American College of Radiology™

Calendar Year 2025 Hospital Outpatient Prospective Payment System Final Rule Detailed Summary

On November 1, 2024, Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2025 Hospital Outpatient Prospective Payment System (HOPPS) final rule. These finalized changes are effective January 1st, 2025.

Conversion Factor Update
CMS finalized an increase to the conversion factor of 2.9 percent, bringing it up to $89.169 for CY 2025. This increase is based on the final estimate of the hospital inpatient market basket percentage increase of 3.4 percent for inpatient services paid under the hospital inpatient prospective payment system (IPPS) reduced by a productivity adjustment of 0.5 percentage point. CMS also finalized further adjustment to the conversion factor to ensure that any revisions made to the wage index and rural adjustment are made on a budget neutral basis. CMS finalized to calculate an overall budget neutrality factor of 0.9927 for wage index changes, as adopted on a calendar year basis for the OPPS. CMS finalized the calculation of an additional budget neutrality factor of 0.9995 to account for the finalized policy to cap wage index reductions for hospitals at 5 percent on an annual basis. CMS finalized the proposal to maintain the current rural adjustment policy, and therefore sets the budget neutrality factor for the rural adjustment to be 1.0000.

In this final rule, hospitals that fail to meet the reporting requirements of the Hospital Outpatient Quality Reporting (OQR) Program will be subject to a further CF reduction of 2.0 percentage points, resulting in a CF of $87.439 for CY 2025.

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

Estimated Impact on Hospitals
In this final rule, CMS estimates that OPPS expenditures, including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case mix will be approximately $87.7 billion, which is approximately $4.7 billion higher than estimated CY 2024 OPPS expenditures.

FINALIZED AMBULATORY PAYMENT CLASSIFICATION GROUP POLICIES

Imaging Ambulatory Payment Classifications
CMS did not finalize 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 will cause changed reimbursement for 2025. CMS is making reassignments to the codes within the series to resolve and/or prevent any violations of the two-times rule.

Finalized CY 2025 Imaging APCs

APC	APC Group Title	SI	CY 2024 Relative Weight	CY 2025 Finalized Relative Weight	CY 2024 Payment Rate	CY 2025 Finalized Payment Rate
5521	Level 1 Imaging without Contrast	S*	0.9908	0.9874	$86.58	$88.05
5522	Level 2 Imaging without Contrast	S	1.1988	1.1926	$104.75	$106.34
5523	Level 3 Imaging without Contrast	S	2.6718	2.7108	$233.47	$241.72
5524	Level 4 Imaging without Contrast	S	6.0153	6.1490	$525.63	$548.30
5571	Level 1 Imaging with Contrast	S	2.0034	1.9964	$175.06	$178.02
5572	Level 2 Imaging with Contrast	S	4.1933	4.0051	$366.42	$357.13
5573	Level 3 Imaging with Contrast	S	8.7304	8.8602	$762.88	$790.06

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

Finalized APC Exceptions to the 2 Times Rule

CMS finalized 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. Based on the updated final rule CY 2023 claims data, CMS found a total of 28 APCs with violations of the 2-times rule. Of these 28, 23 were identified in the proposed rule and 5 are newly identified in this final rule.

Table 18, found below, lists the exemptions to the 2-times rule. Of note to radiology, APC 5722 (Level 2 Diagnostic Tests and Services) was newly identified in this final rule and added to the Exceptions list.

Table 18: Final CY 2025 APC Exceptions to the 2 Times Rule

APC	APC Group Title
5012	Clinic Visits and Related Services
5024	Level 4 Type A ED Visits
5053	Level 3 Skin Procedures
5071	Level 1 Excision/ Biopsy/ Incision and Drainage
5501	Level 1 Extraocular, Repair, and Plastic Eye Procedures
5521	Level 1 Imaging without Contrast
5522	Level 2 Imaging without Contrast
5523	Level 3 Imaging without Contrast

APC	APC Group Title
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
5613	Level 3 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
5722	Level 2 Diagnostic Tests and Related Services
5731	Level 1 Minor Procedures
5733	Level 3 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
5823	Level 3 Health and Behavior Services

Comprehensive APCs

CMS conducted their annual review of Comprehensive APCs and finalized no changes to the current number of 72 C-APCs (listed in Table 5 of this final rule). However, multiple commenters requested that CMS apply a complexity adjustment to additional code combinations, and those final changes are listed in Table 2 of this rule.

