American College of Radiology™

Calendar Year 2026 Hospital Outpatient Prospective Payment System Proposed Rule
ACR Detailed Summary

On July 15, 2025, Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2026 Hospital Outpatient Prospective Payment System (HOPPS) proposed rule. This rule provides for a 60-day comment period ending on September 15, 2025. The finalized changes are effective January 1st, 2026.

Proposed Conversion Factor Update – pg. 85
CMS proposes to increase the conversion factor by 2.4 percent bringing it up to $91.747 for CY 2026. This increase is based on the proposed hospital inpatient market basket percentage increase of 3.2 percent for inpatient services paid under the hospital inpatient prospective payment system (IPPS) reduced by a proposed productivity adjustment of 0.8 percentage point. CMS proposes to further 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 1.0116 for wage index changes. CMS further proposes to calculate an additional budget neutrality factor of 0.9955 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 2026 of $89.958.

CMS proposes to use CY 2024 claims data to set CY 2026 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 – pg. 839
CMS estimates that OPPS expenditures, including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case mix will be approximately $100.0 billion, which is approximately $8.1 billion higher than estimated CY 2025 OPPS expenditures.

Proposed Ambulatory Payment Classification (APC) Group Policies – pg. 35
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 2026. CMS is making reassignments to the codes within the series to resolve and/or prevent any violations of the two-times rule.

Proposed CY 2026 Imaging APCs

APC	APC Group Title	SI	CY 2025 Relative Weight	CY 2026 Proposed Relative Weight	CY 2025 Payment Rate	CY 2026 Proposed Payment Rate
5521	Level 1 Imaging without Contrast	S*	0.9874	0.9743	$88.05	$89.39
5522	Level 2 Imaging without Contrast	S	1.1926	1.1707	$106.34	$107.41
5523	Level 3 Imaging without Contrast	S	2.7108	2.6872	$241.72	$245.72
5524	Level 4 Imaging without Contrast	S	6.1490	6.1263	$548.30	$562.07
5571	Level 1 Imaging with Contrast	S	1.9964	1.9590	$178.02	$179.73
5572	Level 2 Imaging with Contrast	S	4.0051	3.9058	$357.13	$358.35
5573	Level 3 Imaging with Contrast	S	8.8602	8.7456	$790.06	$802.38

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

Comprehensive APCs – pg. 45

CMS conducted an annual review and proposes no changes in this rule to the current number of 72 C-APCs. Table 2 lists all C-APCs for CY2026, all of which were established in past rules.

Proposed APC Placements for Imaging Services

CT Lung Cancer Screening

CMS proposes to place CPT code 71271 for low dose CT lung cancer screening in APC 5522 with payment rate of $107.41. The proposed placement for code G0296 (visit to determine lung LDCT eligibility) is APC 5822, with a payment rate of $107.63.

Medical Physics Dose Evaluation

CMS proposes to place 76145 for medical physics dose evaluation for radiation exposure that exceeds institutional review threshold (including reports) in APC 5723 with payment rate $381.96 for CY2026.

Medical 3D Printing Services

CMS proposes to place code C8001 (3d anatomical segmentation imaging for preoperative planning, data preparation and transmission, obtained from previous diagnostic computed tomographic or magnetic resonance examination of the same anatomy) into APC 5721 with payment rate of $132.89 for CY 2026.

CMS proposes to place code 0559T (Anatomic model 3D printed from image data set(s): first individually prepared and processed component of an anatomic structure) into APC 5733 with Q1 status indicator and payment rate of $60.59. Code 0561T (Anatomic guide 3D

printed from image data set(s): first anatomic guide) is proposed to be placed into APC 5733 with Q1 status indicator and payment rate of $60.59.

Colorectal Cancer (CRC) Screening Services
CMS proposes to assign CPT code 74263 for screening CT colonography (CTC)/virtual colonoscopy a status indicator of "S" and APC 5523 (Level 3 Imaging Without Contrast) with a payment rate of $245.72.

Proposed Payment Adjustments to Cancer Hospitals – pg. 104
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.

Table 7 shows the estimated percentage increase in OPPS payments to each cancer hospital for CY 2026, due to the cancer hospital payment adjustment policy.

