ACR Issues Analysis of OPPS Proposed Rule for CY2018

The Centers for Medicare and Medicaid Services (CMS) released its proposed rule for calendar year (CY) 2018 changes to the Hospital Outpatient Prospective Payment System (HOPPS) on July 13, 2017. Any comments the American College of Radiology (ACR) or other stakeholders would like CMS to consider must be submitted within the 60-day comment period ending September 11, 2017. A detailed summary of the proposed rule follows.

HOPPS Conversion Factor (Page 131)

CMS is proposing to increase the conversion factor by 1.75 percent bringing it up to $76.483 for CY 2018. The reduced conversion factor for hospitals failing to meet the Hospital Outpatient Quality Reporting (OQR) Program requirements is proposed to be $74.953.

MR CT Cost Centers (Page 6)

Beginning in CY 2018, CMS is due to sunset its transition policy on the use of CT and MR cost data and would estimate the imaging ambulatory payment classification (APC) relative payment weight using cost data from all providers, regardless of the cost allocation statistic employed (i.e. direct, dollar or square foot method).

Earlier this year, ACR raised concerns regarding using claims from all providers to calculate CT and MRI cost-to-charge ratios (CCRs) because many providers continue to use the "square feet" cost allocation method. ACR believes that including claims from such providers would cause significant reductions in imaging APC payment rates. In response to ACR's concerns, CMS is proposing to extend the transition policy an additional year and not use claims that include the square foot cost allocation method. This would provide added flexibility for hospitals to improve their cost allocation methods during CY 2018 OPPS. Beginning in CY 2019, CMS will estimate the imaging APC relative payment weights using cost data from all providers, regardless of the cost allocation statistic employed.

Proposed OPPS APC-Specific Policies: Radiology and Imaging Procedures and Services (Page 204)

During its March 2017 meeting with CMS, the ACR requested that CMS halt further APC consolidation and expand the Imaging APC family to include an additional level to address procedures performed with and without contrast APCs. ACR argued that payment stability for radiology services depends on adherence to the principle of grouping procedures in a manner that maintains clinical similarity, a principle inherent to the OPPS since its inception.

CMS responded to these and other comments to more appropriately group many imaging services with higher resource costs. CMS is proposing the addition of a fifth level: Imaging without Contrast APC. This additional APC would result from splitting the previous Level 4

Imaging APC. As a result, the proposed Level 4 Imaging without contrast APC would include higher volume lower cost services, and the proposed Level 5 Imaging without contrast APC would include low frequency services with higher costs. This alteration to the imaging APC family does not affect vascular procedure or nuclear medicine APC's as their structures are proposed to remain identical to those found in the CY 2017 OPPS final rule. In the coming weeks, ACR will further analyze the imaging APCs at the code level toward the development of comments on this proposed rule. Please see the below tables for the CY 2017 and Proposed CY 2018 Imaging APCs.

TABLE 19.--CY 2017 IMAGING APCs

CY 2017 APC	CY 2017 APC Group Title
5521	Level 1 Imaging without Contrast
5522	Level 2 Imaging without Contrast
5523	Level 3 Imaging without Contrast
5524	Level 4 Imaging without Contrast
5571	Level 1 Imaging with Contrast
5572	Level 2 Imaging with Contrast
5573	Level 3 Imaging with Contrast

TABLE 20.—PROPOSED CY 2018 IMAGING APCs

Proposed CY 2017 APC	Proposed CY 2017 APC Group Title
5521	Level 1 Imaging without Contrast
5522	Level 2 Imaging without Contrast
5523	Level 3 Imaging without Contrast
5524	Level 4 Imaging without Contrast
5525	Level 5 Imaging without Contrast
5571	Level 1 Imaging with Contrast
5572	Level 2 Imaging with Contrast
5573	Level 3 Imaging with Contrast

Low Dose CT for Lung Cancer Screening

In the CY 2017 OPPS Final Rule, CMS finalized the placement of G0297 (Low dose CT scan (LDCT) for lung cancer screening) in the lowest level APC (5521 (Level 1 Imaging without Contrast)) cutting its payment from $112.49 to $59.84, despite widespread opposition and comment. For CY 2018, CMS is proposing to keep G0297 in the lowest level Imaging without Contrast APC (5521), an action that would decrease payment for the service from $59.84 to $59.17. In addition, CMS has elected to keep G0296 (visit to determine lung LDCT eligibility) in APC 5822, decreasing payment for the service from $70.23 to $68.92.