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 2025, CMS finalized the proposal to use CY 2023 claims data to determine the rates. The finalized APC placements are detailed in Table 28 of the final rule.

CMS noted in the rule that additional claims for all three PET/CT codes have been processed since the proposed rule. CPT 78431 has an updated geometric mean cost of approximately $2300, and since it is still within the range for APC 1522 (New Technology Level 22 with payment of $2250.50), they are finalizing the proposed APC placement without modification.

CPT code 78432 had an additional 15 single frequency claims become available since the proposed rule, bringing the total to 33 for CY 2023. This is still below the 100 claims per year threshold, so CMS will apply the universal low volume APC policy by using the highest rate of geometric mean cost, arithmetic mean cost, or median cost based on up to 4 years of claims data. Using the updated available claims data, CMS found that the arithmetic mean cost was the highest at $1890, which is an amount outside the proposed cost band for APC 1521 (New Technology Level 21 with payment of $1950.50), so CMS is not finalizing their original proposal. Instead, CPT code 78432 will be assigned to APC 1520 (New Technology Level 20 with payment of $1850.50) for CY 2025.

The geometric mean cost based on updated available claims for CPT code 78433 has changed, decreasing to $1964 from $2010. Therefore, CMS is not finalizing the proposed APC assignment of 1522 (New Technology Level 22 with payment rate $2250.50). Instead, CMS placed code 78433 into APC 1521 (New Technology Level 21 with payment of $1950.50) which is the same APC it was placed in for CY 2024. CMS thanked commenters for their feedback and noted that as they continue to gather adequate claims data, they will consider whether to assign CPT codes 78431 and 78433 to clinical APCs in future rulemaking.

Table 28: Final CY 2024 and Final 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	Final CY 2025 APC	Final 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),	1520	$1850.50	1520	$1850.50

CPT Code	Long Descriptor	Final CY 2024 APC	Final CY 2024 Payment Rate	Final CY 2025 APC	Final CY 2025 Payment Rate
	dual radiotracer (eg, myocardial viability);				
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

Beginning with the CY 2022 HOPPS final rule, CMS adopted and implemented a universal Low Volume APC policy for CY 2022 and subsequent calendar years. This policy states that 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 finalized the proposal to designate six brachytherapy APCs and five clinical APCs as low volume APCs. Table 64 in the final rule lists the finalized low volume APCs using comprehensive (OPPS) ratesetting methodology for CY 2025.

Cost Statistics for Finalized 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	Final Arithmetic Mean Cost	Final Geometric Mean Cost	Final Median Cost	Final CY 2025 APC Cost
2632	Iodine I-125 sodium iodide	1	$495.50	$211.10	$59.42	$28.66	**$211.10**

APC	APC Description	CY 2023 Claims Available for Rate Setting	Geometric Mean Cost without Low Volume APC Designation	Final Arithmetic Mean Cost	Final Geometric Mean Cost	Final Median Cost	Final CY 2025 APC Cost
2635	Brachytx, non-str, HA, P-103	20	$98.61	$70.22	$59.48	$34.04	**$70.22**
2636	Brachy linear, non-str, P-103	1	$3682.16	$53.56	$32.24	$22.17	**$53.56**
2642	Brachytx, stranded, C-131	95	$109.26	$109.17	$89.03	$84.11	**$109.17**
2645	Brachytx, non-str, gold- 198	96	$269.99	$878.86	$260.64	$219.45	**$878.86**
2647	Brachytx, NS, Non-HDRIr-192	2	$120.49	$571.35	$229.20	$303.00	**$571.35**

CT Lung Cancer Screening

In the CY 2025 HOPPS Final Rule, CMS placed 71271 (Low Dose CT for Lung Cancer Screening) in APC 5522 (Level 2 Imaging with Contrast) with payment rate of $106.34. In addition, CMS placed G0296 (visit to determine lung LDCT eligibility) in APC 5822 (Level 2 Health and Behavior Services), with a payment rate of $92.50. The APC assignments for both codes are unchanged from CY 2024.

