

HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM 2025 FINAL RULE SUMMARY

The Hospital Outpatient Prospective Payment System (HOPPS) final rule was issued on November 1, 2024. The final rule will be published in the *Federal Register* on November 27th. All final rule policies and payments are effective on January 1, 2025.

Under the HOPPS, hospital reimbursement is based on Ambulatory Payment Classifications (APCs). CMS assigns CPT and HCPCS codes to an APC based on clinical and resource use similarity. All services in an APC are reimbursed at the same rate.

The Centers for Medicare and Medicaid Services (CMS) updates the HOPPS payment rates by 2.9 percent overall in 2025. This increase factor is based on the final hospital market basket percentage increase of 3.4 percent, minus the multifactor productivity (MFP) adjustment of minus 0.5 percent.

Summary of 2025 Radiation Oncology HOPPS Payments

APC	Description	CPT Codes	2024 Payment	2025 Payment	Payment Change 2024-2025	Percentage Change 2024-2025
5611	Level 1 Therapeutic Radiation Treatment Preparation	77280, 77299, 77300, 77331, 77332, 77333, 77336, 77370, 77399	\$129.28	\$132.77	\$3.49	2.7%
5612	Level 2 Therapeutic Radiation Treatment Preparation	77285, 77290, 77306, 77307, 77316, 77317, 77318, 77321, 77334, 77338	\$352.05	\$366.07	\$14.02	4.0%
5613	Level 3 Therapeutic Radiation Treatment Preparation	32553, 49411, 55876, 77295, 77301, C9728	\$1,320.21	\$1,368.26	\$48.05	3.6%
5621	Level 1 Radiation Therapy	77401, 77402, 77789, 77799	\$114.25	\$109.50	(\$4.75)	-4.2%
5622	Level 2 Radiation Therapy	77407, 77412, 77600, 77750, 77767, 77768, 0394T	\$256.06	\$262.98	\$6.92	2.7%
5623	Level 3 Radiation Therapy	77385, 77386, 77423, 77470, 77520, 77610, 77615, 77620, 77761, 77762	\$560.87	\$578.47	\$17.60	3.1%
5624	Level 4 Radiation Therapy	77605, 77763, 77770, 77771, 77772, 77778, 0395T	\$683.13	\$693.81	\$10.68	1.6%
5625	Level 5 Radiation Therapy	77522, 77523, 77525	\$1,351.62	\$1,275.51	(\$76.11)	-5.6%
5626	Level 6 Radiation Therapy	77373	\$1,700.12	\$1,755.91	\$55.79	3.3%
5627*	Level 7 Radiation Therapy	77371, 77372, 77424, 77425	\$7,419.64	\$7,644.49	\$224.85	3.0%

*Comprehensive APC

APC ASSIGNMENT OF RADIATION ONCOLOGY CODES

There are no APC reassignments for radiation oncology related procedures.

APC ASSIGNMENT OF MEDICAL PHYSICS CODE 76145

For 2025, CMS maintains CPT code 76145 (Medical physics dose evaluation for radiation exposure that exceeds institutional review threshold, including report (medical physicist/dosimetrist)) in APC 5723 *Level 3 Diagnostic Tests and Related Services* with a payment rate of \$530.60, a 3.9 percent increase over current payment.

MAGNETIC RESONANCE EXAM SAFETY PROCEDURES (CPT 76014-76019)

For CY 2025, the AMA CPT Editorial Panel created six codes to report magnetic resonance (MR) examination safety procedures, effective January 1, 2025. The new codes did not have a predecessor code or a one-to-one match to an existing code. When determining the proposed status indicators and APC assignments for CY 2025, CMS reviewed the clinical and resource characteristics of the procedures, considered input from their medical advisors, and reviewed existing APC classifications to identify similar and closely related procedures. After consideration of the public comments received, **CMS is finalizing their proposal with modification for CPT codes 76014 through 76019** (see table below).

CPT Code	Proposed Rule APC Assignment	Proposed Rule Payment	Final Rule APC Assignment	Final Rule Payment
76014 MR safety implant and/or foreign body assessment; initial 15 minutes	5731 Level 1 Minor Procedures	\$24.55	5731 Level 1 Minor Procedures	\$24.49
76015 MR safety implant and/or foreign body assessment; each additional 30 minutes (add-on code)	n/a	\$0	n/a	\$0
76016 MR safety determination	5521 Level 1 Imaging without Contrast	\$87.56	5521 Level 1 Imaging without Contrast	\$88.05
76017 MR safety medical physics examination customization	5734 Level 4 Minor Procedures	\$127.99	5523 Level 3 Imaging without Contrast	\$241.72
76018 MR safety implant electronics preparation	5731 Level 1 Minor Procedures	\$24.55	5742 Level 2 Electronic Analysis of Devices	\$91.79
76019 MR safety implant positioning and/or immobilization	5733 Level 3 Minor Procedures	\$59.07	5733 Level 3 Minor Procedures	\$59.40

Comment: Some commenters disagreed with the proposed assignments for the five separately payable codes and provided recommendations for APC reassignments. They stated that the proposed APC assignments for the new codes would be insufficient to cover the cost of furnishing the procedures and would impact beneficiary access. Commenters detailed that the proposed APC assignments for CPT codes 76017, 76018, and 76019 did not reflect the facility costs associated with these procedures, including additional staff time, MR room time and clinical resources for planning, preparation, and patient positioning.

The commenters requested that CMS reassign CPT codes 76014 (placeholder code 7XX00) and 76016 (placeholder code 7XX05) to APC 5611 (Level 1 Therapeutic Radiation Treatment Preparation) with a proposed payment rate of \$89.12. Commenters requested that CMS reassign CPT codes 76017 (placeholder code 7XX03) and 76019 (placeholder code 7XX05) to APC 5612 (Level 2 Therapeutic Radiation Treatment Preparation);

proposed payment rate of around \$370). Commenters shared that CPT codes 76017 (placeholder code 7XX03) and 76019 (placeholder code 7XX05) require additional staff time and clinical resources for planning, preparation, and positioning which warrants reassignment to APC 5612.

One commenter requested that CMS reassign CPT code 76018 (placeholder code 7XX04) to APC 5612 (Level 2 Therapeutic Radiation Treatment Preparation; proposed payment rate of around \$370). Another commenter requested a reassignment of CPT code 76018 to APC 5742 (Level 2 Electronic Analysis of Devices; proposed payment rate of around \$92). The commenter stated that CPT code 76018 involves interrogation and programming of an implanted device to protect the device and patient against interactions with the MRI scanner and would therefore fit well within APC 5612.