Since the release of the CY 2017 OPPS proposed rule, ACR has been concerned with the APC placement of lung cancer screening services because the CMS proposal strayed from the aforementioned principle of clinical homogeneity and destabilized payments. ACR has repeatedly commented that newly covered services require at least two full years for hospitals

to establish programs to support these services and to report the appropriate associated costs. ACR continues to believe and will provide additional comments emphasizing that the current and proposed placement of G0297 does not adhere to the principle of clinical similarity and that the CMS proposal potentially compromises access to this vital screening service for Medicare beneficiaries.

Proposed Treatment of New and Revised CY 2018 Category I and III CPT Codes That Will Be Effective Jan. 1, 2018 (Page 183)

In March of 2017, ACR presented CMS staff and leadership with a number of requests and data for suggested placements for new and revised CY 2018 Category I and III CPT Codes. These recommendations were based on the clinical expertise of our member volunteers who sought to place the codes in APCs based on the statutorily mandated concepts of clinical similarity and resource use. The new codes relevant to imaging were 32X99 (Cryoablation of Pulmonary Tumors) and 382X3 (Bone Marrow Aspiration). ACR suggested placement of these codes be in APC 5362 (Level 2 Laparoscopy and Related Services) and APC 5073 (Level 3 Excision, Biopsy, Incision, and Drainage), respectively. CMS decided against that placement and instead elected to place each code a level lower in APCs 5631 (Level 1 Laparoscopy and Related Services) and 5072 (Level 3 Excision, Biopsy, Incision, and Drainage).

Proposed Comprehensive APCs (C-APC's) for CY 2018 (Page 77)

In the CY 2014 HOPPS Final Rule, CMS finalized a comprehensive payment policy that packages payment for adjunctive and secondary items, services and procedures into the costliest primary procedure payable under the OPPS at the claim level. These costliest primary procedures are given a "J1" status indicator. With very specific exception, when such a primary ("J1") service is reported on a claim, CMS considers all other items and services reported on that claim as integral, ancillary supportive, dependent and adjunctive. Their payment is packaged into that of the primary service. The comprehensive APC policy was finalized and CMS established an initial 25 C-APCs for CY 2015. In subsequent rule-making cycles CMS added 10 (CY 2016) and 25 (CY 2017) additional C-APCs. However, for the first time since the implementation of the C-APC methodology, CMS proposes no new CAPCs for the CY 2018 proposed rule-making.

Stereotactic Radiosurgery (SRS) (Page 94)

CMS is proposing to continue making separate payment for the 10 planning and preparation services adjunctive to the delivery of Stereotactic Radio Surgery (SRS) treatments using Cobalt-60-based or LINAC-based technology when these services are furnished to beneficiaries within 30 days of SRS treatment.

The American Taxpayer Relief Act of 2012 requires that OPPS payments for Cobalt-60-based SRS be reduced to equal that of payments for LINAC-based SRS for covered outpatient department (OPD) services furnished on or after April 1, 2013. This equalization in payment rates resulted in CMS placing the two SRS treatment codes (77371 (Radiation treatment

delivery, stereotactic radiosurgery [SRS], complete course of treatment cranial lesion(s) consisting of 1 session; multi-source

Cobalt 60-based) and HCPCS code 77372 (Linear accelerator-based)) into the same C-APC (5627 Level 7 Radiation Therapy). CMS noted in that same rule that it identified differences in the billing patterns for SRS procedures delivered using Cobalt-60-based and LINAC-based technologies. Specifically, CMS claimed that many services considered adjunctive were often provided on different dates of service and reported on different claims than the actual delivery of SRS. To collect further data and to identify services adjunctive to primary SRS treatments, CMS implemented the "CP" modifier to be reported during CY 2016 and CY 2017 for those services adjunctive to primary SRS but reported on a separate claim. CMS unbundled payment for those 10 SRS planning and preparation services it had identified as adjunctive and elected to provide separate payment for these services.