Medical Physics Dose Evaluation

CMS finalized the proposal to place 76145 (Medical Physics Dose Evaluation for Radiation Exposure That Exceeds Institutional Review Threshold, Including Report) in APC 5723 with payment rate $530.60 for CY 2025, which is the same APC placement from CY 2024.

Cardiac Computed Tomography Reimbursement

Like the predecessor codes, CPT codes 75572, 75573, and 75574 for cardiac CT services have been paid separately under the HOPPS since 2010. The reimbursement rate for these codes has been declining for years, from $265.02 in CY 2017 to $175.06 in CY 2024. In response to feedback on a specific claims edit affecting cardiac CT services, CMS removed the edit in December 2023. With the edit no longer in place, hospitals may bill for cardiac CT services with whichever revenue code they believe appropriate for CY 2024, including cardiology revenue code 048X, and the CY

2026 OPPS payment rates (which most likely will be based on CY 2024 claims) will reflect those updated revenue code billing patterns.

CMS conducted prior studies to determine whether the revenue edit could have affected the geometric mean costs for codes 75572-75574, and found that if 50 percent or more of HOPDs had billed these services with the cardiology revenue code (048X) and cardiology cost center (03140), the geometric mean cost for these codes would have increased and would have resulted in a revised APC assignment from APC 5571 (Level 1 Imaging with Contrast) to APC 5572 (Level 2 Imaging with Contrast). Table 67 in the final rule shows the study methodology for each code.

Therefore, for CY 2025, CMS used their equitable adjustment authority under section 1833(t)(2)(E) of the Act to utilize an alternative methodology to calculate the payment for the cardiac CT services in CY 2025 and subsequent years. Specifically, CMS finalized a temporary reassignment of the cardiac CT codes (CPT code 75572 through 75574) to APC 5572 (Level 2 Imaging with Contrast), which is outlined in Table 68 of the rule. This APC reassignment will not involve the reprocessing of claims with dates of services prior to January 1, 2025.

CMS anticipates that it will take three to four years to see an impact from the changes in billing practices based on comments received to the HOPPS proposed rule. If CMS does not see a significant change in the geometric mean costs after several years, they will revert to standard OPPS payment methodology and reassign APCs for these codes.

Proposed and Final CY 2025 APC Placement and Payment for Cardiac CT Studies

CPT Code	Short Descriptor	CY 2025 Proposed APC	CY 2025 Proposed Payment	CY 2025 Final APC	CY 2025 Final Payment
75572	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)	5571 – Level 1 Imaging with Contrast	$175.75	5572 – Level 2 Imaging with Contrast	$357.13
75573	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease	5571 – Level 1 Imaging with Contrast	$175.75	5572 – Level 2 Imaging with Contrast	$357.13

CPT Code	Short Descriptor	CY 2025 Proposed APC	CY 2025 Proposed Payment	CY 2025 Final APC	CY 2025 Final Payment
	(including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)				
75574	Computed tomography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)	5571 – Level 1 Imaging with Contrast	$175.75	5572 – Level 2 Imaging with Contrast	$357.13

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 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 proposed 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.

After consideration of the public comments CMS received in response to the PFS proposed rule and desiring uniformity under the PFS and OPPS in how regulations are applied to similarly situated providers and, CMS is finalizing, without modification, their proposal to revise §§ 410.27(a)(1)(iv)(B)(1) and 410.28(e)(2)(iii) to allow for the direct supervision of CR, ICR, PR services and diagnostic services via audio-video real-time communications technology (excluding audio-only) through December 31, 2025.

OPPS Payment for Software as a Service
For CY 2025, CMS finalized the proposal to maintain the APC placement for payable code 0625T describing atherosclerosis imaging-quantitative computer tomography. Despite two additional

claims being identified since the proposed rule which increased the geometric mean, CMS expressed uncertainty about the calculations of available claims data. CMS noted that they referenced the developer's initial New Tech APC application to best estimate the cost of the service, cited as being between $901 and $1,000. For CY 2025, 0625T will be placed in APC 1511 (New Technology Level 11) with a payment rate of $950.50, finalizing the proposal without modification.