Table 7: Estimated CY 2026 Hospital-Specific Payment Adjustment for Cancer Hospitals to be Provided at Cost Report Settlement

Provider Number	Hospital Name	Estimated % Increase in OPPS Payments for CY2026 due to payment adjustment
050146	City of Hope Comprehensive Cancer Center	36.9%
050660	USC Norris Cancer Hospital	36.3%
100079	Sylvester Comprehensive Cancer Center	30.9%
100271	H. Lee Moffitt Cancer Center & Research Institute	16.6%
220162	Dana-Farber Cancer Institute	46.4%
330154	Memorial Sloan-Kettering Cancer Center	51.6%
330354	Roswell Park Cancer Institute	11.9%
360242	James Cancer Hospital & Solove Research Institute	20.9%
390196	Fox Chase Cancer Center	18.2%
450076	M.D. Anderson Cancer Center	48.5%
500138	Seattle Cancer Care Alliance	49.4%

Proposed APC Exceptions to the 2 Times Rule – pg. 146

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 12, found below, lists the 26 APCs that CMS proposes to exempt from the 2 times rule for 2026 based on CY 2024 available claims data.

Table 12: Proposed CY 2026 APC Exceptions to the 2 Times Rule

APC	APC Group Title
5012	Clinic Visits and Related Services
5054	Level 4 Skin Procedures
5071	Level 1 Excision/ Biopsy/ Incision and Drainage
5301	Level 1 Upper GI Procedures
5502	Level 2 Extraocular, Repair, and Plastic Eye Procedures
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
5611	Level 1 Therapeutic Radiation Treatment Preparation
5612	Level 2 Therapeutic Radiation Treatment Preparation
5613	Level 3 Therapeutic Radiation Treatment Preparation
5627	Level 7 Radiation Therapy
5671	Level 1 Pathology
5674	Level 2 Pathology
5691	Level 1 Drug Administration
5692	Level 2 Drug Administration
5724	Level 4 Diagnostic Tests and Related Services
5731	Level 1 Minor Procedures
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
5822	Level 2 Health and Behavior Services
5823	Level 3 Health and Behavior Services

Changes to New-Technology APCs

Cardiac Positron Emission Tomography (PET)/Computed Tomography (CT) Studies – pg. 163

For CY 2026, the OPPS payment rates for the service described by CPT codes 78431, 78432, and 78433 are proposed to be based on available CY 2024 claims data.

CPT code 78431 had over 30,000 single frequency claims in CY 2024 with a geometric mean of approximately $2200, which falls within the cost band for the currently assigned APC 1522 (New Technology Level 22 with payment of $2250.50). Therefore, CMS proposes to continue to assign CPT 78431 its current APC for CY 2026.

CPT code 78432 had only 31 single frequency claims in CY 2024. 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 $1737, which is an amount below 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 1519 (New Technology Level 19 with payment of $1750.50) for CY 2026.

CPT code 78433 had over 1400 single frequency claims in CY 2024. The geometric mean was approximately $2037, 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) for CY 2026.

CMS notes in the rule that, over the past several years, the claims volumes for CPT codes 78431 and 78433 have increased significantly while the geometric mean costs of the codes have remained relatively stable. However, CPT code 78432, which is closely related to CPT codes 78431 and 78433, continues to have low claims frequency and fluctuating geometric mean costs. Due to CMS's concerns regarding CPT code 78432 and the lack of an appropriate clinical APC for CPT codes 78431 and 78433 at this time based on resource cost similarity, CMS proposes to continue to assign CPT codes 78431 through 78433 to New Technology APCs for CY 2026. The proposed APC placements are detailed in Table 17 of the proposed rule.

Table 17: Final CY 2025 and Proposed CY 2026 OPPS New Technology APC and Payment Rates for Cardiac PET/CT CPT Codes 78431, 78432, and 78433

CPT Code	Long Descriptor	Final CY 2025 APC	Final CY 2025 Payment Rate	Proposed CY 2026 APC	Proposed CY 2026 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	1519	$1750.50
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 – pg. 205

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 2026, CMS proposes to designate six brachytherapy APCs as low volume APCs as well as five clinical APCs. Table 39 in the proposed rule lists the proposed low volume APCs using comprehensive (OPPS) ratesetting methodology for CY 2026.

