American College of Radiology™

Calendar Year 2024 Hospital Outpatient Prospective Payment System 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 provides for a 60-day comment period ending on September 11, 2023. The finalized changes are effective January 1st, 2024.

Conversion Factor Update

CMS proposes to increase the conversion factor by 2.8 percent bringing it up to $ 87.488 for CY 2024. 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 0.2 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 0.9974 for wage index changes by comparing proposed total estimated payments from simulation model using the proposed FY 2024 IPPS wage indexes to those payments using the FY 2023 IPPS wage indexes, as adopted on a calendar year basis for the OPPS. CMS further proposes to calculate an additional budget neutrality factor of 0.9975 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 conversion factor for CY 2024 of $ 85.782.

CMS proposes to use CY 2022 claims data to set CY 2024 OPPS and ASC rates. CMS proposes to use the most recently available cost report data, which would be from the Healthcare Cost Report Information System (HCRIS) extracted in December 2022, containing cost reports ending in FY 2020 and 2021 based on each hospital's cost reporting period.

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 $88.6 billion, which is approximately $6.0 billion higher than estimated CY 2023 OPPS expenditures.

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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 2024. CMS is making reassignments to the codes within the series to resolve and/or prevent any violations of the two times rule.

Proposed CY 2024 Imaging APCs

APC	Group Title	SI	CY 2023 Relative Weight	CY 2024 Proposed Relative Weight	CY 2023 Payment Rate	CY 2024 Proposed Payment Rate
5521	Level 1 Imaging without Contrast	S*	1.0151	0.9979	$86.88	$87.30
5522	Level 2 Imaging without Contrast	S	1.2488	1.2120	$106.88	$106.04
5523	Level 3 Imaging without Contrast	S	2.7285	2.7011	$233.52	$236.31
5524	Level 4 Imaging without Contrast	S	5.8787	6.0935	$503.13	$533.11
5571	Level 1 Imaging with Contrast	S	2.1071	2.0242	$180.34	$177.09
5572	Level 2 Imaging with Contrast	S	4.3048	4.2276	$378.43	$369.86
5573	Level 3 Imaging with Contrast	S	8.6551	8.8678	$740.75	$775.83

*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 9, found below, lists the 21 APCs that CMS proposes to exempt from the 2 times rule for 2024 based on CY 2022 available claims data.

Table 9. Proposed APC Exceptions to the 2 Times Rule for 2024

2024 APC	APC Title
5012	Clinic Visits and Related Services
5071	Level 1 Excision/ Biopsy/ Incision and Drainage
5301	Level 1 Upper GI Procedures
5303	Level 3 Upper GI 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
5612	Level 2 Therapeutic Radiation Treatment Preparation
5627	Level 7 Radiation Therapy
5674	Level 4 Pathology
5691	Level 1 Drug Administration
5692	Level 2 Drug Administration
5721	Level 1 Diagnostic Tests and Related Services
5731	Level 1 Minor Procedures
5741	Level 1 Electronic Analysis of Devices
5811	Manipulation Therapy
5821	Level 1 Health and Behavior Services
5822	Level 2 Health and Behavior Services
5823	Level 3 Health and Behavior Services

Comprehensive APCs
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.

Changes to New-Technology APCs

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 2024, CMS proposes to use CY 2022 claims data to determine the rates. The proposed APC placements are detailed in Table 12 of the proposed rule.

CPT code 78431 had over 22,000 single frequency claims in CY 2022 with a geometric mean of $2300, which is below the cost band for the currently assigned APC 1523 (New Technology Level 23 with payment of $2501-3000). CMS proposes to reassign CPT code 78431 to APC 1522 (New Technology Level 22 with payment of $2001-2500) for CY 2024.

CPT code 78432 had only six single frequency claims in CY 2022. 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 CY 2021 and CY 2022, CMS found that the geometric mean cost was the highest at $1658, which is below the cost band for APC 1520 (New Technology Level 20 with payment of $1801-1900). CMS proposes to reassign CPT code 78432 to APC 1518 (New Technology Level 18 with payment of $1601-1700) for CY 2024.

CPT code 78433 had over 1200 single frequency claims in CY 2022. The geometric mean was $1960, which falls within the cost band for APC 1521 (New Technology Level 21 with payment of $1901-2000), which it is currently assigned. CMS proposes to continue to assign CPT 78433 to APC 1521 for CY 2024.

Table 12: Final CY 2023 and Proposed CY 2024 OPPS New Technology APC and Payment Rates for Cardiac PET/CT CPT Codes 78431, 78432, and 78433

CPT Code	Long Descriptor	Final CY 2023 APC	Final CY 2023 Payment Rate	Proposed CY 2024 APC	Proposed CY 2024 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	1523	$2750.50	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	1518	$1650.50

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	1521	$1950.50

Brachytherapy

Universal Low Volume APC Policy for Clinical and Brachytherapy APCs

In the CY 2022 HOPPS final rule with comment period, CMS adopted 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 2024, CMS proposes to designate five brachytherapy APCs and five clinical APCs as low volume APCs.