In addition, CMS removed those services from geometric mean cost calculation for C-APC 5627. The data collection period for SRS claims with modifier "CP" began on January 1, 2016. CMS reports that it has, indeed, identified a number of services that are adjunctive to SRS services outside of the 10 separately paid planning and preparation codes. CMS further notes that the CP modifier has been used incorrectly and inconsistently. CMS will conclude the data collection period for SRS claims with the "CP" modifier on December 31, 2017 and will subsequently discontinue its required use for CY 2018 and future years.

Brachytherapy (Page 73)

For CY 2018, CMS is proposing to assign status indicator "E2" (Items and Services for Which Pricing Information and Claims Data Are Not Available) to HCPCS code C2645 (Brachytherapy planar, p-103) due to a complete absence of claims data for CY 2016. In contrast, after reviewing claims data, CMS is proposing to change the status indicator for HCPCS code C2644 (Brachytherapy cesium-131 chloride) from "E2" to "U" (Paid under OPPS; separate APC payment) after identifying a single hospital with a single claim reporting the service. CMS will continue to consider external data for the development of payment rates for new brachytherapy services.

Section 1833(t)(2)(H) of the Social Security Act mandates that CMS create additional groups of covered OPD services classifying devices of brachytherapy consisting of a seed or seeds (or radioactive source) ("brachytherapy sources") separately from other services or groups of services. However, due to the abovementioned lack of claims data, CMS reports that it was unable to calculate a proposed payment rate based on the general OPPS rate-setting methodology.

Brachytherapy Insertion Procedures (Page 90)

In this rule, CMS reiterated public comments received in response to previous rulemaking noting that claims including several of the insertion codes for brachytherapy devices often lacked a brachytherapy treatment delivery code. In response to these comments, CMS analyzed claims that include brachytherapy insertion codes assigned to status indicator "J1" and that received payment through a C-APC. To address this issue and to base payment on claims for the most

common clinical scenario, CMS is moving forward with the establishment of a code edit requiring a brachytherapy treatment code accompanying any billed brachytherapy insertion code for CY 2018 and subsequent years.

On a related note, CMS is proposing the deletion of composite APC 8001 (LDR Prostate Brachytherapy Composite) and the assignment of status indicator J1 to HCPCS code 55875 (Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy). This means that when 55875 is reported on a hospital outpatient claim, CMS is proposing to package payment for all adjunctive services reported on the same claim. The aforementioned code edits would require that a treatment code (in this case, 77778 [Interstitial radiation source application; complex]) be reported on any claim with 55875. The brachytherapy codes that will be required to be billed with an accompanying treatment code can be found in the table below.

PROPOSED BRACHYTHERAPY INSERTION PROCEDURES ASSIGNED TO STATUS INDICATOR "J1"

HCPCS Code	Long Descriptor
19296	Placement of radiotherapy after loading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy
19298	Placement of radiotherapy after loading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance
19499	Unlisted procedure, breast
20555	Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure)
31643	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of catheter(s) for intracavitary radioelement application

HCPCS Code	Long Descriptor
43241	Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube catheter
55875	Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy
55920	Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application
57155	Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy
58346	Insertion of Heyman capsules for clinical brachytherapy

Changes for Payment and establishment of new Modifiers for X-Ray using Film and Computed Radiography (Page 371)

For CY 2017, CMS has implemented section The Act by establishing the modifier "FX" for X-ray taken using film. Payment for services using the "FX" modifier will be reduced by 20 percent for CY 2017 and subsequent years. Additionally, CMS is establishing a new "XX" modifier to be reported on claims including codes that describe X-rays taken using computed radiography. Payments for services furnished between CY 2018 and CY 2021 will be reduced by 7 percent and in subsequent years payment will be reduced by a further 10 percent. Section 502 of the Consolidated Appropriations Act of 2016 contains provisions aimed at incentivizing the transition from traditional X-ray imaging to digital radiography.

