold- 198	86	$297.26	$276.81	$896.43	$265.45	**$896.43**
2647	Brachytx, NS, Non-HDRIr-192	2	$120.48	$303.00	$571.35	$229.20	**$571.35**

*For this proposed rule, there are no CY 2023 claims that contain the HCPCS code assigned to APC 2632 that are available for CY 2025 OPPS/ASC ratesetting.

CT Lung Cancer Screening

In the CY 2025 HOPPS Proposed Rule, CMS proposes to place 71271 (Low Dose CT for Lung Cancer Screening) in APC 5522 with payment rate of $106.30. In addition, CMS proposes to place G0296 (visit to determine lung LDCT eligibility) in APC 5822, with a payment rate of $90.09.

Medical Physics Dose Evaluation
CMS proposes to place 76145 (Medical Physics Dose Evaluation for Radiation Exposure That Exceeds Institutional Review Threshold, Including Report) in APC 5723 with payment rate $527.44 for CY2025.

Virtual Direct Supervision of Diagnostic Services Furnished to Hospital Outpatients
In the CY 2023 OPPS/ASC final rule with comment period, CMS extended the end date of the flexibility allowing for the virtual supervision. This allowed for the flexibility allowing for the flexibility of virtual supervision of outpatient diagnostic services through audio/video real-time communications technology from the end of the PHE to the end of the calendar year in which the PHE ends. In the CY 2024 OPPS/ASC final rule this was once again extended to December 31, 2024.

In the CY 2025 PFS proposed rule, CMS proposes to revise the definition of direct supervision at § 410.32(b)(3)(ii) to extend the availability of virtual direct supervision of therapeutic and diagnostic services under the PFS through December 31, 2025.

Desiring uniformity under the PFS and OPPS in how regulations are applied to similarly situated providers, CMS proposes to revise § 410.27(a)(1)(iv)(B)(*l*) and § 410.28(e)(2)(iii) to allow for the direct supervision of cardiac rehabilitation (CR), intensive cardiac rehabilitation (ICR), and pulmonary rehabilitation (PR) diagnostic services via audio-video real-time communications technology (excluding audio-only) through December 31, 2025.

OPPS Payment for Software as a Service
CMS proposes to maintain the APC placement for separately payable code 0625T used to describe atherosclerosis imaging-quantitative computer tomography (AI-QCT) services. CMS noted within the rule that the claims submitted for 0625T had inconsistent values for geometric mean, arithmetic mean, and median across recent calendar years, and that there were too few claims to confidently assess this service for APC reassignment. This code is proposed to remain in its current APC of 1511 (New Technology Level 11) with a payment rate of $950.50 for CY 2025.

CPT codes 0648T and 0649T describe quantitative magnetic resonance analysis used by services such as LiverMultiScan. CMS identified 71 claims for CPT code 0648T and 72 claims for 0649T from CY 2023 data, which falls below the 100-claim threshold for the universal low volume APC policy. CMS analyzed the combined available claims data from CYs 2021 through 2023 and found there were sufficient claims to capture the cost of the service. The arithmetic mean of $234 was estimated to be the highest cost, so CMS proposes to reassign code 0648T to APC 1504 (New Technology Level 4) with a payment rate of $250.50. Code 0649T is an add-on code that is assigned the same APC and status indicator as the standalone code 0648T in accordance with CMS's SaaS add-on codes policy (87 FR 72032 to 72033) and is proposed to be reassigned to APC 1504 for CY 2025.

CMS proposes to maintain the APC placement for CPT codes 0721T and 0722T that describe quantitative computed tomography tissue characterization used in products such as Optellum's lung cancer prediction (LCP) technology. There were only three claims submitted for these services in CY 2023, and they are the only available data to CMS for ratesetting. The claims showed a much lower cost than would be expected based on the current APC assignment, and CMS expressed concerns that the universal low volume APC policy calculations do not accurately capture the costs of this service. CMS proposes continuing the assignment of code 0721T to its current APC of 1508 (New Technology Level 8) with a payment rate of $650.50. Code 0722T is an add-on code that is assigned the same APC and status indicator as the standalone code 0721T in accordance with CMS's SaaS add-on codes policy (87 FR 72032 to 72033) and is proposed to be placed in APC 1508 for CY 2025.