Table 27: Cost Statistics for Proposed Low Volume APCs Using Comprehensive (OPPS) Ratesetting Methodology for CY 2024

APC	APC Description	CY 2022 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 2024 APC Cost
2632	Iodine I-125 sodium iodide	0	---*	$31.74	$61.83	$41.06	**$61.83**
2635	Brachytx, non-str, HA, P-103	121	$98.73	$58.38	$60.86	$54.77	**$60.86**
2636	Brachy linear, non-str, P-103	1	$89.34	$22.17	$57.15	$33.66	**$57.15**

2642	Brachytx, stranded, C-131	76	$99.92	$79.90	$100.65	$79.90	**$100.65**
2647	Brachytx, NS, Non-HDRIr-192	2	$452.28	$201.69	$403.29	$167.08	**$403.29**

*For this proposed rule, there are no CY 2022 claims that contain the HCPCS code assigned to APC 2632 that are available for CY 2024 OPPS/ASC ratesetting.

CT Lung Cancer Screening

In the CY 2024 HOPPS Proposed Rule, 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.

Supervision by Nonphysician Practitioners, Physician Assistants and Clinical Nurse Specialists of Cardiac, Intensive Cardiac and Pulmonary Rehabilitation Services Furnished to Outpatients

For CY 2024, to comply with the Bipartisan Budget Act of 2018 and to ensure consistency with proposed revisions to § 410.47 and § 410.49 in the CY 2024 PFS proposed rule, CMS proposes to revise § 410.27(a)(1)(iv)(B)(1) to expand the practitioners who may supervise cardiac rehabilitation (CR), intensive cardiac rehabilitation (ICR), and pulmonary rehabilitation (PR) services to include nurse practitioners (NPs), physician assistants (Pas), and clinical nurse specialists (CNSs). CMS also proposes to allow for the direct supervision requirement for CR, ICR, and PR services to include virtual presence of the physician through audio video real-time communications technology (excluding audio-only) through December 31, 2024, and extend this policy to the nonphysician practitioners, that is NPs, Pas, and CNSs, who are eligible to supervise these services in CY 2024.

OPPS Payment for Software as a Service

For CY 2024, CMS proposes to keep the APC placement and payment rates the same for the imaging-related Software as a Service (SaaS) procedures, except for CPT codes 0648T and 0649T that report Q-MR procedures. Many uses of Q-MR exist, including the product with the trade name LiverMultiScan. CMS only identified 39 claims each for CPT code 0648T and 0649T using claims data from CY 2022. 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. Using available claims data from CY 2021 and CY 2022, the arithmetic mean was the highest for both codes, with $320 for 0648T and $136 for 1649T. CMS proposes to assign codes 0648T and 0649T to APC 1505 (New Technology Level 5 with payment of $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).

OPPS Software as a Service (SaaS) Procedures

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

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.

Threshold-packaged drugs under the OPPS are drugs, non-implantable biologicals and therapeutic radiopharmaceuticals whose packaging status is determined by the packaging threshold. If a drug's average cost per day exceeds the annually determined packaging

threshold, it is separately payable and, if not, it is packaged. For CY 2024, CMS proposes a packaging threshold for drugs, biologicals, and radiopharmaceuticals that are not new and do not have pass-through status of $140.

Payment Policy for Therapeutic Radiopharmaceuticals
For CY 2024, 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 2024 payment rates based on 2022 geometric mean unit costs.

OPPS Comment Solicitation on Packaging Policy for Diagnostic Radiopharmaceuticals
Under the OPPS, CMS packages several categories of non-pass-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 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; or
- 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.

Requirements for the Hospital Outpatient Quality Reporting (OQR) Program
Hospital OQR Program Quality Measures (p. 550)

Hospital Outpatient Quality Reporting (OQR) Program
The Hospital OQR Program, a pay-for-reporting quality program for the hospital outpatient department, requires hospitals to meet quality reporting requirements or receive a reduction of 2.0 percentage points in their annual payment update if these requirements are not met.

CMS also proposes the adoption of the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults, an electronic clinical quality measure (eCQM) intended to promote patient safety, and two new non-radiology measures within the OQR Program. Notably, if these new measures are finalized during this rulemaking process, they would become available for voluntary reporting for the 2025 reporting period and eventually mandatory beginning in the calendar year 2026 reporting period. Until now, the OQR Program has not mandated specific measures for reporting. CMS also proposes modifying three non-radiology measures (these measures would remain voluntary for reporting) and removing the Left Without Being Seen measure, as it does not provide actionable information in sufficient detail to improve quality and, subsequently, patient outcomes.