Proposed Low Volume Brachytherapy APCs for CY 2026

APC	APC Description	CY 2024 Claims Available for Rate Setting	Proposed CY 2026 APC Payment Rate
2632	Iodine I-125 sodium iodide	1	**$401.24**
2635	Brachytx, non-str, HA, P-103	9	**$107.78**
2636	Brachy linear, non-str, P-103	0	**$88.71**
2642	Brachytx, stranded, C-131	49	**$117.92**
2643	Brachytx, non-stranded, c-131	88	**$100.07**
2647	Brachytx, NS, Non-HDRIr-192	3	**$901.63**

*For this proposed rule, there are no CY 2024 claims that contain the HCPCS code assigned to APC 2636 that are available for CY 2026 OPPS/ASC ratesetting.

OPPS Payment for Software as a Service

Atherosclerosis Imaging-Quantitative Computer Tomography (AI-QCT) – pg. 167

Atherosclerosis Imaging-Quantitative Computer Tomography (AI-QCT) is a Software as a Service (SaaS) that assesses the extent of coronary artery disease severity. The AMA CPT Editorial Panel is creating a new Category I CPT code for AI-QCT, which is currently described by CPT placeholder code 75XX6. Since CPT placeholder code 75XX6 will not be effective until January 1, 2026, CMS will not have claims data available for ratesetting for this code until the CY 2028 rulemaking cycle. However, as CPT code 0625T will still be in use until December 31, 2025, CMS proposes to determine the payment rate for CPT placeholder code 75XX6 using the available CY 2024 claims data for CPT code 0625T.

For CY 2024, the geometric mean cost of around $496 based on 22 claims may better reflect the cost of the procedure described by CPT code 0625T, but there are not enough claims to be confident about the result. Due to these issues, CMS is not confident that the results of the 4-year lookback period accurately reflect the actual costs of CPT code 0625T. Therefore, CMS proposes to use their authority under section 1833(t)(2)(E) to assign CPT placeholder code 75XX6 to APC 1511 (New Technology - Level 11) with a payment rate of $950.50 for CY 2026, which based on the information currently available, best reflects the cost of the service as described by the New Technology APC application.

Quantitative Magnetic Resonance for Analysis of Tissue Composition – pg. 179

LiverMultiScan is a SaaS that is intended to aid the diagnosis and management of chronic liver disease, the most prevalent of which is Non-alcoholic Fatty Liver Disease (NAFLD). CMS identified 107 claims for code 0648T and 104 claims for 0649T for CY2024. The geometric mean cost for CPT code 0648T is $253.68 and is $162.96 for CPT code 0649T. Based on the geometric mean cost for CPT code 0648T, CMS would assign CPT codes 0648T and 0649T to APC 1504 (New Technology – Level 4) with a payment rate of $250.50. However, assigning these SaaS services based on the geometric costs would significantly impact the payment by decreasing the payment rate by around 75 percent.

CMS states in the rule that they recognize that software-based technologies, like those described by CPT codes 0648T and 0649T, continue to evolve and that the limited claims data that we have may not truly represent the cost of this service. Therefore, CMS proposes to use their authority under section 1833(t)(2)(E) for CY 2026 to continue to assign CPT codes 0648T and 0649T to APC 1511 (New Technology—Level 11) with a payment rate of $950.50 which we believe best reflects the cost of the service at this time, based on information provided by the applicant.

Lung Cancer Prediction (LCP) – pg. 181
CPT codes 0721T and 0722T describe quantitative computed tomography tissue characterization, used in products such as Optellum's lung cancer prediction (LCP) technology,

There were 496 combined claims for CPT codes 0721T and 0722T for CY 2024: only 7 claims for CPT code 0721T and 489 claims for 0722T. The geometric mean cost of CPT code 0721T is $30.24 and the geometric mean cost for CPT code 0722T is $60.47. Based on the geometric mean cost for CPT code 0722T, which has a significantly greater number of claims than 0721T, CMS would assign both codes to APC 1502 (New Technology – Level 2 with a payment rate of $75.50. However, assigning these SaaS services based on the geometric costs would significantly impact the payment by decreasing the payment rate by close to 90 percent in 1 year.