CPT codes 0723T and 0724T for quantitative magnetic resonance cholangiopancreatography (QMRCP) services were found to have insufficient claims data. CMS identified only three claims for 0723T and none for 0724T during CY 2023. Due to being below the 100 claims threshold, CMS would usually apply the universal low volume APC policy but found that their analysis of available claims data does not accurately capture the cost of this service. Given CMS's proposal to maintain current New Technology APC assignments for CY 2025 for New Technology APC services with fewer than 10 claims in the 4- year lookback period applicable for the universal low-volume APC policy, CMS proposes to continue to assign CPT code 0723T to New Technology APC 1511 (New Technology Level 11) with a payment rate of $950.50. Code 0724T is an add-on code that is assigned the same APC and status indicator as the standalone code 0723T in accordance with CMS's SaaS add-on codes policy (87 FR 72032 to 72033) and is proposed to also be placed in APC 1511 for CY 2025.

Software as a Service (SaaS) CY 2025 Proposed APC Placements and Payment Rates

CPT Code	Long Descriptor	CY2024 APC	CY2024 Payment Rate	Proposed CY2025 APC	Proposed CY2025 Payment Rate
0625T	Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computer tomographic angiography; computerized analysis of data from coronary computed tomographic angiography	1511	$950.50	1511	$950.50
0648T	Quantitative magnetic resonance for analysis of tissue composition (e.g., fat, iron, water content), including multiparametric data acquisition, data	1511	$950.50	1504	$250.50

	preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the same anatomy (e.g., organ, gland, tissue, target structure) during the same session				
0649T	Quantitative magnetic resonance for analysis of tissue composition (e.g., fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the same anatomy (e.g., organ, gland, tissue, target structure) (List separately in addition to code for primary procedure)	1511	$950.50	1504	$250.50
0721T	Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging	1508	$650.50	1508	$650.50
0722T	Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained with concurrent CT examination of any structure contained in the concurrently acquired diagnostic imaging dataset (List separately in addition to code for primary procedure)	1508	$650.50	1508	$650.50
0723T	Quantitative magnetic resonance cholangiopancreatography (QMRCP) including data preparation and transmission, interpretation and report, obtained without diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (e.g., organ, gland, tissue, target structure) during the same session	1511	$950.50	1511	$950.50

0724T	Quantitative magnetic resonance cholangiopancreatography (QMRCP) including data preparation and transmission, interpretation and report, obtained with diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (e.g., organ, gland, tissue, target structure) (List separately in addition to code for primary procedure)	1511	$950.50	1511	$950.50

Payment for Non-Pass-Through Drugs, Biologicals, and Radiopharmaceuticals

Policy Packaged Drugs, Biologicals, and Radiopharmaceuticals
CMS currently pays for drugs, biologicals, and radiopharmaceuticals that do not have pass-through payment status in one of two ways: packaged into the payment for the associated service or separate payment (individual APCs). Hospitals do not receive a separate payment for packaged items and may not bill beneficiaries separately for any packaged items; these costs are recognized and paid within the OPPS payment rate for the associated procedure or service.

Payment Policy for Therapeutic Radiopharmaceuticals
For CY 2025, CMS proposes to continue paying for therapeutic radiopharmaceuticals at ASP+6 percent. For therapeutic radiopharmaceuticals for which ASP data are unavailable, CMS also proposes to determine 2025 payment rates based on 2023 geometric mean unit costs.

Separate Payment for Diagnostic Radiopharmaceuticals
CMS proposes to pay separately for diagnostic radiopharmaceuticals with per day costs above a threshold of $630, which is approximately two times the volume weighted average cost amount currently associated with diagnostic radiopharmaceuticals. CMS also proposes to update the $630 threshold in CY 2026 and subsequent years by the Producer Price Index (PPI) for Pharmaceutical Preparations. CMS proposes to pay separately for payable diagnostic radiopharmaceuticals based on their Mean Unit Cost (MUC) derived from OPPS claims and is seeking comments on the use of Average Sales Price (ASP) for payment in future years.

Requirements for the Hospital Outpatient Quality Reporting (OQR) Program

CMS proposes removing two imaging measures beginning with the CY 2025 reporting period/CY 2027 payment: *MRI Lumbar Spine for Low Back Pain* measure and *Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery* measure. CMS is also proposing a revision to the program's immediate measure removal policy, which applies when continued use of a measure raises patient safety concerns and results in an immediate measure suspension. In addition, CMS proposed to require that Electronic Health Record (EHR) technology be certified to

all eCQMs available to report in the Hospital OQR Program measure set to ensure that hospitals can accurately capture and report data for all eCQMs in the measure set.