For CPT codes 0648T and 0649T describe quantitative magnetic resonance analysis services in products such as LiverMultiScan. In the proposed rule, CMS applied the universal low volume policy to these codes due to insufficient number of claims for both codes. However, in the final rule, CMS agreed with commenters who expressed that there are not sufficient claims data to justify an APC reassignment at this time. Therefore, CPT 0648T will remain in APC 1511 for CY 2025 with a payment rate of $950.50 until CMS can obtain additional claims data. In accordance with the SaaS add-on codes policy (87 FR 72032 to 72033), SaaS CPT add-on codes are assigned to the same APCs and status indicators as their standalone codes. Thus, CPT code 0649T, the add-on code, is assigned to the identical APC and status indicator as CPT code 0648T, the standalone code for the same service.

CPT codes 0697T and 0698T are used to describe quantitative magnetic resonance for analysis of tissue composition services used in products like CoverScan. CMS identified 48 claims for CPT 0698T but none for 0697T in CY 2023. CMS stated in the rule that they recognize that the few claims available for CPT codes 0697T and 0698T may not truly represent the cost of these services. CMS will use their equitable adjustment authority under section 1833(t)(2)(E) to assign CPT codes 0697T and 0698T to New Technology APC 1511 (New Technology Level 11) with a payment rate of $950.50 for CY 2025.

Codes 0721T and 0722T describe quantitative computed tomography tissue characterization in products such as Optellum's lung cancer prediction technology. Only identifying three claims for code 0721T and none for 0722T, CMS believes it is appropriate to continue to assign these codes to their current APC of 1508 (New Technology Level 8) with payment rate of $650.50 due to insufficient claims data to capture the cost of service. CMS finalized their proposal without modification. In accordance with the SaaS add-on codes policy (87 FR 72032 to 72033), SaaS CPT add-on codes are assigned to the same APCs and status indicators as their standalone codes. Thus, CPT code 0722T, the add-on code, is assigned to the identical APC as CPT code 0721T for CY 2025.

For codes 0723T and 0724T that describe quantitative magnetic resonance cholangiopancreatography (QMRCP), CMS finalized the proposal to continue to assign them to APC 1511 (New Technology Level 11) due to insufficient claims data. For CY 2023, only 3 claims were identified for 0724T and none for 0723T. In accordance with the SaaS add-on codes policy (87 FR 72032 to 72033), SaaS CPT add-on codes are assigned to the same APCs and status indicators as their standalone codes.

CMS noted in the final rule that they recognize that software-based technologies are rapidly evolving and, therefore, CMS is considering for future rulemaking whether specific adjustments to payment policies, including their New Technology APC policies, are needed to more accurately and appropriately pay for these products and services across settings of care. The final CY 2025 payment rates can be found in Addendum B to this final rule via the CMS website.

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

CPT Code	Long Descriptor	CY2024 APC	CY2024 Payment Rate	Finalized CY2025 APC	Finalized 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 – New Technology Level 11	$950.50	1511 – New Technology 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 Technology Level 11	$950.50	1511 – New Technology 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)	1511 – New Technology Level 11	$950.50	1511 – New Technology Level 11	$950.50

CPT Code	Long Descriptor	CY2024 APC	CY2024 Payment Rate	Finalized CY2025 APC	Finalized CY2025 Payment Rate
	(List separately in addition to code for primary procedure)				
0697T	(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; multiple organs	1509 – New Technology Level 9	$750.50	1511 – New Technology Level 11	$950.50
0698T	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); multiple organs (list separately in addition to code for primary procedure)	1509 – New Technology Level 9	$750.50	1511 – New Technology 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 Technology Level 8	$650.50	1508 – New Technology Level 8	$650.50
0722T	Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained with concurrent CT examination of any structure	1508 – New Technology Level 8	$650.50	1508 – New Technology Level 8	$650.50

CPT Code	Long Descriptor	CY2024 APC	CY2024 Payment Rate	Finalized CY2025 APC	Finalized CY2025 Payment Rate
	contained in the concurrently acquired diagnostic imaging dataset (List separately in addition to code for primary procedure)				
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 Technology Level 11	$950.50	1511 – New Technology 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 Technology Level 11	$950.50	1511 – New Technology Level 11	$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 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 finalized the proposal to continue paying for therapeutic radiopharmaceuticals at Average Sales Price (ASP) plus 6 percent. For therapeutic radiopharmaceuticals for which ASP

data are unavailable, CMS will determine 2025 payment rates based on 2023 geometric mean unit costs.