Response: We thank the commenters for their feedback and recommendations. In determining the appropriate APC placement for new codes, CMS relies on input from a variety of sources, including, but not limited to, review of the resource costs and clinical similarity of the service to existing procedures; input from CMS medical advisors; and information from interested specialty societies. CMS evaluated the recommendations, modeled the suggestions, analyzed the cost results of the suggested APC reassignments, and received additional input from our medical advisors. Because we believe that the services assigned to the Therapeutic Radiation Treatment Preparation APC family have higher degrees of technicality, require higher levels of trained professional staff, and therefore have additional facility costs beyond those described by the CPT codes 76014 through 76019, we disagree with the commenter requests to assign these CPT codes to APCs 5611 and 5612. And while we recognize that there is not currently a one-to-one match to crosswalk to the new codes, we based the proposed APC assignments for CPT codes 76014, 76016, and 76019 on crosswalks to CPT codes that have similar service and resource elements, as well as required staff, to the new codes.

Specifically, we continue to believe that:

- CPT code 76014 is similar to the service described by CPT code 0521T (Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording, and disconnection per patient encounter, wireless cardiac stimulator for left ventricular pacing), which is assigned to APC 5731.
- CPT code 76016 is similar to the service described by CPT code 77091 (Trabecular bone score (tbs), structural condition of the bone microarchitecture; technical calculation only), which is assigned to APC 5521.
- CPT code 76019 is similar to CPT code 29520 (Strapping; hip), which is assigned to APC 5733.

After consideration of the public comments, our review of CPT code 76017 identified procedures in APC 5523 (Level 3 Imaging without Contrast) that we believe better align with the clinical characteristics and resources required for CPT code 76017, including CPT code 73718 (Magnetic resonance (e.g., proton) imaging, lower extremity other than joint; without contrast material(s)). After further input from CMS medical advisors, we believe that it may be appropriate to assign CPT code 76017 to APC 5523.

Additionally, we believe that we have identified additional procedures in APC 5742 that share similar resource and clinical characteristics with CPT code 76018. Specifically, we believe that CPT code 76018 shares resource and clinical similarities to the service

described by CPT code 29125 (Application of short arm splint (forearm to hand); static). Based on our assessment, we believe it appropriate to assign CPT code 76018 to APC 5742, based on shared resource and clinical characteristics.

In summary, CMS believes that the assignment of the new codes is the most appropriate, in terms of clinical and resource homogeneity. CMS notes that they review the claims data on an annual basis to establish the HOPPS payment rates and will reevaluate the status indicator and APC assignments annually.

IMAGING APCs

For 2025, CMS maintains the seven Imaging APCs, which consist of four levels of Imaging without Contrast APCs and three levels of Imaging with Contrast APCs. Five of the 7 Imaging APCs have 2X Rule violations, including APCs 5521, 5522, 5523, 5524 and 5572.

The table below lists the 7 Imaging APCs. (Specific APC assignments for each service grouping are listed in Addendum B).

APC	APC Title	2024 Payment	2025 Payment	Percent Change 2024-2025
5521	Level 1 Imaging Without Contrast	\$86.58	\$88.05	1.7%
5522	Level 2 Imaging Without Contrast	\$104.75	\$106.34	1.5%
5523	Level 3 Imaging Without Contrast	\$233.47	\$241.72	3.5%
5524	Level 4 Imaging Without Contrast	\$525.63	\$548.30	4.3%
5571	Level 1 Imaging With Contrast	\$175.06	\$178.02	1.7%
5572	Level 2 Imaging With Contrast	\$366.42	\$357.13	-2.5%
5573	Level 3 Imaging With Contrast	\$762.88	\$790.06	3.6%

NUCLEAR MEDICINE APCs

For 2025, CMS maintains five Nuclear Medicine APCs. (Specific APC assignments for each service grouping are listed in Addendum B).

APC	APC Title	2024 Payment	2025 Payment	Percent Change 2024-2025
5591	Level 1 Nuclear Medicine	\$392.97	\$401.83	2.3%
5592	Level 2 Nuclear Medicine	\$514.99	\$538.27	4.5%
5593	Level 3 Nuclear Medicine	\$1,352.93	\$1,305.48	-3.5%
5594	Level 4 Nuclear Medicine	\$1,490.60	\$1,458.59	-2.1%
5661	Therapeutic Nuclear Medicine	\$237.04	\$224.13	-5.4%

BIOLOGY GUIDED RADIATION THERAPY (BgRT)

Biology Guided Radiation Therapy (BgRT) uses positron-emitting radiopharmaceuticals to control delivery of radiation therapy to treat primary and metastatic lung or bone tumors. During radiation treatment delivery, the same system applies these firing filters to the real-time positron emission tomography (PET) data collected by the radiation treatment delivery machine.

Effective January 1, 2024, CMS created HCPCS codes C9794 (Therapeutic radiology simulation-aided field setting; complex, including acquisition of PET and CT imaging data required for radiopharmaceutical-directed radiation therapy treatment planning (i.e.,

modeling) and C9795 (Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions) to describe the modeling and treatment delivery portions of the BgRT service.

For CY 2025, the HOPPS payment rates are based on available CY 2023 claims data. As HCPCS codes C9794 and C9795 were effective January 1, 2024, CMS does not have any claims data for the service. Therefore, **for CY 2025, CMS continues to assign these HCPCS codes to the same New Technology APCs in 2024.**

Effective January 1, 2025, CMS establishes new HCPCS G-codes for the Biology Guided Radiation Therapy (BgRT), which replaces current HCPCS codes C9794 and C9795.

HCPCS C9794 is being deleted and replaced by G0562 (Therapeutic radiology simulation-aided field setting; complex, including acquisition of PET and CT imaging data required for radiopharmaceutical-directed radiation therapy treatment planning (i.e., modeling)). **CMS proposes to continue to assign HCPCS G0562 to New Technology APC 1521 (New Technology - Level 21 (\$1901-\$2000)) with a 2025 payment of \$1,950.50.**

HCPCS C9795 is being deleted and replaced by G0563 (Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance and real-time positron emissions-based delivery adjustments to 1 or more lesions, entire course not to exceed 5 fractions). **CMS proposes to continue to assign HCPCS G0563 to New Technology APC 1525 (New Technology - Level 25 (\$3501-\$4000)) with a 2025 payment of \$3,750.50.**

BRACHYTHERAPY SOURCES

The Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 requires CMS to continue separate payment for brachytherapy sources in 2025 and subsequent years, in addition to the procedure APCs.