Rural Emergency Hospital Quality Reporting (REHQR) Program (p. 694)

REHQR Program Quality Measures
As part of the 2023 Hospital Outpatient Prospective Payment System (HOPPS) rulemaking, CMS finalized the formation of the REHQR Program for hospitals with fewer than 51 beds located in rural areas. Participating in this quality reporting program requires REHs to submit quality measure data to CMS. In this year's proposed rule, CMS proposes the adoption and codification of several standard quality program reporting policies and four initial measures for the REHQR Program. The four proposed initial measures, consisting of three claims-based measures and one chart-abstracted measure, are:

1. Abdomen **CT - Use of Contrast Material** (currently included in the OPQR Program) provides the percentage of CT abdomen and abdominopelvic studies performed with, and without contrast out of all CT abdomen studies performed (those with and without contrast).
2. Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients.
3. Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy.
4. Risk-Standardized Hospital Visits Within Seven Days After Hospital Outpatient Surgery.

CMS solicits public comments on using eCQMs, care coordination measures, and a tiered approach for quality measures and reporting requirements to incentivize REH reporting.

Other HOPPS Payment Policies

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 2024, 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). CMS proposes to reduce the CY 2023 target PCR of 0.89 by 1 percentage point and proposes the cancer hospital target PCR of 0.88 for CY 2024. Table 5 in the proposed rule shows the estimated hospital-specific payment adjustment for each of the 11 cancer hospitals, with increases in OPPS payments for 2024 ranging from 11.6 percent to 56.9 percent.

Table 5. Estimated CY 2024 Hospital-Specific Payment Adjustment for Cancer Hospitals to be Provided at Cost Report Settlement

Provider Number	Hospital Name	Estimated Percentage Increase in OPPS Payments for CY 2024 due to Payment Adjustment
050146	City of Hope Comprehensive Cancer Center	43.9%
050660	USC Norris Cancer Hospital	30.2%
100079	Sylvester Comprehensive Cancer Center	41.9%
100271	H. Lee Moffitt Cancer Center & Research Institute	25.0%
220162	Dana-Farber Cancer Institute	41.1%
330154	Memorial Sloan-Kettering Cancer Center	56.9%
330354	Roswell Park Cancer Institute	19.1%
360242	James Cancer Hospital & Solove Research Institute	11.6%
390196	Fox Chase Cancer Center	22.1%
450076	M.D. Anderson Cancer Center	47.7%
500138	Seattle Cancer Care Alliance	39.4%

Hospital Price Transparency
The hospital price transparency regulations implement Section 2718(e) of the Public Health Service (PHS) Act, effective January 1, 2021, which requires hospitals each year to establish, update, and make public a list of the hospital's standard charges for items and services provided by the hospital. CMS proposes to modify the standard charge display requirements at 45 CFR 180.50 as well as update the enforcement provisions at 45 CFR 180.70 to streamline and improve the transparency of the enforcement process.

Specifically, CMS proposes to:

(1) add definitions for "CMS template", "consumer-friendly expected allowed charges", "encode", and "machine-readable file" (MRF);
(2) require hospitals to affirm the accuracy and completeness of data in their MRF;
(3) revise and expand the data elements hospitals must include in the MRF;
(4) require hospitals to conform to a CMS template layout and other technical specifications for encoding standard charge information in the MRF;
(5) require hospitals to establish and maintain a txt file and footer as specified by CMS; and
(6) revise the enforcement process by updating our methods to assess hospital compliance, requiring hospitals to acknowledge receipt of warning notices, working with health system officials to address noncompliance issues in one or more hospitals that are part of a health system, and publicizing more information about CMS enforcement activities related to individual hospital compliance.

CMS is also seeking comments on additional considerations for improving compliance and aligning consumer-friendly policies and requirements with other federal price transparency initiatives, including the No Surprises Act (NSA) and Transparency in Coverage (TIC) regulations.

Changes to Beneficiary Coinsurance for Certain Colorectal Cancer Screening Tests
Medicare pays 100 percent of the payment amount for certain colorectal cancer screening tests that are recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B. Thus, a beneficiary pays no cost-sharing for these screening tests.

When the colorectal cancer screening test benefit category was enacted into law, the statute specifically provided that if, during the course of a screening flexible sigmoidoscopy or screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under Medicare Part B shall not be made for the screening flexible sigmoidoscopy, but rather shall be made for the procedure classified as a flexible sigmoidoscopy with such biopsy or removal. The result was that beneficiaries faced unexpected coinsurance charges because the procedure was classified as a diagnostic test instead of a preventive service screening test.

Section 4104 of the ACA addressed this issue with respect to the deductible but not for any coinsurance that may apply. Section 122 of the CAA addresses this issue for the coinsurance by successively reducing, over a period of years, the percentage amount of coinsurance for which the beneficiary is responsible so that for services furnished on or after January 1, 2030, the coinsurance will be zero. The phased-in increases in the amount the Medicare program pays for these services on or after January 1, 2023 are as follows:

Year	Medicare Payment Percent	Beneficiary Coinsurance Percent
2023 – 2026	85	15
2027 – 2029	90	10
2030 and subsequent years	100	0

The ACR's HOPPS Committee and staff will review these changes and will draft comments during the 60-day comment period. Those comments are due to CMS by September 11, 2023.