American College of Radiology

CMS Released CY 2025 HOPPS Proposed Rule

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

CMS proposes to increase the conversion factor by 2.6 percent bringing it up to $89.379 for CY 2025. 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 $87.636.

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

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

CY 2025 HOPPS Proposed Imaging APCs

APC	APC Title	CY 2024 Payment Rate	CY 2025 Proposed Payment Rate
5521	Level 1 Imaging without Contrast	$86.58	$87.56
5522	Level 2 Imaging without Contrast	$104.75	$106.30
5523	Level 3 Imaging without Contrast	$233.47	$240.31
5524	Level 4 Imaging without Contrast	$525.63	$544.85
5571	Level 1 Imaging with Contrast	$175.06	$175.75
5572	Level 2 Imaging with Contrast	$366.42	$373.77
5573	Level 3 Imaging with Contrast	$762.88	$779.02

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

Comprehensive-APC Policies

CMS conducted an annual review and proposes no changes to the current number of 72 C-APCs. Table 2 lists all C-APCs for CY2025, all of which were established in past rules.

OPPS Payment for Software as a Service

For CY 2025, CMS proposes to maintain the APC placement for payable code 0625T describing atherosclerosis imaging-quantitative computer tomography. CMS proposes to assign the universal

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low volume APC policy to CPT codes 0648T and 0649T for quantitative magnetic resonance analysis, reassigning these services to APC 1504 (New Technology Level 4) with a payment rate of $250.50. Despite only identifying three claims for code 0721T and none for 0722T for quantitative computed tomography tissue characterization, 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 at this time. For codes 0723T and 0724T that describe quantitative magnetic resonance cholangiopancreatography, CMS proposes to continue to assign them to APC 1511 (New Technology Level 11 - $950.50) due to insufficient claims data.

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

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

	(List separately in addition to code for primary procedure)				
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

Separate Payment for Diagnostic Radiopharmaceuticals

CMS proposes to pay separately for diagnostic radiopharmaceuticals with per day costs above a threshold of $630, which is approximately two times the volume weighted average cost amount currently associated with diagnostic radiopharmaceuticals. CMS also proposes to update the

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$630 threshold in CY 2026 and subsequent years by the Producer Price Index (PPI) for Pharmaceutical Preparations. CMS proposes to pay separately for payable diagnostic radiopharmaceuticals based on their Mean Unit Cost (MUC) derived from OPPS claims and is seeking comments on the use of Average Sales Price (ASP) for payment in future years.

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

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

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.

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