Therefore, CMS proposes to use their authority under section 1833(t)(2)(E) for CY 2026 to continue to assign CPT codes 0721T and 0722T to APC 1508 (New Technology - Level 8) with a payment rate of $650.50 based on the information provided to us by the manufacturer in their application, which CMS believes may better reflect the cost of the service at this time than the available claims data.

Quantitative Magnetic Resonance (QMR) for Analysis of Tissue Composition – pg. 184
CPT codes 0697T and 0698T are for services such as CoverScan, a medical image management and processing software package that analyzes MR data and provides quantified metrics of multiple organs such as the heart, lungs, liver, spleen, pancreas, and kidney. For CY 2026, CMS identified 55 single frequency claims for 0698T and no claims for 0697T in CY 2024. Because the SaaS standalone and add-on services are identical, CMS used available data from the add-on code for ratesetting.

As the 55 single frequency claims for 0698T are below the threshold of 100 claims for a service within a year, CMS would usually apply the universal low volume APC policy. This would have yielded a geometric median cost of approximately $777. CMS would propose to assign CPT codes 0697T and 0698T to APC 1509 (New Technology – Level 9) with a payment of $750.50. But, because CMS continues to have the same concerns about payment variability and the possible effects the payment may have on patient access to these SaaS services, CMS proposes to use their authority under section 1833(t)(2)(E) for CY 2026 to continue to assign CPT codes 0697T and 0698T to APC 1511 (New Technology—Level 11) with a payment of $950.50 which they believe best reflects the cost of the service at this time.

Quantitative Magnetic Resonance Cholangiopancreatography (QMRCP) – pg.187
CPT codes 0723T and 0724T describe quantitative magnetic resonance cholangiopancreatography (QMRCP) services that performs quantitative assessment of the biliary tree and gallbladder. For CY 2026, the OPPS payment rates are proposed to be based on available CY 2024 claims data. There are only four new claims for HCPCS code 0724T and no claims for CPT code 0723T. Given CMS's proposal to maintain current New Technology APC assignments for CY 2026 for New Technology APC services with fewer than 10 claims in the 4-year lookback period due to an exception from the universal low-volume APC policy, CMS proposes to continue to assign CPT codes 0723T and 0724T to APC 1511 (New Technology—Level 11), with a payment rate of $950.50 for CY 2026.

Fractional Flow Reserve Derived From Computed Tomography (FFRct) – pg. 211
Fractional Flow Reserve Derived from Computed Tomography (FFRCT), also known by the trade name HeartFlow®, is a noninvasive diagnostic service that allows physicians to measure coronary artery disease in a patient through the use of coronary CT scans. CPT code 75580 is used to report this service.

While CMS identified 17,813 single frequency claims that were used to calculate the geometric mean cost of $278.51 in CY 2024, CMS believes that the geometric mean cost may have been impacted by an outdated automated return-to-provider (RTP) Healthcare Common Procedure Coding System-to-revenue code edit that occurred when the Category I CPT code became effective. The edit prevented providers from reporting the cardiology revenue code (0480), which maps to the cardiology cost center (03140), when billing CPT code 75580. Although the edit was removed, and providers were notified to resubmit any incorrectly returned claims, CMS believes that the outdated edit may have impacted the geometric mean for CPT code 75580.

Therefore, CMS proposes to use their authority under section 1833(t)(2)(E) to continue to assign CPT code 75580 to APC 5724 (Level 4 Diagnostic Tests and Related Services) with a payment amount of approximately $1,000 which we believe best reflects the cost of the service at this time.

The following table lists the Software as a Service (SaaS) final CY 2025 APCs and proposed CY 2026 APCs with their corresponding payment rates.