The Act additionally includes provisions limiting payment for both film X-ray and computed radiography imaging services. CMS notes that when payment for X-ray or computed radiography services are packaged into those for another item or service under the OPPS, there is no payment attributable to X-ray or computed radiography, and therefore, there would be no corresponding payment reduction to either service. CMS further notes that the "XX" modifier is a placeholder and that the final 2-digit modifier and descriptor will be included in the CY 2018 OPPS final rule. CMS is seeking comment on these proposals.

Requests for Comments on Packaging (Page 125)

In response to repeated comments regard the deleterious effect packaging has on patient access, CMS is formally seeking feedback from a broad cross section of stakeholders on the impact and appropriateness of packaging under the OPPS. CMS states that its analysis shows no decrease in utilization volume due to OPPS packaging policies, but the Agency seeks commentary on both common clinical scenarios: one where currently packaged codes are inappropriate and decrease patient access and the other where the opposite is true and packaging would, indeed, be appropriate. ACR commented extensively on the issue of packaging in the CY 2017 OPPS

final rule and previous rules. After reviewing those comments, we plan to reiterate our concerns in this year's final rule comment letter.

Pass-Through Payments (Page 258)

CMS is proposing to continue pass-through payment status in CY 2018 for 38 drugs and biologicals at ASP+6 percent, which would render payments equivalent to the rates these drugs and biologicals would receive in the physician's office setting in the same year. CMS is proposing the same ASP+6 payment status for a number of policy packaged drugs including contrast agents, radiopharmaceuticals and stress agents.

Proposed Procedures Assigned to New Technology APC Groups for CY 2018 (Page 193)

New technology APCs under the OPPS were created by CMS to contain comprehensive services and procedures that CMS considered truly new and significant that otherwise could not be appropriately reported by an existing or new HCPCS code assigned to a clinical APC. CMS has stated in previous guidance that the central criterion for determining whether a technology is truly new is the inability to describe appropriately the complete service within a current individual HCPCS code or combination of codes. New technology APCs are defined not on the clinical characteristics of the service but rather on the basis of cost, an array of which are averaged to determine the payment rate as opposed to the usual relative payment weighting. CMS retains a procedure in its New Technology APC until sufficient claims data exists to justify reassignment to a clinical APC.

CMS is proposing to continue the current APC placement of all four HCPCS codes describing image-guided, high intensity forced ultrasound (MRgFUS), one of which (0398T (Magnetic resonance image-guided, high intensity focused ultrasound (MRgFUS), stereotactic ablation lesion, intracranial for movement disorder including stereotactic navigation and frame placement when performed)) resides in APC 1537 (New Technology - Level 37 ($9501-$10000)) with a proposed payment rate of $9751 for CY 2018. Two of the remaining MRgFUS codes (0071T (focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume of less than 200 cc of tissue)) and 0072T (total leiomyomata volume greater or equal to 200 cc of tissue)) are proposed to remain in the same APC as last year (APC 5414 (Level 4 Gynecological Procedures) as is the final MRgFUS code (C9734 (Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with or without magnetic resonance (MR) guidance) contained in APC 5114 (Level 4 Musculoskeletal Procedures)). See the below table for the proposed CY 2018 Status Indicators, APC assignments and payment rates for the MRgFUS procedures.