CMS continues to pay separately for each of the brachytherapy sources on a prospective basis, with 2025 payment rates using the 2023 geometric mean unit costs for each source, with the exception of brachytherapy sources designated as “Low Volume.”

CMS reports that there were no 2023 claims available for HCPCS code C2645 (Brachytherapy planar source, Palladium-103, per square millimeter). Therefore, in the absence of claims data, CMS continues to use their equitable adjustment authority to maintain the current 2024 payment rate of \$4.69 per mm² for HCPCS code C2645 for CY 2025.

Additionally, for 2022 and subsequent years, CMS established a Low Volume APC policy for New Technology APCs, clinical APCs, and brachytherapy APCs. CMS designates 6 brachytherapy APCs as Low Volume APCs for 2025 (see below).

CMS continues the other payment policies for brachytherapy sources finalized and implemented in the 2010 HOPPS final rule.

Comparison of Brachytherapy Source Payment 2024 to 2025

HCPCS	Long Descriptor	APC	2024 Payment	2025 Payment	Payment Change 2024-2025	Percentage Change 2024-2025
A9527 *	Iodine I-125, sodium iodide solution, therapeutic, per mCi	2632	\$60.15	\$208.58	\$148.43	246.8%
C1716*	Brachytherapy source, Gold-198, per source	2645	\$270.91	\$868.33	\$597.42	220.5%
C1717	Brachytherapy source, High Dose Rate Iridium-192, per source	2646	\$346.98	\$457.32	\$110.34	31.8%
C1719*	Brachytherapy source, Non-High Dose Rate Iridium-192, per source	2647	\$348.42	\$564.50	\$216.08	62.0%
C2616	Brachytherapy source, Yttrium-90, per source	2616	\$17,177.01	\$19,354.20	\$2,177.19	12.7%
C2634	Brachytherapy source, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source	2634	\$150.81	\$189.28	\$38.47	25.5%
C2635*	Brachytherapy source, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source	2635	\$59.13	\$69.38	\$10.25	17.3%
C2636*	Brachytherapy linear source, Palladium-103, per 1MM	2636	\$54.05	\$52.91	(\$1.14)	-2.1%
C2637	Brachytherapy source, Ytterbium-169, per source		\$0.00	\$0.00	\$0	0%
C2638	Brachytherapy source, stranded, Iodine-125, per source	2638	\$41.78	\$46.97	\$5.19	12.4%
C2639	Brachytherapy source, non-stranded, Iodine-125, per source	2639	\$34.95	\$48.77	\$13.82	39.5%
C2640	Brachytherapy source, stranded, Palladium-103, per source	2640	\$76.19	\$88.87	\$12.68	16.6%
C2641	Brachytherapy source, non-stranded, Palladium-103, per source	2641	\$73.86	\$91.27	\$17.41	23.6%
C2642*	Brachytherapy source, stranded, Cesium-131, per source	2642	\$97.51	\$107.86	\$10.35	10.6%
C2643	Brachytherapy source, non-stranded, Cesium-131, per source	2643	\$80.33	\$111.60	\$31.27	38.9%
C2644	Brachytherapy source, Cesium-131 chloride solution, per mCi	2644	\$0.00	\$0.00	\$0.00	0%
C2645	Brachytherapy planar source, Palladium-103, per square millimeter	2648	\$4.69	\$4.69	\$0.00	0%
C2698	Brachytherapy source, stranded, not otherwise specified, per source	2698	\$41.78	\$46.97	\$5.19	12.4%
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source	2699	\$34.95	\$48.77	\$13.82	39.5%

*Designated as a Low Volume Brachytherapy APC

LOW VOLUME POLICY FOR CLINICAL, BRACHYTHERAPY & NEW TECHNOLOGY APCS

Historically, CMS has used their equitable adjustment authority on a case-by-case basis to adjust how they determine the costs for certain low volume services. CMS has acknowledged that for low volume procedures with significant device costs, the median cost would be a more appropriate measure of the central tendency for purposes of calculating the cost and the payment rate for low volume procedures. CMS explained that the median cost is impacted to a lesser degree than the geometric mean cost by more extreme observations. CMS notes that low utilization of services can lead to wide variation in payment rates from year to year. CMS believes that where there are fewer than 100 single claims from the most recent year available for rate setting for an APC, there is often significant volatility in the payment rate for those APCs that could be addressed with a low-volume adjustment policy.

For APCs with fewer than 100 single claims that can be used for rate setting purposes in the existing claims year, CMS will use up to four years of claims data to establish a payment rate for each item or service as they currently do for low volume services assigned to New Technology APCs. CMS calculates the cost for Low Volume APCs based on the greatest of the arithmetic mean cost, median cost, or geometric mean cost.

For 2025 designates 6 brachytherapy APCs as low volume APCs under the HOPPS. The brachytherapy APCs meet the CMS criteria of having fewer than 100 single claims in the claims year 2023 and therefore, subject to the low volume APC policy.

Based on data for the 2025 HOPPS rule, **APC 2645 (Brachytherapy source, non-stranded, Gold-198) now meets the CMS criteria to be designated a Low Volume APC; and CMS designates it as such for CY 2025.**

This policy includes the following brachytherapy sources:

- APC 2632: A9527 Iodine-125, sodium iodide solution, therapeutic, per millicurie (1 claim)
- APC 2635: C2635 Brachytherapy source, High Activity, Palladium-103, greater than 2.2 mCi, per source (20 claims)
- APC 2636: C2636 Brachytherapy linear source, Palladium-103, per 1 MM (1 claim)
- APC 2642: C2642 Brachytherapy source, stranded, Cesium-131, per source (95 claims)
- APC 2645: C1716 Brachytherapy source, Gold-198, per source (96 claims)
- APC 2647: C1719 Brachytherapy source, Non-High Dose Rate Iridium-192, per source (2 claims)

Under the Low Volume APC policy, the payment rates for these APCs are set at the highest amount among the geometric mean, median, or arithmetic mean, calculated using up to four years of data, which in the case of these APCs, would be claims data from 2019, 2021, 2022 and 2023 (CMS does not use claims data from 2020 due to concerns with claims data as a result of the public health emergency).

