American College of Radiology

CMS Released CY 2024 HOPPS Proposed Rule

On July 13, 2023, the Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2024 Hospital Outpatient Prospective Payment System (HOPPS) proposed rule. This rule has a 60-day comment period. The finalized changes will appear in the final rule and are effective January 1, 2024.

CMS proposes to increase the conversion factor by 2.8 percent bringing it up to $ 87.488 for CY 2024. CMS proposes to continue to implement the statutory 2.0 percentage point reduction in payments for hospitals that fail to meet the hospital outpatient quality reporting requirements by applying a reporting factor of 0.9805 to the OPPS payments and copayments for all applicable services. The reduced conversion factor for hospitals failing to meet the Hospital Outpatient Quality Reporting (OQR) Program requirements is proposed to be $ 85.782.

CMS proposes to place 71271 (Low Dose CT for Lung Cancer Screening) in APC 5522 with payment rate of $106.04. In addition, CMS proposes to place G0296 (visit to determine lung LDCT eligibility) in APC 5822, with a payment rate of $86.86.

CY 2024 HOPPS Proposed Imaging APCs

APC	Group Title	CY 2023 Payment Rate	CY 2024 Proposed Payment Rate
5521	Level 1 Imaging without Contrast	$86.88	$87.30
5522	Level 2 Imaging without Contrast	$106.88	$106.04
5523	Level 3 Imaging without Contrast	$233.52	$236.31
5524	Level 4 Imaging without Contrast	$503.13	$533.11
5571	Level 1 Imaging with Contrast	$180.34	$177.09
5572	Level 2 Imaging with Contrast	$368.43	$369.86
5573	Level 3 Imaging with Contrast	$740.75	$775.83

CMS has proposed no structural changes to the seven imaging APCs.

Comprehensive-APC

CMS proposes to add one additional Comprehensive APC (C-APC) under the existing C-APC payment policy in CY 2024: Proposed C-APC 5342 (Level 1 Abdominal/Peritoneal/Biliary and Related Procedures). CMS also proposes to split C-APC 5492 (Level 2 Intraocular Procedures) into two distinct C-APCs. Table 1 in the proposed rule lists the proposed C-APCs for CY 2024.

OPPS Payment for Software as a Service

CMS proposes to keep the APC placement and reimbursement the same for all imaging-related Software as a Service (SaaS) procedures, with the exception of 0648T and 0649T that report Q-MR procedures. Many uses of Q-MR exist, including the product with the trade name LiverMultiScan. For CY2024, the OPPS

payment rates are proposed to be based on available CY2022 claims data. CMS only identified 39 claims each for CPT code 0648T and 0649T during that time period. As this is below the threshold of 100 claims, CMS applied the universal low volume APC policy to assign these codes to the appropriate New Technology APC. CMS proposes to assign codes 0648T and 0649T to APC 1505 (New Technology – Level 5 $301-$400) for CY2024. The add-on code, 0649T, is assigned to the identical APC as the standalone code, 0648T, in accordance with CMS's SaaS Add-on Codes policy (87 FR 72032 to 72033).

CPT Code	Long Descriptor	CY2023 APC	CY2023 Payment Rate	Proposed CY2024 APC	Proposed CY2024 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 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	$950.50	1505	$350.50
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	$950.50	1505	$350.50
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

OPPS Comment Solicitation on Packaging Policy for Diagnostic Radiopharmaceuticals

Under the OPPS, CMS packages several categories of nonpass-through drugs, biologicals, and radiopharmaceuticals, regardless of the cost of the products. Diagnostic radiopharmaceuticals, which include contrast agents, are one type of product that is policy packaged under the category described by § 419.2(b)(15). Since this policy was implemented in 2008, CMS has received feedback on the concerns regarding the packaging of diagnostic radiopharmaceuticals. In response, CMS is soliciting comment on how the OPPS policy packaging policy for diagnostic radiopharmaceuticals has impacted beneficiary access, including whether there are specific populations or clinical disease states for whom this issue is especially critical.

In addition, CMS is soliciting comments on the following potential approaches that would enhance beneficiary access, while maintaining the principles of the outpatient prospective payment system. These approaches include:

- Paying separately for diagnostic radiopharmaceuticals with per-day costs above the OPPS drug packaging threshold of $140;

- Establishing a specific per-day cost threshold that may be greater or less than the OPPS drug packaging threshold;
- Restructuring APCs, including by adding nuclear medicine APCs for services that utilize high-cost diagnostic radiopharmaceuticals;
- Creating specific payment policies for diagnostic radiopharmaceuticals used in clinical trials; and
- Adopting codes that incorporate the disease state being diagnosed or a diagnostic indication of a particular class of diagnostic radiopharmaceuticals.

CMS is interested in hearing from stakeholders how the discussed policy modifications might impact their overarching goal of utilizing packaging policies to better align OPPS policies with that of a prospective payment system rather than a fee schedule. Depending on the comments received, CMS may adopt as final one or more of the above-mentioned alternative payment mechanisms for CY2024.

The ACR is reviewing the proposed rule and will release a detailed summary in the coming weeks. If you have any questions, please email Kimberly Greck at kgreck@acr.org or Christina Berry at cberry@acr.org.