Software as a Service (SaaS) CY 2026 Proposed APC Placements and Payment Rates

CPT Code	Long Descriptor	CY2025 APC	CY2025 Payment Rate	Proposed CY2026 APC	Proposed CY2026 Payment Rate
75XX6	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 – New Tech Level 11	$950.50	1511 – New Tech Level 11	$950.50
0648T	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 without diagnostic MRI examination of the same anatomy (e.g., organ, gland, tissue, target structure) during the same session	1511 – New Tech Level 11	$950.50	1511 – New Tech Level 11	$950.50
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 – New Tech Level 11	$950.50	1511 – New Tech Level 11	$950.50
0697T	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission,	1511 – New Tech Level 11	$950.50	1511 – New Tech Level 11	$950.50

	interpretation and report, obtained without diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure) during the same session; multiple organs				
0698T	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure); multiple organs (List separately in addition to code for primary procedure)	1511 – New Tech Level 11	$950.50	1511 – New Tech Level 11	$950.50
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 – New Tech Level 8	$650.50	1508 – New Tech Level 8	$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 – New Tech Level 8	$650.50	1508 – New Tech Level 8	$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 – New Tech Level 11	$950.50	1511 – New Tech Level 11	$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 – New Tech Level 11	$950.50	1511 – New Tech Level 11	$950.50
0865T	Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study(ies), including lesion identification, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the brain during the same session	5523 – Level 3 Imaging without contrast	$241.72	5523 – Level 3 Imaging without contrast	$245.72
0866T	Quantitative magnetic resonance image (MRI) analysis of the brain with comparison to prior magnetic resonance (MR) study(ies), including lesion detection, characterization, and quantification, with brain volume(s) quantification and/or severity score, when performed, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the brain (List separately in addition to code for primary procedure)	5523 – Level 3 Imaging without contrast	$241.72	5523 – Level 3 Imaging without contrast	$245.72
0944T	3D contour simulation of target liver lesion(s) and margin(s) for image-guided percutaneous microwave ablation	5523 – Level 3 Imaging	$241.72	5523 – Level 3 Imaging	$245.72

		without contrast		without contrast	
75580	Noninvasive estimate of coronary fractional flow reserve (FFR) derived from augmentative software analysis of the data set from a coronary computed tomography angiography, with interpretation and report by a physician or other qualified health care professional	5724 – Level 4 Diagnostic Tests & Related Services	$1,017.39	5724 – Level 4 Diagnostic Tests & Related Services	$879.34

Comment Solicitation on Payment Policy for Software as a Service (SaaS) - pg. 213
Prior to CY 2018, SaaS procedures were considered supportive or ancillary services, and therefore, payment for the SaaS was packaged into the payment for the underlying clinical service. In recent years, CMS has paid separately for SaaS procedures under the OPPS through New Technology APCs and various clinical APCs based on clinical and resource similarity to existing services, including Imaging APCs and Diagnostic Tests and Related Services APCs.

CMS currently does not have a payment methodology specifically for SaaS, and as these technologies have continued to evolve and diversify, some interested parties have stated that the lack of a consistent payment policy for SaaS can be an impediment to patient access when these services are otherwise approved by the FDA.

CMS welcomes public comment as they consider how to appropriately pay for these services, how CMS can determine that Medicare payments for SaaS truly reflect the value of the technologies to medical practice, and how to ensure that any payment policies on this topic demonstrate fiscal responsibility and good stewardship by promoting high-value, cost-effective care.

While there has been a rapid increase in the development and coding of these services in recent years, there is a very limited amount of Medicare claims data for these services. Given these issues and CMS's interest in developing payment policies that seek to reflect the underlying value of a service or technology to the practice of medicine, CMS is requesting public comment on future SaaS payment ideas, including:

- What factors could Medicare consider when setting payment rates for SaaS?
- What APCs, existing or new, should we use to pay for SaaS?
- How should we assess the costs of SaaS, and how can we account for hospital acquisition costs?

- What cost or claims data should be used to establish the payment rates for the services?
- Why are the geometric mean costs, as provided in our claims data, for SaaS currently assigned to APCs (both clinical and New Technology APCs) consistently lower than the manufacturers' purported costs of the technologies?
- Is there an alternative data source outside of the limited Medicare claims data currently available and hospital invoices provided by manufacturers, which may not fully depict total hospital acquisition costs, that can accurately reflect the costs of the SaaS?
  What kinds of efficiencies, if any, would SaaS provide for services performed in hospital outpatient departments and ambulatory surgical centers?
- In the context of setting Medicare payment rates, how can CMS best reflect the quality and efficacy of SaaS technologies?