COMPREHENSIVE APCs

CMS continues to apply the comprehensive APC (C-APC) payment policy methodology in 2025. CMS did not propose to convert any standard APCs to C-APCs in CY 2025. The total number of C-APCs for CY 2025 is 72.

CMS defines a C-APC as a classification for the provision of a primary service and all adjunctive services and supplies provided to support the delivery of the primary service. CMS continues the C-APC payment policy methodology of including all covered outpatient department services on a hospital outpatient claim reporting a primary service that is assigned to status indicator “J1,” excluding services that are not covered outpatient department services or that cannot by statute be paid under the HOPPS. Under this policy, CMS calculates a single payment for the entire hospital stay, defined by a single claim, regardless of the date of service span.

CMS only excludes charges for services that are not payable under the HOPPS, such as certain mammography and ambulance services that are never covered hospital outpatient services; brachytherapy seeds, which must receive separate payment; pass-through drugs and devices, which also require separate payment; self-administered drugs that are not otherwise packaged as supplies because they are not covered under Medicare Part B; and preventive services.

CMS will continue to exclude payment for any procedure that is assigned to a New Technology APC (APCs 1491 through 1599 and APCs 1901 through 1908) from being packaged when included on a claim with a “J1” service assigned to a C-APC.

Beginning January 1, 2023 and subsequent years, CMS excludes any drug, biological, or radiopharmaceutical described by HCPCS code C9399 (Unclassified drugs or biologics) from packaging included on a claim with a J1 comprehensive-APC service or J2 comprehensive observation service.

CMS finalized the proposal to exclude non-opioid treatments for pain relief identified as satisfying the required criteria for payment under Section 4135 of the Consolidated Appropriations Act (CAA), 2023 from the C-APC policy to ensure payment is not packaged into any C-APC and that separate payment is made in accordance with the statute.

CMS proposed to exclude qualifying cell and gene therapies from C-APC packaging for one year in 2025 in order to gather more information from interested parties as to whether this proposed policy appropriately captures all of the unique therapies that function as primary treatments and do not support C-APC primary services. **CMS modified this proposal, for CY 2025 and subsequent years, CMS is finalizing a policy not to package payment for cell and gene therapies into C-APCs, when those cell and gene therapies are not functioning as integral, ancillary, supportive, dependent, or adjunctive to the primary C-APC service.** For new cell and gene therapy products that are not integral, ancillary, supportive, dependent, or adjunctive to any C-APC primary service, CMS will continue to add their product specific HCPCS codes, when created, to the C-APC exclusion list (see Table 4 on pages 80-81).

A. Brachytherapy Insertion Procedures

In the 2017 HOPPS/ASC final rule, CMS finalized 25 new C-APCs. Some of the HCPCS codes assigned to the C-APCs established for 2017 described surgical procedures for inserting brachytherapy catheters/needles and other related brachytherapy procedures such as the insertion of tandem and/or ovoids and the insertion of Heyman capsules.

CMS did not propose any changes or reassignments to the brachytherapy insertion code C-APC policy for 2025.

Comprehensive APCs Related to Brachytherapy Insertion Procedures

C-APC	CPT Codes	2024 C-APC Payment	2025 C-APC Payment	Percent Change 2024-2025
5091 <i>Level 1 Breast Surgery</i>	19499 Unlisted breast procedure	\$3,631.79	\$3,829.28	5.4%
5092 <i>Level 2 Breast Surgery</i>	19298 Breast brachytherapy button & tube catheter placement	\$6,213.24	\$6,521.46	5.0%
5093 <i>Level 3 Breast Surgery</i>	19296 Breast brachytherapy balloon catheter placement	\$8,981.62	\$9,569.05	6.5%
5113 <i>Level 3 Musculoskeletal</i>	20555 Placement needles/catheters into muscle and/or soft tissue for subsequent interstitial radioelement application	\$3,084.03	\$3,244.61	5.2%
5153 <i>Level 3 Airway Endoscopy</i>	31643 Diagnostic bronchoscope, catheter placement	\$1,617.14	\$1,724.47	6.6%
5165 <i>Level 5 ENT</i>	41019 Placement needles/catheters into head and/or neck region for radioelement application	\$5,579.71	\$5,915.66	6.0%
5302 <i>Level 2 Upper GI</i>	43241 Upper GI endoscopy, catheter placement	\$1,812.99	\$1,896.99	4.6%
5375 <i>Level 5 Urology and Related Services</i>	55874 Peri-prostatic implantation of biodegradable material* 55875 Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy	\$4,930.08	\$5,083.62	3.1%
5415 <i>Level 5 Gynecological</i>	55920 Placement needles/catheters into pelvic organs and/or genitalia (except prostate) for radioelement application 57155 Insertion uterine tandem and/or vaginal ovoids 58346 Insertion of Heyman capsules for clinical brachytherapy	\$4,739.10	\$4,936.45	4.2%

Comment: Two commenters expressed concerns with the C-APC methodology for surgical insertion codes for brachytherapy treatment, stating that these concerns impact beneficiary access to brachytherapy in the HOPD setting. These commenters stated that the C-APC methodology lacks the appropriate charge capture mechanisms to accurately reflect the services associated with the C-APC, that there are significant variations in the clinical practice and billing patterns in the hospital claims data used for ratesetting, and that the C-APC rates do not accurately or fully reflect the services and costs associated with the primary procedure. Commenters urged the agency to explore alternatives, including that CMS discontinue the C-APC policy for all brachytherapy insertion codes. Alternatively, one commenter suggested that CMS could continue to pay for “J1” brachytherapy insertion codes under the C-APC payment methodology but exclude and make separate payment for designated preparation and planning services in addition to

the C-APC payment. Another commenter called for education on whether services, like brachytherapy, that are assigned to a J1 indicators and delivered over multiple patient encounters may be reported per encounter.

Response: We appreciate the comments on the C-APC methodology. However, we believe that the current C-APC methodology is appropriately applied to surgical insertion for brachytherapy treatment procedures and is accurately capturing costs, particularly as the brachytherapy sources used for these procedures are excluded from C-APC packaging and are separately payable. We will evaluate if provider education may be appropriate in this circumstance. We will continue to examine these concerns and will determine if any modifications on this policy are warranted in future rulemaking.