PROPOSED CY 2018 STATUS INDICATOR (SI), APC ASSIGNMENTS, AND PAYMENT RATES FOR THE MAGNETIC RESONANCE IMAGE GUIDED HIGH INTENSITY FOCUSED ULTRASOUND (MRgFUS) PROCEDURES

CPT / HCPCS Code	Long Descriptor	CY 2017 OPPS SI	CY 2017 OPPS APC	CY 2017 OPPS Payment Rate	Proposed CY 2018 OPPS SI	Proposed CY 2018 OPPS APC	Proposed CY 2018 OPPS Payment Rate
0071T	Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue.	J1	5414	$2,084.59	J1	5414	$2,188.97
0072T	Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater or equal to 200 cc of tissue.	J1	5414	$2,084.59	J1	5414	$2,188.97
0398T	Magnetic resonance image-guided high intensity focused ultrasound (MRgFUS), stereotactic ablation lesion, intracranial for movement disorder including stereotactic navigation and frame placement when performed.	S	1537	$9,750.50	S	1537	$9,750.50
C9734	Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with magnetic resonance (MR) guidance.	J1	5114	$5,219.36	J1	5114	$5,385.23

Proposed OPPS Payment Rate and Modifier for 340B Purchased Drugs (Page 298)

The 340B drug discount program, established in 1992 and administered by HHS, allows participating hospitals and providers to purchase "covered outpatient drugs" at discounted prices from drug manufacturers. The stated intent of this program is to maximize federal resources and increase patient access to care.

Citing recent studies by the Medicare Payment Advisory Commission (MedPAC) and the Government Accountability Office (GAO), CMS states in the rule that it is concerned that Medicare beneficiaries are potentially liable for drug copayments tied to an ASP+6 methodology when the purchasing cost for the hospital is much lower.

In the CY 2018 OPPS proposed rule, CMS is proposing to establish a modifier, effective January
1, 2018, for hospitals to report with drugs not purchased under the 340B program. Additionally, CMS is proposing to apply a 22.5 percent discount (ASP-22) to the average sales price for drugs purchased through the 340B program. This discount and the use of the modifier is limited to

drugs separately payable under the OPPS. It excludes drugs on pass-through status, which are statutorily required to be paid based on the ASP methodology, and vaccines, which are excluded from the 340B drug discount program. CMS is soliciting comment regarding whether other classes of drugs should be excluded from reduced payment.

Expansion of Services Excepted Off-Campus Hospital Outpatient Departments (Page 355)

For CY 2018, CMS proposes to revise the Physician Fee Schedule (PFS) Relativity Adjuster for nonexcepted items and services furnished by nonexcepted off-campus provider-based departments (PBDs) down from the CY2017 rate of 50 percent of the OPPS payment to 25 percent. Additionally, after reviewing public comments, CMS elected not to move forward with the proposed service line limitations instead choosing to allow excepted PBD payment under the OPPS for all bill items and services regardless of whether they were furnished before the enactment of Section 603. CMS is considering comments and is monitoring how it might limit expansion of service lines in excepted sites in the future.

Section 603 of the Bipartisan Budget Act of 2015 mandates that applicable items and services furnished by certain off-campus outpatient departments of a provider on or after January 1, 2017, will not be considered covered OPD services for purposes of payment under the OPPS. They will instead be paid "under the applicable payment system" if the requirements for such payment are otherwise met. In the CY 2015 OPPS final rule, CMS created a HCPCS modifier (PO) for hospital claims to be reported with items or services furnished in off-campus PBDs paid under the OPPS. The use of this modifier was voluntary in CY 2015 and only became required in CY 2016. This modifier was intended to provide CMS with data to be used for OPPS rate setting determinations.

While reducing Medicare payments for a number of off-campus provider-based departments, Section 603"excepts" a certain type of off-campus provider-based department from OPPS payment elimination. CMS defines excepted off-campus outpatient departments as those billing Medicare under the OPPS prior to November 2, 2015.

