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2025 Hospital Outpatient Prospective Payment System – Final Rule Summary

On Friday, November 1, 2024, the Centers for Medicare & Medicaid Services (CMS) released the 2025 Hospital Outpatient Prospective Payment System (HOPPS) final rule, which includes modest payment increases for radiation therapy services effective January 1, 2025.

In the Medicare hospital outpatient environment, hospital reimbursement is based on Ambulatory Payment Classifications or APCs. CMS assigns CPT codes to an APC based on clinical and resource use similarity. All services in an APC are reimbursed at the same rate. Cost data collected from HOPPS claims are used to calculate rates. Certain services are considered ancillary, and their costs are packaged into the primary service. Packaged services do not receive separate payment. For example, in the hospital outpatient environment, imaging is not paid separately when reported with treatment delivery services.

Below is a summary of key issues impacting radiation oncology, including:

- *Conversion Factor Update*
- *Ambulatory Payment Classifications (APC)*
- *Comprehensive Ambulatory Payment Classifications (C-APCs)*
- *Extension of Virtual Direct Supervision through December 31, 2025*
- *Two-Times Rule Exception*
- *Brachytherapy Sources*
- *Changes to the Review Timeframes for the Hospital Outpatient Department (OPD) Prior Authorization Process*
- *Payment Policy for Radiopharmaceuticals*
- *Diagnostic Radiopharmaceuticals Separate Payment*
- *Add-on Payment for Radiopharmaceutical Technetium-99m (Tc-99m)*
- *Cancer Hospital Payment Adjustment*
- *Biology Guided Radiation Therapy (BgRT)*
- *Applications Received for Device Pass-Through Status for CY 2025*
- *New Technology APCs*

Conversion Factor Update

CMS is increasing the payment rates under the HOPPS by an Outpatient Department (OPD) fee schedule increase factor of 2.9%. This increase factor is based on the hospital inpatient market basket percentage increase of 3.4% for inpatient services paid under the hospital Inpatient Prospective Payment System (IPPS), minus a proposed 0.5% productivity adjustment.

Based on this update, CMS estimates that proposed total payments to HOPPS providers (including beneficiary cost-sharing and estimated changes in enrollment, utilization, and case-mix), for CY 2025 will be approximately $87.7 billion, an increase of $1.98 billion compared to 2024 HOPPS payments.

For CY 2025 rate setting, CMS is using claims data from 2023 and the most updated cost report data available from the Healthcare Cost Report Information System (HCRIS), which includes data from 2022.

Ambulatory Payment Classifications (APC)

Below is a list of radiation oncology APCs with their final 2025 payment rates:

Radiation Oncology - Ambulatory Payment Classification 2025 Payment Rates				
APC	**Descriptor**	**2024 Rate**	**2025 Rate**	**% Change**
5611	Level 1 Therapeutic Radiation Treatment Preparation	$129.41	$132.77	2.60%
5612	Level 2 Therapeutic Radiation Treatment Preparation	$352.41	$366.07	3.88%
5613	Level 3 Therapeutic Radiation Treatment Preparation	$1,321.58	$1,368.26	3.53%
5621	Level 1 Radiation Therapy	$114.37	$109.50	-4.26%
5622	Level 2 Radiation Therapy	$256.33	$262.98	2.59%
5623	Level 3 Radiation Therapy	$561.45	$578.47	3.03%
5624	Level 4 Radiation Therapy - HDR Brachytherapy	$683.84	$693.81	1.46%
5625	Level 5 Radiation Therapy - Proton Therapy	$1,353.02	$1,275.51	-5.73%
5626	Level 6 Radiation Therapy - SBRT	$1,701.89	$1,755.91	3.17%

Comprehensive Ambulatory Payment Classifications (C-APCs)

Under the C-APC policy, CMS provides a single payment for all services on the claim regardless of the span of the date(s) of service. Conceptually, the C-APC is designed so there is a single primary service on the claim, identified by the status indicator (SI) of "J1". All adjunctive services provided to support the delivery of the primary service are included on the claim. While ASTRO supports policies that promote efficiency and the provision of high-quality care, we have long expressed concern that the C-APC methodology lacks the appropriate charge capture mechanisms to accurately reflect the services associated with the C-APC.