Other HOPPS Payment Policies

Coverage Changes for Colorectal Cancer (CRC) Screening Services

CMS proposes to remove coverage for double contrast barium enema for colorectal cancer screening and add coverage for computed tomography colonography (CTC). CMS also proposes to expand the existing definition of a "complete colorectal cancer screening" to include a follow-on screening colonoscopy after a Medicare covered blood-based biomarker colorectal cancer screening test.

CMS proposes to assign CPT code 74263 (screening computed tomography colonography (CTC)/virtual colonoscopy a status indicator of "S" and to APC 5522 (Level 2 Imaging Without Contrast) to indicate that the code is separately payable. CMS believes the time and resources associated with performing a screening virtual colonoscopy is similar to a diagnostic virtual colonoscopy, which is described by CPT code 74261 (Computed tomographic (ct) colonography, diagnostic, including image postprocessing; without contrast material). The proposed APC assignment for CPT code 74263 is based on its clinical and resource homogeneity to CPT code 74261, which is assigned to APC 5522.

Payment Policy for Devices in Category B Investigational Device Exemption Clinical Trials and Drugs and Devices with a Medicare Coverage with Evidence Development (CED) Designation

In the CY 2023 OPPS final rule with comment period, CMS finalized a policy to make a single blended payment for devices and services in Category B Investigational Device Exemptions (IDE) studies in order to preserve the scientific validity of these studies by avoiding differences in Medicare payment methods that would otherwise reveal the group to which a patient had been assigned. CMS is now also proposing to extend their coding and payment policy to trials for drugs and devices that meet CAG's coverage and evidence development (CED) requirement, for which the trial includes a treatment and control arm.

Proposed Payment Adjustments to Cancer Hospitals

The ACA requires an adjustment to cancer hospitals' outpatient payments to bring each hospital's payment-to-cost ratio (PCR) up to the level of the PCR for all other hospitals, the target PCR. The changes in additional payments from year to year are budget neutral. The 21st Century Cures Act reduced the target PCR by 1.0 percentage point and excludes the reduction from OPPS budget neutrality. The cancer hospital adjustment is applied at cost report settlement rather than on a claim-by-claim basis.

For CY 2025, CMS proposes to transition from the target PCR of 0.89 used for CYs 2020 through 2023 and incrementally reduce the target PCR by an additional 1.0 percentage point for each calendar year, beginning with CY 2024, until the target PCR equals the PCR of non-cancer

hospitals (required by section 16002(b) of the 21st Century Cures Act). For CY 2025, CMS proposes a target PCR of 0.87 to determine the CY 2025 cancer hospital payment adjustment to be paid at cost report settlement.

Table 8: Estimated CY 2025 Hospital-Specific Payment Adjustment for Cancer Hospitals to be Provided at Cost Report Settlement

Provider Number	Hospital Name	Estimated % Increase in OPPS Payments for CY2025
050146	City of Hope Comprehensive Cancer Center	51.5%
050660	USC Norris Cancer Hospital	44.3%
100079	Sylvester Comprehensive Cancer Center	32.4%
100271	H. Lee Moffitt Cancer Center & Research Institute	23.9%
220162	Dana-Farber Cancer Institute	46.6%
330154	Memorial Sloan-Kettering Cancer Center	56.3%
330354	Roswell Park Cancer Institute	21.3%
360242	James Cancer Hospital & Solove Research Institute	16.0%
390196	Fox Chase Cancer Center	30.0%
450076	M.D. Anderson Cancer Center	45.1%
500138	Seattle Cancer Care Alliance	47.7%

Provisions Related to Medicaid and the Children's Health Insurance Program (CHIP)

Continuous eligibility (CE) provides important health coverage protections for low-income children who are eligible for Medicaid or CHIP. CMS proposes to update the Medicaid and CHIP regulations to conform to the Consolidated Appropriations Act (CAA, 2023) which added a new paragraph (K) to section 2107(e)(1) to make the previously optional continuous eligibility policy a requirement under the state plan or a waiver of the state plan for children enrolled in Medicaid and CHIP. CMS proposes to require 12-months of continuous eligibility for children under the age of 19 enrolled in Medicaid and CHIP. Additionally, CMS proposes to remove the previous options of applying continuous eligibility to a subgroup of enrollees or limiting continuing eligibility to a time period of less than 12 months. CMS also proposes to remove failure to pay premiums as one of the optional exceptions to continuous eligibility for CHIP beneficiaries.

The ACR's HOPPS Committee and staff will review these changes and will draft comments during the 60-day comment period. Comments are due to CMS by September 9, 2024.

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