B. Complexity Adjustments

CMS uses complexity adjustments to provide increased payment for certain comprehensive services. CMS applies a complexity adjustment by promoting qualifying paired “J1” service code combinations or paired code combinations of “J1” services and certain add-on codes from the originating C-APC (the C-APC to which the designated primary service is first assigned) to the next higher paying C-APC in the same clinical family of C-APCs. CMS applies this type of complexity adjustment when the paired code combination represents a complex, costly form or version of the primary service.

Key complexity adjustments that apply to radiation oncology or related surgical codes are below:

Primary HCPCS	Primary APC Assignment (Payment)	Secondary HCPCS	Secondary APC Assignment (Payment)	Complexity Adjusted HCPCS	Complexity Adjusted APC Assignment (payment)
55874 Peri-prostatic implantation of biodegradable material	5375 (\$5083.62)	55875 Transperineal placement of needles into prostate	5375 (\$5083.62)	5587D	5376 (\$9247.15)
55875 Transperineal placement of needles into prostate	5375 (\$5083.62)	55875 Transperineal placement of needles into prostate	5375 (\$5083.62)	5587E	5376 (\$9247.15)
55920 Place needles into pelvic organ (except prostate)	5415 (\$4,936.45)	55920 Place needles into pelvic organ (except prostate)	5415 (\$4,936.45)	5592X	5416 (\$7,394.81)
55920 Place needles into pelvic organ (except prostate)	5415 (\$4,936.45)	57155 Insert uterine tandem/ovoids	5415 (\$4,936.45)	5592X	5416 (\$7,394.81)
57155 Insert uterine tandem/ovoids	5415 (\$4,936.45)	57155 Insert uterine tandem/ovoids	5415 (\$4,936.45)	5715E	5416 (\$7,394.81)

COMPOSITE APCS

In 2008, CMS developed composite APCs to provide a single payment for groups of services that are typically performed together during a single clinical encounter and that result in the provision of a complete service. CMS states that an advantage to the composite APC model is that they are able to use data from correctly coded multiple procedure claims to calculate payment rates for the specified combinations of services, rather than relying upon single procedure claims that may be low in volume and/or

incorrectly coded. For 2025 and subsequent years, CMS continues the established composite APC policies for multiple imaging services.

A. Multiple Imaging Composite APCs (APC 8004, 8005, 8006, 8007 and 8008)

CMS implemented the multiple imaging composite APCs effective January 1, 2009. CMS provides a single payment each time a hospital bills more than one imaging procedure within an imaging family on the same date of service. CMS utilizes 3 imaging families (ultrasound; CT/CTA; and MRI/MRA) and 5 composite APCs to differentiate payment for services provided with and without contrast.

CMS continues to pay for all multiple imaging procedures using the multiple imaging composite payment methodology. The standard (noncomposite) APC assignments continue to apply for single imaging procedures and multiple imaging procedures performed across families. (See Table 6 on pages 94-97 for a list of HCPCS codes subject to the multiple imaging composite policies.)

CMS provides one composite APC payment each time a hospital bills more than one procedure described by the HCPCS codes in one HOPPS imaging family on a single date of service. If the hospital performs a procedure without contrast during the same session as at least one other procedure with contrast using the same imaging modality, then the hospital would receive payment for the “with contrast” composite APC. A single imaging procedure, or imaging procedures reported with HCPCS codes assigned to different HOPPS imaging families, are paid according to the standard HOPPS rate setting methodology.

Composite APC	2024 Payment	2025 Payment	Percentage Change 2024-2025
8004 Ultrasound Composite	\$305.75	\$306.50	0.2%
8005 CT and CTA without Contrast Composite	\$225.11	\$224.55	-0.2%
8006 CT and CTA with Contrast Composite	\$427.60	\$435.12	1.8%
8007 MRI and MRA without Contrast Composite	\$522.70	\$540.27	3.4%
8008 MRI and MRA with Contrast Composite	\$831.45	\$854.83	2.8%

PACKAGING POLICY

The HOPPS currently packages many categories of items and services that are typically provided as part of the outpatient hospital service. Packaging encourages hospital efficiency, flexibility, and long-term cost containment, and it also promotes the stability of payment for services over time.

CMS continues to package payment for items and services in multiple categories into the payment for the primary diagnostic or therapeutic modality to which these items and services are typically ancillary and supportive. Packaged services do not receive separate payment.

For 2025, CMS did not propose any changes to the overall packaging policy.

Diagnostic Radiopharmaceuticals: CMS notes that commenters historically have been concerned that packaging payment for precision diagnostic radiopharmaceuticals in the outpatient setting creates barriers to beneficiary access for safety net hospitals serving a high proportion of Medicare beneficiaries and hospitals serving underserved communities.

CMS reiterated its commitment to ensuring beneficiary access to diagnostic radiopharmaceuticals while also ensuring the availability of new and innovative diagnostic tools for Medicare beneficiaries. CMS agrees with commenters that payment for diagnostic radiopharmaceuticals is a complex and important issue.

After significant consideration and ongoing engagement from interested parties, CMS proposed a change to the current policy that packages diagnostic radiopharmaceuticals regardless of their cost. **CMS finalized the proposal to pay separately for any diagnostic radiopharmaceutical with per day cost greater than \$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 below the threshold would continue to be packaged under the current packaging policy.

CMS finalized the proposal to update the \$630 threshold in CY 2026 and subsequent years by the Producer Price Index (PPI) for Pharmaceuticals for Human Use.

Finally, **CMS finalized the proposal to pay for separately payable diagnostic radiopharmaceuticals based on their Mean Unit Cost (MUC) derived from HOPPS claims.** CMS states that the ASP data they have is not usable for the purpose of paying for diagnostic radiopharmaceuticals. CMS is paying for qualifying nonpass-through diagnostic radiopharmaceuticals with claims data based on mean unit cost data derived from hospital claims. CMS believes that paying for diagnostic radiopharmaceuticals using mean unit cost would appropriately pay for the average price of nonpass-through separately payable diagnostic radiopharmaceuticals for the applicable year. CMS believes MUC is an appropriate proxy for the average price for a diagnostic radiopharmaceutical for a given year, as it is calculated based on the average costs for a particular year and is directly reflective of the actual cost data that hospitals submit to CMS.