Payment for Radiation Therapy Services Furnished at Nonexcepted Off-Campus PBDs – pg. 216

The PFS Relativity Adjuster is not applied to radiation therapy services (radiation treatment delivery and related imaging guidance services) furnished by nonexcepted off-campus PBDs. As discussed in the CY 2026 Physician Fee Schedule (PFS) proposed rule, CMS proposes to delete radiation therapy G-codes (G6001 – G6017) that describe imaging guidance for radiation treatment (G6001, G6002, G6017) and radiation treatment delivery (G6003-G6015) because CPT codes 77402, 77407, and 77412 have been revised and may be used to report these services instead. Table 44 in the rule lists the long descriptors of the G codes that will be deleted effective January 1, 2026, and Table 45 lists the current and revised long descriptors for CPT codes 77402, 77407, and 77412.

If finalized as proposed, the G-codes that nonexcepted off-campus PBDs currently use to report radiation therapy services will no longer be available after December 31, 2025. To continue paying the PFS-equivalent rate for these services to these departments, CMS proposes that, effective January 1, 2026, nonexcepted off-campus PBDs use the revised CPT codes described in the 2026 PFS proposed rule.

<u>Payment for Non-Pass-Through Drugs, Biologicals, and Radiopharmaceuticals</u>

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 – pg. 347
For CY 2026, 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 2026 payment rates based on 2024 geometric mean unit costs.

Separate Payment for Diagnostic Radiopharmaceuticals – pg. 348
In the CY 2025 HOPPS final rule, CMS finalized a policy to pay separately for any diagnostic radiopharmaceutical with a per day cost greater than $630 for 2025. Those at or below this threshold will remain policy packaged.

For CY 2026, CMS proposes to continue this policy finalized in CY 2025. CMS proposes to update the CY 2025 $630 threshold amount by the four-quarter moving average PPI levels for Pharmaceuticals for Human Use, Prescription to trend the $630 threshold forward.

CMS proposes for CY 2026 to continue with the current policy to pay qualifying diagnostic radiopharmaceuticals with per day costs above the diagnostic radiopharmaceutical packaging threshold, based on their arithmetic mean unit cost (MUC), which would be derived from calendar year 2024 claims data. CMS continues to encourage manufacturers to submit average sales price (ASP) information for diagnostic radiopharmaceuticals, if possible.

Services That Will Be Paid Only as Inpatient Services
Current Methodology for Identifying Appropriate Changes to the IPO List – pg. 452
Currently, there are 1,731 services on the IPO list. Under CMS's longstanding policy and current regulations, the IPO list is annually reviewed to identify any services that should be added to, or removed from, the list based on the most recent data and medical evidence available.

The criteria for assessing procedures for removal from the IPO list are:

- Most outpatient departments are equipped to provide the service or procedure to the Medicare population.
- The simplest service or procedure described by the code may be performed in most outpatient departments.
- The service or procedure is related to codes that CMS has already removed from the Inpatient Only list.
- CMS determines that the service or procedure is being performed in numerous hospitals on an outpatient basis.
- CMS determines that the service or procedure can be appropriately and safely performed in an ambulatory surgical center, and is specified as a covered

ambulatory surgical procedure, or CMS has proposed to specify it as a covered ambulatory surgical procedure.

CY 2026 Proposal to Eliminate the IPO List – pg. 453
For CY 2026 and subsequent years, CMS proposes to eliminate the IPO list through a 3-year transition, completing the elimination by January 1, 2029. While CMS agreed with commenters in previous rulemakings that the IPO list was necessary, and that it would be inappropriate for us to establish payment rates for those services under the OPPS (78 FR 75055, 86 FR 63673), CMS has reconsidered the various comments from interested parties requesting that they eliminate the IPO list, and reevaluated the need for CMS to restrict payment for certain procedures in the hospital outpatient setting.

As a result of that reconsideration, CMS no longer believes there is a need for the IPO list to identify services that require inpatient care. CMS states that the physician should use clinical knowledge and judgment, together with consideration of the beneficiary's specific needs, to determine whether a procedure can be performed appropriately in a hospital outpatient setting. CMS proposes to eliminate the current IPO list of 1,731 services, starting with the 285 mostly musculoskeletal-related services as provided in Table 69 of the proposed rule.