Separate Payment for Diagnostic Radiopharmaceuticals
CMS finalized the proposal 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. Any diagnostic radiopharmaceutical with a per day cost at or below that threshold would continue to be policy packaged under the longstanding policy at § 419.2(b)(15). CMS also finalized the policy to update the $630 threshold in CY 2026 and subsequent years by the Producer Price Index (PPI) for Pharmaceutical Preparations for Human Use. CMS finalized the proposal to pay separately for payable diagnostic radiopharmaceuticals based on their Mean Unit Cost (MUC) derived from OPPS claims, as they believe MUC is an appropriate proxy for the average price for a diagnostic radiopharmaceutical for a given year.

In this final rule, CMS agrees with commenters that payment for diagnostic radiopharmaceuticals is a complex issue, and that they intend to further consider the feedback given on these policies, taking them into consideration for future rulemaking. The finalized list of diagnostic radiopharmaceuticals that have calculated per day costs that exceed $630 and their status indicators can be found in Table 9 of the rule.

Requirements for the Hospital Outpatient Quality Reporting (OQR) Program
CMS finalized 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. It also finalized 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, it is now required that Electronic Health Record (EHR) technology be certified to all electronic clinical quality measures (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 and APC Changes for Colorectal Cancer (CRC) Screening Services
For CY 2024, CPT code 74263 for CT colonography screening services had a status indicator of "E1" indicating that the service was not payable by Medicare under the OPPS. In the CY 2025 HOPPS proposed rule, CMS changed the status indicator to "S" to indicate that the code is separately payable based on the proposed coverage changes for the colorectal cancer screening. CMS stated that they believed that the time and resources for 74263 are comparable those for CPT 74261 (CT colonography, diagnostic), thus placing it in APC 5522 in the proposed rule.

In response to comments, CMS stated in the final rule that this newly covered screening test should be assigned to an APC where payment is more comparable to purported resource costs. Given that any claims data in CY 2023 would be from before this service was payable under the OPPS, it would be difficult to rely on claims data to determine an appropriate APC assignment. Based on their review compared to other services in the "Imaging without Contrast" APC series, CMS believes that CPT code 74176 is an appropriate crosswalk for CPT code 74263. As a result, CMS finalized their proposal with modification to change the APC placement to APC 5523 (Level 3 Imaging without Contrast) and payment rate of $241.72.

CPT Code	Short Descriptor	CY 2025 Proposed SI	CY2025 Proposed APC	CY 2025 Proposed Payment	CY 2025 Final SI	CY 2025 Final APC	CY 2025 Final Payment
74263	Computed tomographic (CT) colonography, screening, including image postprocessing	S	5522 – Level 2 Imaging without Contrast	$106.30	S	5523 – Level 3 Imaging without Contrast	$241.72

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 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. After consideration of the public comments CMS received, CMS is not finalizing their proposal to develop alternative methods of payment under Medicare Part B for drugs and devices being studied in clinical trials under a CED NCD at this time. Additionally, CMS is not finalizing their proposal to codify the coding and payment policy for Category B IDE clinical trials with control arms through revisions to § 419.47(a) to specify that the policy applies only to IDE studies with a control arm and where a payment adjustment is necessary to preserve the scientific validity of such a study.

Finalized 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 finalized the proposal 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 finalized a target PCR of 0.87 to determine the CY 2025 cancer hospital payment adjustment to be paid at cost report settlement.

Table 12: 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 finalized the proposal 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 also finalized the proposal to require 12-months of continuous eligibility for children under the age of 19 enrolled in Medicaid and CHIP. Additionally, CMS finalized the policy 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 finalized the policy to remove failure to pay premiums as one of the optional exceptions to continuous eligibility for CHIP beneficiaries.