For 2025, CMS is not converting any standard APCs to C-APCs, leaving the number of C-APCs for 2025 at 72.

Below is a comparison table of the 2024 payment rates and final 2025 payment rates for the radiation oncology services in several key C-APCs:

C-APC 5627 Level 7 Radiation Therapy				
CPT Code	Descriptor	2024 Rate	2025 Rate	% Change
77371	SRS Multisource	$7,427.37	$7,644.49	2.92%
77372	SRS Linear Based	$7,427.37	$7,644.49	2.92%
77424	IORT delivery by x-ray	$7,427.37	$7,644.49	2.92%
77425	IORT delivery by electrons	$7,427.37	$7,644.49	2.92%
C-APC 5092 Level 2 Breast/Lymphatic Surgery and Related Procedures				
19298	Place breast rad tube/caths	$6,219.70	$6,521.46	4.85%
C-APC 5093 Level 3 Breast/Lymphatic Surgery and Related Procedures				
19296	Place po breast cath for rad	$8,990.96	$9,569.05	6.43%

C-APC 5113 Level 3 Musculoskeletal Procedures				
20555	Place ndl musc/tis for rt	$3,087.24	$3,244.61	4.85%
C-APC 5165 Level 5 ENT Procedures				
41019	Place needles h&n for rt	$5,585.51	$5,915.66	5.91%
C-APC 5302 Level 2 Upper GI Procedures				
43241	Egd tube/cath insertion	$1,814.88	$1,896.99	4.52%
C-APC 5375 Level 5 Urology and Related Services				
55875	Transperi needle place pros	$4,935.21	$5,083.62	3.01%
C-APC 5415 Level 5 Gynecologic Procedures				
55920	Place needles pelvic for rt	$4,744.03	$4,936.45	4.06%
57155	Insert uteri tandem/ovoids	$4,744.03	$4,936.45	4.06%
58346	Insert heyman uteri capsule	$4,744.03	$4,936.45	4.06%

ASTRO has long expressed concern that the Medicare Claims Processing Manual does not provide clear guidance regarding how hospital-based practices should bill for repetitive services included in the C-APC methodology, particularly brachytherapy. The CMS' MLN Matters Publication MM4047 addresses the Frequency of Billing to Fiscal Intermediaries (FIs) for Outpatient Services. However, the MLN publication guidance does not address billing associated with services that are included in a C-APC. The publication states *"repetitive Part B services furnished to a single individual by providers who bill FIs should be billed monthly (or at the conclusion of treatment)."* The publication goes on to address radiation therapy services:

> *Revenue codes usually reported for chemotherapy and radiation therapy are not on the list of revenue codes that may only be billed monthly. Therefore, hospitals may bill chemotherapy or radiation therapy sessions on separate claims for each date of service. However, because it is common for these services to be furnished in multiple encounters that occur over several weeks or over the course of a month, hospitals have the option of reporting charges for those recurring services on a single bill, as though they were repetitive services. If hospitals elect to report charges for recurring, non-repetitive services (such as chemotherapy or radiation therapy) on a single bill, they must also report all charges for services and supplies associated with the recurring service on the same bill.*

ASTRO has engaged with CMS regarding billing for radiation oncology CPT codes that are part of the C-APC methodology. The Agency has indicated that services delivered over multiple patient encounters can be reported per encounter.