CMS stated in the CY 2017 proposed and final rules that those excepted off-campus PBDs would be paid only for those items and services furnished by the PBDs prior to the date of enactment. CMS further proposed that items and services outside the clinical families of those furnished and billed by excepted off-campus PBDs prior to the date of enactment for Section 603 should not be payable under the OPPS. Further, in the CY 2017 OPPS Final Rule, CMS established the "PN" modifier for use on claims furnished in non-excepted off-campus PBDs providing non-excepted services. For CY 2017, claims containing the PN modifier were paid at 50 percent of the OPPS payment rate.

For a more detailed summary of the proposed payment pates under the PFS for nonexcepted items and services furnished by nonexcepted off-campus PBDs, please see the CY 2018 ACR Medicare Physician Fee Schedule Detailed Summary.

Appropriate Use Criteria for Advanced Diagnostic Imaging Services (Page 367)

CMS is proposing an additional component to the Appropriate Use Criteria (AUC) program. The AUC program applies to the Medicare Physician Fee Schedule (MPFS), the Outpatient Prospective Payment System (OPPS) and the Ambulatory Surgical Center rules. More details on this proposal are in the ACR summary of the CY 2018 MPFS proposed rule. Additionally, CMS announced the list of qualified clinical decision support mechanisms (CDSMs) and new qualified provider-led entities (PLEs) on their website.

Multiple Imaging Composite APCs (Page 106)

In the CY 2009 OPP final rule, CMS implemented a policy providing a single payment for each claim containing more than one imaging procedure within the same imaging family. CMS recognizes three imaging families for the purpose of this methodology. These families are ultrasound, computed tomography (CT) and computed tomographic angiography (CTA), and magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA). Due to statutory a statutory requirement that payment for OPPS imaging services are differentiated between services with or without contrast, these three families are further broken out into five multiple imaging composite APCs. CMS defines a single imaging session for the "with contrast" composite APCs as having one or more imaging procedures from the same family performed with contrast on the same date of service. CMS provides a single payment for any imaging procedures and their corresponding packaged services provided on the same date of service. Single imaging procedures and multiple imaging procedures performed across families will continue to be paid at the standard rate determined by APC assignment.

For CY 2018, CMS is not proposing any changes to the Multiple Imaging Composite APCs and will continue to pay for all multiple imaging procedures within an imaging family performed on the same date of service using the above methodology. The table below details the five multiple imaging APCs, the codes placed within them and their proposed CY 2018 geometric mean costs.

PROPOSED OPPS IMAGING FAMILIES AND MULTIPLE IMAGING PROCEDURE COMPOSITE APCs

Family 1 – Ultrasound	
Proposed CY 2018 APC 8004 (Ultrasound Composite)	**Proposed CY 2018 Approximate APC Geometric Mean Cost = $303**
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp
76776	Us exam k transpl w/Doppler
76831	Echo exam, uterus
76856	Us exam, pelvic, complete
76857	Us exam, pelvic, limited

Family 2 - CT and CTA with and without Contrast	
Proposed CY 2018 APC 8005 (CT and CTA without Contrast Composite)*	**Proposed CY 2018 Approximate APC Geometric Mean Cost = $280**
70450	Ct head/brain w/o dye
70480	Ct orbit/ear/fossa w/o dye
70486	Ct maxillofacial w/o dye
70490	Ct soft tissue neck w/o dye
71250	Ct thorax w/o dye
72125	Ct neck spine w/o dye
72128	Ct chest spine w/o dye
72131	Ct lumbar spine w/o dye
72192	Ct pelvis w/o dye
73200	Ct upper extremity w/o dye
73700	Ct lower extremity w/o dye
74150	Ct abdomen w/o dye
74261	Ct colonography, w/o dye
74176	Ct angio abd & pelvis
Proposed CY 2018 APC 8006 (CT and CTA with Contrast Composite)	**Proposed CY 2018 Approximate APC Geometric Mean Cost = $503**
70487	Ct maxillofacial w/dye
70460	Ct head/brain w/dye
70470	Ct head/brain w/o & w/dye
70481	Ct orbit/ear/fossa w/dye
70482	Ct orbit/ear/fossa w/o & w/dye
70488	Ct maxillofacial w/o & w/dye