The list of diagnostic radiopharmaceuticals that have calculated per day costs that exceed \$630 are listed in Table 9 on page 141 of this final rule.

(For additional detail see pages 100-142.)

TWO TIMES RULE

APCs are organized such that each group is homogenous both clinically and in terms of resource use. An APC group cannot be considered comparable with respect to the use of resources if the highest cost for a procedure in the group is more than 2 times greater than the lowest cost for a procedure in the same group (referred to as the 2x Rule). The statute authorizes CMS to make exceptions to the 2x Rule in unusual cases, such as low-volume items and services.

CMS identified 28 APCs with 2X Rule violations in 2025, including 3 Radiation Oncology, 5 Radiology Imaging and 1 Nuclear Medicine APCs:

- 5611 *Level 1 Therapeutic Radiation Treatment Preparation*
- 5613 *Level 3 Therapeutic Radiation Treatment Preparation*
- 5627 *Level 7 Radiation Therapy*
- 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*
- 5593 *Level 3 Nuclear Medicine and Related Services*

These APCs are exempt from the 2 times rule (see Table 18 on page 243-244 for list of APC exceptions to the 2 times rule for 2025).

NEW TECHNOLOGY

For new technology items and services, special payments under the HOPPS may be made in one of two ways: 1.) Transitional Pass-through Payments, for at least 2 but not more than 3 years for certain drugs, biological agents, brachytherapy devices used for the treatment of cancer, and categories of other medical devices; and 2.) New Technology APCs for new procedures.

A. Transitional Device Pass-through Payments

CMS received fourteen (14) applications for device pass-through payments. No application was specific to radiation therapy.

B. New Technology APCs

Services that are assigned to New Technology APCs are typically new services that do not have sufficient outpatient claims to establish an accurate payment for services. New Technology APCs are designated by cost bands which allows CMS to provide appropriate and consistent payment for designated new procedures that are not yet reflected in the claims data. Similar to pass-through payments, an assignment to a New Technology APC is temporary; that is, CMS retains a service within a New Technology APC until they acquire sufficient data to assign it to a clinically appropriate APC group. There are currently 52 levels of New Technology APCs.

In addition, CMS excludes services assigned to New Technology APCs from bundling into Comprehensive-APC procedures. The goal of such a policy is to promote transparency and predictability in the payment rates for these low-volume new technology procedures and to mitigate wide variation from year to year for such services.

CANCER HOSPITAL PAYMENT ADJUSTMENT

CMS is continuing to provide additional payments to cancer hospitals so that the cancer hospital's payment-to-cost ratio (PCR) after the additional payments is equal to the weighted average PCR for the other HOPPS hospitals using the most recently submitted or settled cost report data. Beginning in 2018, the 21st Century Cures Act requires this weighted average PCR be reduced by 1.0 percentage point.

For 2025, CMS uses a target PCR of 0.87 to determine the CY 2025 cancer hospital payment adjustment to be paid at cost report settlement. That is, the payment adjustments will be the additional payments needed to result in a PCR equal to 0.87 for each cancer hospital.

This methodology would result in the estimated percentage payment adjustments for the 11 cancer hospitals (see table below).

Table 12:

Hospital Name	Estimated Percentage Increase in 2025 HOPPS Payments
City of Hope Comprehensive Cancer Center	51.5%
USC Norris Cancer Hospital	44.3%
University of Miami/Sylvester Comprehensive Cancer Center	32.4%
H. Lee Moffitt Cancer Center & Research Institute	23.9%
Dana-Farber Cancer Institute	46.6%
Memorial Sloan-Kettering Cancer Center	51.6%
Roswell Park Cancer Institute	21.3%
James Cancer Hospital & Solove Research Institute	16.0%
Fox Chase Cancer Center	30.0%
M.D. Anderson Cancer Center	45.1%
Seattle Cancer Care Alliance	47.7%

METHODOLOGY TO RECALIBRATE RELATIVE WEIGHTS

CMS is required to review and revise the relative payment weights for APCs at least annually. CMS recalibrates the APC relative payment weights for services furnished on or after January 1, 2025 and before January 1, 2026 (calendar year 2025), using the same basic methodology described in the 2024 HOPPS final rule, using 2023 claims data.

To set 2025 HOPPS payment rates, CMS typically uses the most updated claims and cost report data available. The best available claims data is the most recent set of data which would be from 2 years prior to the calendar year that is the subject of rulemaking. Cost report data usually lags the claims data by a year and CMS believes that using the most updated cost report extract available from the Healthcare Cost Report Information System (HCRIS) is appropriate for CY 2025 HOPPS rate setting. Therefore, **CMS resumes the typical data process of using the most updated cost reports and claims data available for CY 2025 HOPPS rate setting.**

A. Geometric Mean-Based Payment Weights

CMS continues to use geometric mean costs to calculate the relative weights on which the 2025 HOPPS payment rates are based.

B. Database Source and Methodology

CMS recalibrates the relative APC payment weights for 2025 using claims data for outpatient services furnished on or after January 1, 2023 and before January 1, 2024. The APC costs are based on single and “pseudo” single procedure claims for services furnished in 2023.

C. Cost to Charge Ratio (CCR)

In accordance with longstanding policy, CMS calculates cost-to-charge ratios (CCRs) for the standard and nonstandard cost centers accepted by the electronic cost report database. In general, the most detailed level at which CMS calculates CCRs is the hospital-specific departmental level.

Additionally, CMS has historically not included cost report lines for certain nonstandard cost centers in the HOPPS rate setting database construction when hospitals have reported these nonstandard cost centers on cost report lines that do not correspond to the cost center number. CMS believes it is important to further investigate the accuracy of these cost report data before including such data in the rate setting process. Further, CMS believes it is appropriate to gather additional information from the public before including them in HOPPS rate setting.

D. Use of Single and Multiple Procedure Claims

CMS states that it is generally desirable to use the data from as many claims as possible to recalibrate the APC relative payment weights, including those claims for multiple procedures. CMS continues to use date of service stratification and a list of codes to be bypassed to convert multiple procedure claims to “pseudo” single procedure claims.

The 2025 Bypass List includes the following radiation oncology codes: 77280, 77300, 77301, 77307, 77316, 77318, 77321, 77331, 77336, 77338, 77370, 77373, 77385, 77401, 77520, 77600, 77605, 77610, 77767, 77768 and 0394T. CMS did not add any new radiation oncology CPT codes to the 2025 Bypass List. (See Addendum N for code list.)