Extension of Virtual Direct Supervision through December 31, 2025

For CY 2025, CMS is finalizing, without modification, its proposal to revise §§ 410.27(a)(1)(iv)(B)(*1*) and 410.28(e)(2)(iii) to allow for the direct supervision of cardiac rehabilitation (CR), intensive CR, pulmonary rehabilitations services, and diagnostic services via audio-video real-time communications technology (excluding audio-only) through December 31, 2025. The Agency is concerned that reverting to the pre-PHE definition of direct supervision would create a barrier to access for many services, and practices would need time to adjust their now-established practice patterns to reimplement pre-PHE standards.

Two-Times Rule Exception

CMS established two-times rule criteria within the APC methodology that requires that the highest calculated cost of an individual procedure categorized to any given APC cannot exceed two times the calculated cost of the lowest-costing procedure categorized to that same APC. However, the Agency can exempt any APC from the two-times rule for any of the following reasons:

- Resource homogeneity
- Clinical homogeneity
- Hospital outpatient setting utilization
- Frequency of service (volume)
- Opportunity for upcoding and code fragments

Based on CY 2023 claims data, CMS will apply the two-times rule exception to APC 5611 *Level 1 Therapeutic Radiation Treatment Preparation,* APC 5613 *Level 3 Therapeutic Radiation Treatment Preparation*, and APC 5627 *Level 7 Radiation Therapy*

Brachytherapy Sources

For 2025, CMS will continue to base the payment rates for brachytherapy sources on the geometric mean cost for each source, which is consistent with the methodology used for other services under HOPPS. Additionally, the Agency used the costs derived from 2023 claims data to set the 2025 payment rates for brachytherapy sources. However, C2645 *Brachytherapy planar source, palladium-103, per square millimeter* had insufficient claims data, so the Agency will continue to use the CY 2019 payment rate of $4.69 per mm^2 in CY 2025.

CMS will pay for HCPCS codes C2698 *Brachytherapy source, stranded, not otherwise specified* and C2699 *Brachytherapy source, non-stranded, not otherwise specified*, at a rate equal to the lowest stranded or non-stranded prospective payment rate for such sources, respectively on a per source basis. For 2025, the rates are $46.97 for C2698 and $48.77 for C2699. This is a 12.3% change in payment for C2698 ($41.82 in 2024) and a 39.4% change for C2699 ($34.99 in 2024) from the 2024 rates.

In the 2022 HOPPS final rule, CMS established a Low Volume APC policy for brachytherapy APCs (also for New Technology APCs and clinical APCs—it is universal). For those APCs with fewer than 100 single claims that can be used for rate setting purposes in the existing claims year, CMS uses up to four years of claims data to establish a payment rate for each item or service, which is a similar methodology that the Agency applies to low volume services assigned to New Technology APCs. Further, the Agency calculates the cost based on the greatest of the arithmetic mean cost, median cost, or geometric mean cost.

CMS is designating six brachytherapy APCs as Low Volume APCs for CY 2025 (See Table 35 below).

Table 64: Final Low Volume APCs Using Comprehensive (OPPS) Rate Setting Methodology for CY 2025

APC	APC Description	CY 2023 Claims Available for Rate Setting	CY 2025 APC Cost
2632	Iodine I-125 sodium iodide	1	$208.58
2635	Brachytx, non-str, HA, P-103	20	$69.38
2636	Brachy linear, nonstr, P-103	1	$52.91
2642	Brachytx, stranded, C-131	95	$107.86
2645	Brachytx, non-str, gold-198	96	$868.33

2647	Brachytx, NS, Non-HDRIr-192	2	$564.50

Changes to the Review Timeframes for the Hospital Outpatient Department (OPD) Prior Authorization Process

After considering public comments, for 2025, CMS is finalizing its proposal to change the current review timeframe for provisionally affirmed or non-affirmed standard review requests for covered OPD services subject to prior authorization from 10-business days to 7-calendar days and making this change in § 419.82(d)(1)(iii) of the regulatory text.

Go Deeper

The CMS Interoperability and Prior Authorization final rule (89 FR 8758) shortened PA timeframes for certain payers, including Medicare Advantage organizations. It requires impacted payers to send PA decisions as expeditiously as the enrollee's health condition requires or as the beneficiary's health condition requires, but no later than 72 hours for expedited requests and 7 calendar days for standard requests.