70491	Ct soft tissue neck w/dye
70492	Ct sft tsue nck w/o & w/dye
70496	Ct angiography, head
70498	Ct angiography, neck
71260	Ct thorax w/dye
71270	Ct thorax w/o & w/dye
71275	Ct angiography, chest
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
72191	Ct angiograph pelv w/o & w/dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o & w/dye
73206	Ct angio upr extrm w/o & w/dye
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o & w/dye
73706	Ct angio lwr extr w/o & w/dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o & w/dye
74175	Ct angio abdom w/o & w/dye
74262	Ct colonography, w/dye
75635	Ct angio abdominal arteries
74177	Ct angio abd & pelv w/contrast
74178	Ct angio abd & pelv 1+ regns
* If a "without contrast" CT or CTA procedure is performed during the same session as a "with contrast" CT or CTA procedure, the I/OCE assigns the procedure to APC 8006 rather than APC 8005.	

Family 3 - MRI and MRA with and without Contrast	
Proposed CY 2018 APC 8007 (MRI and MRA without Contrast Composite)*	**Proposed CY 2018 Approximate APC Geometric Mean Cost = $571**
70336	Magnetic image, jaw joint
70540	Mri orbit/face/neck w/o dye

70544	Mr angiography head w/o dye
70547	Mr angiography neck w/o dye
70551	Mri brain w/o dye
70554	Fmri brain by tech
71550	Mri chest w/o dye
72141	Mri neck spine w/o dye
72146	Mri chest spine w/o dye
72148	Mri lumbar spine w/o dye
72195	Mri pelvis w/o dye
73218	Mri upper extremity w/o dye
73221	Mri joint upr extrem w/o dye
73718	Mri lower extremity w/o dye
73721	Mri jnt of lwr extre w/o dye
74181	Mri abdomen w/o dye
75557	Cardiac mri for morph
75559	Cardiac mri w/stress img
C8901	MRA w/o cont, abd
C8904	MRI w/o cont, breast, uni
C8907	MRI w/o cont, breast, bi
C8910	MRA w/o cont, chest
C8913	MRA w/o cont, lwr ext
C8919	MRA w/o cont, pelvis
C8932	MRA, w/o dye, spinal canal
C8935	MRA, w/o dye, upper extr

Proposed CY 2018 APC 8008 (MRI and MRA with Contrast Composite)	**Proposed CY 2018 Approximate APC Geometric Mean Cost = $888**
70549	Mr angiograph neck w/o & w/dye
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w/dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o & w/dye
70547	Mr angiography neck w/o dye
70548	Mr angiography neck w/dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
72142	Mri neck spine w/dye

72147	Mri chest spine w/dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o & w/dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o & w/dye
73719	Mri lower extremity w/dye
73720	Mri lwr extremity w/o & w/dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o & w/dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
75561	Cardiac mri for morph w/dye
75563	Card mri w/stress img & dye
C8900	MRA w/cont, abd
C8902	MRA w/o fol w/cont, abd
C8903	MRI w/cont, breast, uni
C8905	MRI w/o fol w/cont, brst, un
C8906	MRI w/cont, breast, bi
C8908	MRI w/o fol w/cont, breast,
C8909	MRA w/cont, chest
C8911	MRA w/o fol w/cont, chest
C8912	MRA w/cont, lwr ext
C8914	MRA w/o fol w/cont, lwr ext
C8918	MRA w/cont, pelvis
C8920	MRA w/o fol w/cont, pelvis
C8931	MRA, w/dye, spinal canal
C8933	MRA, w/o&w/dye, spinal canal
C8934	MRA, w/dye, upper extremity
C8936	MRA, w/o&w/dye, upper extr
* If a "without contrast" MRI or MRA procedure is performed during the same session as a "with contrast" MRI or MRA procedure, the I/OCE assigns the procedure to APC 8008 rather than APC 8007.	

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, 2017.