<u>Impact of Unnecessary Increases in Volume on the OPPS</u>
Utilization of Drug Administration Services– pg. 491
CMS is concerned about unnecessary increases in the volume of drug administration services being tied to the health and sustainability of the OPPS. For CY 2026 CMS proposes to use their authority under section 1833(t)(2)(F) of the Act to apply an amount equal to the site-specific PFS payment rate for nonexcepted items and services furnished by a non-excepted off-campus PBD (the PFS payment rate) for any HPCPCs codes assigned to the drug administration services APCs, 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). Table 71 shows the specific APCs that we would identify for this proposal, which are APCs 5691-5694.

Method to Control Unnecessary Increases in the Volume of Outpatient Services Furnished in Excepted Off-Campus Provider-Based Departments (PBDs) – pg. 496
While CMS is refining their method to control for unnecessary increases in the volume of hospital outpatient department services, CMS continues to recognize the importance of not impeding development or beneficiary access to new innovations.

CMS is soliciting public comments on other ways to exercise the Secretary's statutory authority under section 1833(t)(2)(F) of the Act:

- Are there other services for which CMS should develop a method to control unnecessary increases in the volume of covered OPD services by paying a PFS-equivalent rate for services provided at excepted off-campus PBDs?
- Of particular concern are the services within the imaging without contrast APCs (APCs 5521-5524). Imaging without contrast services are some the most costly and frequently provided services at excepted PBDs.
- CMS believes that there is a high likelihood that there has been unnecessary growth in this space and that a volume control method would be appropriate to apply here in the future. Would it be appropriate to apply this method to the Imaging Without Contrast APCs?

Request for Information on Adjusting Payment under the OPPS for Services Predominately Performed in the Ambulatory Surgical Center or Physician Office Settings – pg. 503

CMS is requesting information for future rulemaking on the development of a systematic process for identifying ambulatory services at high risk of shifting to the hospital setting based on financial incentives rather than medical necessity and adjusting payments according.

While CMS has implemented site-neutral policies to pay for certain hospital outpatient clinic visits at a rate closer to that under the PFS and propose to expand this policy to drug administration services, CMS is seeking feedback for future rulemaking on the development of a more systematic process for identifying ambulatory services at high risk of shifting to the hospital setting based on financial incentives rather than medical necessity and adjusting payments according.

Specifically, CMS is seeking feedback on the following questions:

- What items and services paid under the OPPS may have experienced unnecessary increases in volume? Should any policies that address those increases be more targeted to those services that have the most notable increases in volume indicative of shifting care from the ASC or physician office setting to the hospital OPD setting?
- Should CMS limit OPPS payment for certain services to the payment made for that service under the ASC payment system or the PFS – depending on the setting where the service is performed most frequently?
- If CMS were to adjust payment based on the setting-specific volume of ambulatory services, should they pay the ASC payment amount if the service is predominantly performed in the ASC setting; and if the service is predominantly performed in the physician office setting, should CMS continue to calculate the PFS-equivalent rate using a PFS relativity adjuster that we would periodically update?

- In determining the setting in which a service is performed most frequently, should CMS use the most recent data available or should we use data that is 5 or even 10 years prior to the rate-setting year?
- What are the best ways to address different packaging and bundling policies across ambulatory payment systems?
- Should CMS exempt certain services from a larger site neutral policy if such services are delivered in relation to emergent care, trauma-related care, or other care where the hospital is the most appropriate setting regardless of whether the item or service is typically furnished in a different setting?
- What other methods may be warranted to control unnecessary increases in the volume of outpatient services besides changes to payment rates, including prior authorization or other utilization management policies?
- What impact would the proposed ambulatory payment adjustment have on beneficiaries and the health care market, including the development of or beneficiary access to new health care innovations?

Virtual Direct Supervision of Diagnostic Services Furnished to Hospital Outpatients – pg. 508

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 HOPPS final rule, CMS again revised 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.

In addition to desiring uniformity under the PFS and OPPS in how regulations are applied to similarly situated clinicians and providers, CMS states that the approach proposed in the PFS proposed rule strikes the appropriate balance between recognizing that the virtual supervision of diagnostic services has been available and widely utilized since the beginning of the PHE and ensuring quality of care and patient safety.