Under the CY 2020 HOPPS final rule, CMS established a nationwide PA process and requirements for certain OPD services. OPD providers must submit to the Medicare Administrative Contractor (MAC) a PA request for any service on the list of outpatient department services that require prior authorization. Upon receipt of the prior authorization request, the MAC should review it and issue a decision within specific timeframes, which are listed in the regulatory text.

While Medicare FFS is not an impacted payer under the CMS Interoperability and Prior Authorization final rule, CMS proposes to align its Medicare FFS PA review timeframe for standard review requests for OPD services with the timeframe in that final rule. This change would not only streamline the PA processes so that they are the same across payers, but also would help to reduce provider burden by having the same timeframe and reducing the potential for delays in care by decreasing the time beneficiaries and providers wait for prior authorization decisions on standard requests in FFS Medicare.

Payment Policy for Radiopharmaceuticals

The Agency's policy of paying for separately payable pass-through therapeutic radiopharmaceuticals under the Average Sales Price (ASP) methodology adopted for separately payable drugs and biologicals will continue to apply for CY 2025 (generally ASP plus 6%). It also will pay for separately payable nonpass-through therapeutic radiopharmaceuticals through a modified ASP methodology of ASP plus 6%, if ASP data is available. But, if ASP information is unavailable for a separately payable nonpass-through therapeutic radiopharmaceutical, CMS will continue to base the payment rate on mean unit cost data derived from hospital claims. For 2025, CMS will continue its policy of not using weighted average cost (WAC) or average wholesale price (AWP) to establish payment for separately payable nonpass-through therapeutic radiopharmaceuticals if ASP is not available.

Go Deeper

Transitional pass-through payments are provided for certain "new" drugs and biologicals that were not being paid for as an HOPD service as of December 31, 1996, and whose cost is "not insignificant" in relation to the HOPPS payments for the procedures or services associated with the new drug or biological. Transitional pass-through payments for a drug can be made for a period of at least 2 years, but not more

than 3 years, after the payment was first made for the drug as a hospital outpatient service under Medicare Part B.

In the CY 2024 HOPPS final rule, CMS stated that the ASP payment methodology for separately payable nonpass-through therapeutic radiopharmaceuticals allowed for using WAC or AWP to establish a payment rate for these items. This was an error and conflicted with the policy implemented in CY 2010 and continued in subsequent years. Therefore, CMS will pay for all nonpass-through separately payable therapeutic radiopharmaceuticals at ASP plus 6%.

Diagnostic Radiopharmaceuticals Separate Payment

CMS is finalizing its proposal to pay separately for diagnostic radiopharmaceuticals with per day costs above a threshold of $630, which is approximately two times the volume weighted average cost amount currently associated with diagnostic radiopharmaceuticals in the Nuclear Medicine APCs. It is also finalizing the proposal to update the $630 threshold in CY 2026 and subsequent years by the Producer Price Index (PPI) for Pharmaceutical Preparations, as well as finalizing payment for separately payable diagnostic radiopharmaceuticals based on their Mean Unit Cost (MUC) derived from HOPPS claims for CY 2025.

Go Deeper

In some instances, the payment amount for the nuclear medicine tests may not cover the cost of some specialized diagnostic radiopharmaceuticals, even when those agents may be the most clinically appropriate. This proposal for separate payment is an effort to improve the accuracy of the overall payment amounts. Any diagnostic radiopharmaceutical with a per-day cost equal to or below the $630 threshold would continue to be policy-packaged—the costs are incorporated into the payment rates for the nuclear medicine tests.

