American College of Radiology™

CMS Released CY 2024 HOPPS Final Rule

On November 2, 2023, the Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2024 Hospital Outpatient Prospective Payment System (HOPPS) final rule. The finalized changes are effective January 1, 2024.

CMS increased the conversion factor by 3.1 percent bringing it up to $ 87.382 for CY 2024. CMS will 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 0.9806 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 $ 85.687.

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

CY 2024 HOPPS Finalized Imaging APCs

APC	Group Title	CY 2023 Payment Rate	Finalized CY 2024 Payment Rate
5521	Level 1 Imaging without Contrast	$86.88	$86.67
5522	Level 2 Imaging without Contrast	$106.88	$104.87
5523	Level 3 Imaging without Contrast	$233.52	$233.71
5524	Level 4 Imaging without Contrast	$503.13	$526.17
5571	Level 1 Imaging with Contrast	$180.34	$175.24
5572	Level 2 Imaging with Contrast	$368.43	$366.80
5573	Level 3 Imaging with Contrast	$740.75	$763.67

In the final rule, CMS has not made any structural changes to the seven imaging APCs.

Comprehensive-APC

In the final rule, CMS finalized additional Comprehensive APCs (C-APC) under the existing C-APC payment policy in CY 2024: C-APC 5342 (Level 1 Abdominal/Peritoneal/Biliary and Related Procedures) and C-APC 5496 (Level 6 Intraocular APC). Table 2 in the final rule lists the C-APCs for CY 2024.

OPPS Payment for Software as a Service

CMS did not finalize the proposal to place CPT codes 0648T and 0649T that report Q-MR procedures into the APC 1505 with a payment rate of $350.50. (Many uses of Q-MR exist, including the product with the trade name LiverMultiScan.) Instead, CMS implemented the proposal with modifications. CMS is using the equitable adjustment authority under section 1833(t)(2)(E) to continue to assign CPT codes 0648T and 0649T to APC 1511 (New Technology – Level 11) with a payment rate of $950.50. CMS is considering for

future rulemaking whether specific adjustments to payment policies and rate calculations are necessary to more accurately and appropriately pay for these products and services across settings of care.

CMS finalized the proposals to continue to place all other listed SaaS codes in the same APCs for CY2024, as seen in the table below.

CPT Code	Long Descriptor	CY2023 APC	CY2023 Payment Rate	Final CY2024 APC	Final 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	1511	$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	$950.50	1511	$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	$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 the CY 2024 HOPPS proposed rule, CMS solicited comments on how the OPPS policy packaging policy for diagnostic radiopharmaceuticals has impacted beneficiary access. CMS also solicited comments on five potential approaches of reimbursement for diagnostic radiopharmaceuticals that would enhance beneficiary access, while maintaining the principles of the outpatient prospective payment system.

These approaches included:

- 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 stated in the final rule that since they believe this is a complex and vital issue, CMS will further consider the commenter's feedback on potential policy changes for future notice and comment rulemaking. CMS welcomes ongoing engagement from stakeholders on any potential solutions regarding future payment changes.

The ACR is reviewing the final 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.