CONVERSION FACTOR

The 2025 conversion factor is \$89.169 for hospitals that meet reporting requirements for quality data.

Hospitals that do not meet the reporting requirements of the Hospital Outpatient Quality Reporting (OQR) program are subject to a 2 percent reduction from the market basket update to the conversion factor. The reduced conversion factor is \$87.439 for hospitals that fail to meet the Hospital OQR program requirements.

OTHER CMS PAYMENT POLICIES

A. Adjustment for Rural Sole Community Hospitals

For 2025 and subsequent years, CMS continues the current policy of a budget neutral 7.1 percent payment adjustment for rural sole community hospitals (SCH), including essential access community hospitals, for all services paid under the HOPPS, excluding separately payable drugs and biologicals, devices paid under the pass-through payment policy and items paid at charges reduced to costs. Brachytherapy sources are eligible for the 7.1 percent payment increase because CMS pays them at prospective rates based on their geometric mean costs as calculated from claims data.

B. Outlier Policy

Outlier payments were created to provide additional payment for high cost services not covered by the HOPPS payment rate. For 2025, CMS continues the policy of estimating outlier payments to be 1.0 percent of the estimated aggregate total payment under HOPPS.

CMS triggers outlier payments when the cost of furnishing a service or procedure by a hospital exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus a \$7,175 fixed dollar threshold. CMS continues to pay 50 percent of the amount over the 1.75 times threshold.

For hospitals that fail to meet the quality reporting data requirements, CMS continues the policy that the hospitals' costs be compared to the reduced payments for purposes of outlier eligibility and payment calculation.

C. Software as a Service (SaaS)

New clinical software, which includes clinical decision support software, clinical risk modeling, and computer aided detection (CAD), is becoming increasingly available to providers. These technologies often perform data analysis of diagnostic images from patients. While many of these technologies are new, CMS notes that clinical software, particularly CAD, has been used to aid or augment clinical decision making for decades. These technologies rely on complex algorithms or statistical predictive modeling to aid in the diagnosis or treatment of a patient's condition. CMS refers to these algorithm-driven services that assist practitioners in making clinical assessments, and that providers pay for either on a subscription or per-use basis, as Software as a Service (SaaS).

CMS notes the proliferation of SaaS procedures approved by the FDA and their subsequent assignment of CPT codes by the AMA has led the Agency to seek a workable SaaS payment strategy. CMS is seeking a strategy that would provide equitable payment for these new technologies while also preserving the integrity of the HOPPS payment bundles, an essential component of a prospective payment system. CMS is seeking a payment strategy that aligns with the Agency's mission to improve quality, health, reduce cost, and strengthen the health care system. CMS notes that the manufacturer-supplied cost data of these SaaS services is often high and the true return in investment for these services is still unknown. Moreover, many SaaS services often do not share clinical and resource similarity to existing medical services. Thus, it generally has been challenging to compare a new SaaS service to existing medical services for the purpose of determining a fair payment rate for these new services. Although some have recently received separate payment for these SaaS procedures under the HOPPS, CMS recognizes that certain clinical decision support software, including machine learning or "AI," has been available for many years. In the past ten years, clinical decision support software has been commonly used alongside electronic medical records by medical practitioners. Nonetheless, the number of FDA approved or cleared "machine learning" or "AI" clinical software programs has rapidly increased in the past few years. CMS notes that the FDA has approved many SaaS procedures for similar functions: there are at least six software products that purport to detect findings in Computed Tomography (CT) studies of the chest. Additionally, CMS notes some clinical software developers are now using alternative licensing that charges per use rather than using the traditional annual subscription or bulk use subscription. As a result of these variables and potentially others, there is significant price variation within the SaaS procedure space.

CMS recognizes that SaaS procedures are a heterogenous group of services, which presents challenges when it comes to adopting payment policy for SaaS procedures as a whole. In the CY 2023 HOPPS/ASC final rule, CMS solicited public comment on a payment approach that would broadly apply to SaaS procedures and have received some valuable feedback. Some of the feedback includes incorporating AI taxonomy across agencies and interested parties, or not to establish a single policy that would apply to all SaaS-type technology but instead separately evaluate each new technology to determine

the appropriate HCPCS coding, including whether or not a potential CPT code can be used to support payment for the separate and distinct service under the HOPPS.

For CY 2025, CMS is continuing to work to formulate a workable SaaS payment policy that would enhance their ability to provide equitable payment for SaaS procedures while responsibly managing cost and protecting the Medicare trust fund. Specifically, CMS is working to address the following:

- Identifying a payment strategy that is applicable across the settings of care (e.g. physician offices);
- Identifying the fair costs associated for SaaS services;
- Distinguishing services that should be paid separately versus services that should be packaged under a prospective payment system; and
- Identifying a payment strategy for SaaS services that are part of other medical devices versus those that are distinct services.

CMS did not make any proposals on HOPPS payment for SaaS for CY 2025 but received a number of comments on the topic.

Comment: Commenters suggested CMS formulate a SaaS payment policy that would incentivize adoption of new AI and ensure access and provide stability for its adoption of SaaS technologies. Commenters stated that CMS payment decisions have not uniformly and consistently ensured appropriate levels of payment. Some commenters recommended that we adopt the term “Algorithm-based healthcare services” (ABHS), which include SaaS procedures. ABHS includes these services regardless of whether they are delivered by a third party, or a health care professional using the AI software through the cloud, the web, a workstation, or embedded in imaging acquisition hardware. Commenters also recommended that ABHS codes be initially assigned to New Technology APCs for at least 5 years based on manufacture-supply cost data, until sufficient claims data are available. Some commenters also recommend that we codify the 2023 packaging exemption for SaaS add-on codes policy.

Response: We appreciate the commenters’ valuable input on a SaaS payment policy approach, and we will consider their input for any future SaaS payment policy. We note that the suggestion for any new SaaS services to remain in the initial New Technology APC assignment for at least 5 years is in contrast to our current Transitional Pass-Through policy of three years for device or drugs. Moreover, we would need to examine the feasibility of payment determination based on manufacture-supplied cost data, which has historically not been comparable when the claims data become available.