Consequently, CMS proposes to revise § 410.27(a)(1)(iv)(B)(1) and § 410.28(e)(2)(iii) to make the availability of the direct supervision of CR, ICR, PR services and diagnostic services via audio-video real-time communications technology (excluding audio-only) permanent, except for diagnostic services that have a global surgery indicator of 010 or 090.

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Proposals for the Hospital Outpatient Quality Reporting (OQR) Program

The following summarizes the proposed updates to the Hospital Outpatient Quality Reporting (OQR) Program and Rural Emergency Hospital Quality Reporting (REHQR) Program, and the Request for Information (RFI) on New Measure Concepts.

Measure Concepts under Consideration for Future Years in the Hospital OQR, REHQR, and ASCQR Programs – Request for Information (RFI) - pg. 623

In the Cross-Program Measures section of the RFI, CMS is proposing a broad expansion of digital quality measures (dQM) in outpatient settings through the implementation of electronic Clinical Quality Measures (eCQMs) in the Hospital Outpatient Quality Reporting (OQR), Rural Emergency Hospital Quality Reporting (REHQR), and Ambulatory Surgical Center Quality Reporting (ASCQR) Programs. These changes are intended to modernize data collection, reduce provider burden, and improve the accuracy and timeliness of quality reporting. For example, in the Hospital OQR Program, CMS proposes the Emergency Care Access & Timeliness eCQM, which would be voluntarily reported in calendar year 2027 and become mandatory in CY 2028. This measure would replace two existing chart-abstracted metrics: OP-18: *Median Time from Emergency Department (ED) Arrival to Departure* and OP-22: *Left Without Being Seen*.

In the REHQR Program, the same Emergency Care Access & Timeliness eCQM would be introduced, with optional reporting in CY 2027 and mandatory reporting in CY 2029. Rural emergency hospitals would have the option to report either this eCQM or the chart-abstracted ED Departure measure.

To support these transitions, CMS outlines technical requirements for eCQM reporting that also comply with the Office of the National Coordinator's (ONC) standards and submission of data. CMS is also proposing to codify its discretion for granting eCQM reporting extensions under the Extraordinary Circumstances policy, which would apply across all three programs.

In addition to these proposals, CMS plans to remove several existing measures to reduce redundancy and reporting burden, including *COVID-19 Vaccination Coverage Among Healthcare Personnel*, *Hospital Commitment to Health Equity (HCHE), Facility Commitment to Health Equity (FCHE), Screening for Social Drivers of Health (SDOH), and the Screen Positive Rate for SDOH*.

These proposals are part of CMS's broader Digital Quality Measurement Strategy, which aims to transition to fully digital, interoperable quality reporting systems to improve data timeliness, accuracy, and usability while reducing the need for manual data abstraction.

Hospital Outpatient Quality Reporting (OQR) Program - pg. 633
Annually, CMS proposes updates to the Hospital OQR Program, which include the introduction of new measures, revisions to existing measures to better align with current outpatient care practices, and the removal of existing measures considered topped out, duplicative, or outdated.

Under the final rule for the CY 2025 Hospital Outpatient Prospective Payment System (HOPPS), CMS introduced OP-40: *Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults*, set for voluntary reporting starting in 2025, with plans to make it mandatory in 2027. However, in response to public comments highlighting significant burdens and resource challenges, particularly for facilities lacking the necessary infrastructure, CMS is now proposing to keep OP-40 as a voluntary measure indefinitely, repealing the requirement for mandatory reporting.

For 2026, CMS proposes removing OP-10 – *Abdomen CT: Use of Contrast Material*, citing that performance on this measure is consistently high across hospitals, making it no longer helpful for distinguishing quality. Unlike OP-10, which is limited to abdominal imaging, CMS finds that OP-40 is superior to OP-10 as it is applied more broadly and is considered a more comprehensive indicator of imaging quality and safety.

Rural Emergency Hospital Quality Reporting (REHQR) Program - pg. 659
Acknowledging the unique challenges rural emergency hospitals face, CMS described its goal to ensure future REHQR program measures are clinically meaningful, feasible, and present minimal burden, and support data consistency. As such, it seeks feedback on aligning REHQR measures with those in the Hospital OQR program, including proposals that would make OP-40 available for indefinite voluntary reporting in 2026.

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 15, 2025.