Comment: One commenter requested CMS clarify that SaaS codes created by the AMA CPT are to be vendor neutral, and that these codes do not represent any single vendor’s services. The commenter stated the focus on a single commercial platform for a code is not accurate, confuses the applicability, and limits adoption of other tools for which the code was intended. The commenter recommended removing the current language that these codes are “associated with” a specific service, which may result in an increase in claims, therefore allowing for a more accurate understanding of actual costs associated with these services.

Response: We thank commenter for the valuable input. We recognize that the proliferation of SaaS procedures has created a need for the agency to continue to update our payment approach. We are continuing to work to improve SaaS payment policy in future

rulemakings to enhance our ability to provide equitable payment for SaaS procedures while responsibly managing cost and protecting the Medicare trust fund.

D. Hospital Outpatient Visits

CMS continues the current policy for clinic visits. HCPCS code G0463 (Hospital outpatient clinic visit for assessment and management of patient) for hospital use only will represent any and all clinic visits under the HOPPS. CMS assigns HCPCS code G0463 to APC 5012 *Clinic Visits and Related Services*. The 2025 payment for an outpatient clinic visit is \$128.87.

E. Inpatient Only List

For 2025, CMS is removing CPT code 22848 (pelvic fixation) from the Inpatient Only (IPO) list. CMS adds three liver allograft services to the IPO list. These codes were newly created by the AMA CPT Editorial Panel for CY 2025.

F. Device-Intensive Procedures

In 2019, CMS modified the device-intensive criteria to allow procedures that involve single-use devices, regardless of whether or not they remain in the body after the conclusion of the procedure, to qualify as device-intensive procedures. CMS also modified the policy to allow procedures with a device offset percentage of greater than 30 percent to qualify as device-intensive procedures.

CMS states that as hospital outpatient departments (HOPDs) and ASCs perform new procedures with significant device costs, they believe it is appropriate to modify the default device offset methodology to pay HOPDs and ASCs more appropriately when CMS lack claims data for these newer procedures.

Therefore, for CY 2025 and subsequent calendar years, **CMS is finalizing the proposal to modify their default device offset percentage policy for new device-intensive procedures. Specifically, for new HCPCS codes that describe a procedure that requires the implantation or insertion of a single-use device that meets CMS requirements of a device as described above and the procedure lacks claims data (from either the new HCPCS code or any predecessor code), CMS would apply a default device offset percentage that is the greater of 31 percent or the device offset percentage of the APC to which the procedure has been assigned.** CMS believes that a HCPCS code-level device offset is, in most cases, a more accurate representation of a procedure's device cost than an APC-wide average device offset based on the average device offset of all the procedures assigned to an APC. However, because newer device-intensive procedures lack claims data, CMS believes the APC-wide average device offset percentage is, in many cases, a better reflection of the estimated device costs of the procedure than a default 31 percent offset.

While historically the device edits policy has only applied to procedures that are device-intensive based on the most recent claims data available, for CY 2025 and subsequent calendar years, **CMS is finalizing a policy to apply the device edit policy permanently once a procedure is designated as a device-intensive procedure in a given year.** For the procedures designated as device-intensive for CY 2025, CMS proposes that the device edit requirement would apply in CY 2025 and subsequent calendar years as well. CMS is concerned that the loss of an applicable device edit may impact hospital reporting of device costs and impede their ability to properly set payment rates and determine

appropriate device offset percentages for device-intensive procedures. Additionally, CMS is finalizing a policy to reinstate their device edits policy for procedures that have been device-intensive since CMS began assigning device-intensive status at the HCPCS code level on January 1, 2017. CMS believes that by applying their device edit policy to procedures that were device-intensive on or after January 1, 2017, CMS might continue to receive device cost information for relatively new procedures with limited claims data, which may have been impacted by the policy to require that only existing device-intensive procedures be subject to the device edits policy. For CY 2025, under the modified device edits policy, the device edits requirement will apply to procedures that are device-intensive in CY 2025 as well as procedures that have been device-intensive on or after January 1, 2017.

(For additional detail see pages 709-731)

CMS designates the following radiation oncology procedures as device-intensive for 2025:

- CPT 19296 (Placement of radiotherapy afterloading expandable catheter (single or multichannel) into breast, delayed) with a device offset of 33.95%
- CPT 19298 (Placement of radiotherapy afterloading 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 image guidance with a device offset of 36.94%
- CPT 32553 (Insert marker thoracic for radiation therapy, percutaneous) with a device offset of 38.74%
- CPT 55874 (Peri-prostatic implantation of biodegradable material) with a device offset of 56.01%
- CPT 55876 (Interstitial device placement for radiation therapy guidance, prostate) with a device offset of 36.19%

G. Payment Adjustment Policy for Radioisotopes Derived from Non-Highly Enriched Uranium Sources

CMS continues the policy of providing an additional \$10 payment for radioisotopes produced by non-highly enriched uranium sources (non-HEU) through December 31, 2025. Under this policy, hospitals report HCPCS code Q9969 (Tc-99m from non-highly enriched uranium source, full cost recovery add-on per study dose) once per dose along with any diagnostic scan or scans furnished using Tc-99m as long as the Tc-99m doses used can be certified by the hospital to be at least 95 percent derived from non-HEU sources.

CMS finalized the proposal for CY 2026 that they would replace the add-on payment for radiopharmaceuticals produced without the use of Tc-99m derived from non-HEU sources with an add-on payment of \$10 for radiopharmaceuticals that use Tc-99m derived from domestically produced Mo-99.

H. Payments for 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). Separately paid drugs must meet a packaging threshold of \$140 cost per day. CMS continues the policy to pay for separately

payable drugs, biologicals and radiopharmaceuticals at the average sales price (ASP) plus 6 percent.

CMS continues to package all contrast agents and some diagnostic radiopharmaceuticals that do not exceed the \$630 per day threshold. (See separate payment for diagnostic radiopharmaceuticals above.)

I. Hospital Outpatient Department (OPD) Prior Authorization Process

CMS is changing the current review timeframe for prior authorization requests for hospital outpatient department services from 10-business days to 7-calendar days for standard reviews.

J. Hospital Outpatient Quality Reporting Program

For the Hospital OQR Program measure set, CMS previously adopted the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults eCQM for voluntary reporting that begins with the CY 2025 reporting period, and mandatory reporting that begins with the CY 2027 reporting period/CY 2029 payment determination. The additional year of voluntary reporting would allow time to monitor implementation progress with regards to data collection burden and response rates.