Add-on Payment for Radiopharmaceutical Technetium-99m (Tc-99m)

CY 2025 is the final year in which an add-on payment will apply for radiopharmaceuticals that use Tc-99m produced without the use of highly enriched uranium (HEU). For CY 2026, CMS is finalizing the proposal to replace this add-on payment with one for radiopharmaceuticals that use Tc-99m derived from domestically produced molybdenum-99 (Mo-99). CMS believes the $10 add-on payment for domestically produced Tc-99m will ensure equitable payments, by paying providers who use domestically produced Tc-99m radiopharmaceuticals, when available, an amount that reflects the anticipated higher cost of these products.

Go Deeper

Foreign Mo-99 production has historically been subsidized by foreign governments, making the price far below the true cost of production and a disincentive for domestic investments in Mo-99 production infrastructure. To address this payment inequity, CMS proposed an add-on payment of $10 per dose for radiopharmaceuticals that use Tc-99m derived from domestically produced Mo-99

Cancer Hospital Payment Adjustment

Since the inception of HOPPS, Medicare has paid the 11 hospitals that meet the criteria for “cancer hospitals” under HOPPS for covered outpatient hospital services to reflect their higher outpatient costs. For CY 2025, CMS will continue providing additional payments to cancer hospitals so that a cancer hospital’s payment-to-cost ratio (PCR) after the additional payments is equal to the weighted average PCR for the other OPPS hospitals using the most recently submitted or settled cost report data. Section 16002(b) of the 21st Century Cures Act requires that this weighted average PCR be reduced by 1.0%. Due to the PHE’s impact on claims and cost data used to calculate the target PCR, CMS has maintained

the CY 2021 target PCR of 0.89 through CYs 2022 and 2023.

For CY 2024, CMS finalized a policy to reduce the target PCR by 1.0% each calendar year until the target PCR equals the PCR of non-cancer hospitals using the most recently submitted or settled cost report data. For CY 2025, it is finalizing the proposal to use a target PCR of 0.87 to determine the CY 2025 cancer hospital payment adjustment to be paid at cost report settlement.

Go Deeper
In 1983, when the IPPS was established, Congress authorized CMS to develop regulations for exceptions to IPPS for hospitals involved extensively in cancer research and treatment. After HOPPS was created in 1999, these cancer hospitals received special treatment under it as well. Essentially, the Congressional action ensures that PPS Exempt Cancer Hospitals receive the same amount they would have received pre-HOPPS—they're permanently "held harmless."[1]

Cancer hospitals receive additional payments so that their PCR after the additional payment is equal to the weighted average PCR for other HOPPS hospitals using the most recently submitted or settled cost report data. The actual final amount of the CY 2025 cancer hospital payment adjustment for each cancer hospital will be determined at cost report settlement and will depend on each hospital's CY 2025 payments and costs from the settled CY 2025 cost report. So, the actual increase for 2025 may end up being much less than estimated in the table below.

Table 8 below, excerpted from the rule, shows the estimated percentage increase in OPPS payments to each cancer hospital for CY 2025, due to the cancer hospital payment adjustment policy.

Table 12: Estimated CY 2025 Hospital-Specific Payment Adjustment for Cancer Hospitals to be Provided at Cost Report Settlement

Provider Number	Hospital Name	Estimated Percentage Increase in OPPS Payments for CY 2025 due to Payment Adjustment
050146	City of Hope Comprehensive Cancer Center	51.5%
050660	USC Norris Cancer Hospital	44.3%
100079	Sylvester Comprehensive Cancer Center	32.4%
100271	H. Lee Moffitt Cancer Center & Research Institute	23.9%
220162	Dana-Farber Cancer Institute	46.6%
330154	Memorial Sloan-Kettering Cancer Center	51.6%
330354	Roswell Park Cancer Institute	21.3%
360242	James Cancer Hospital & Solove Research Institute	16.0%
390196	Fox Chase Cancer Center	30.0%
450076	M.D. Anderson Cancer Center	45.1%
500138	Seattle Cancer Care Alliance	47.7%

Biology Guided Radiation Therapy (BgRT)
Effective January 1, 2025, two new G-codes are replacing HCPCS codes C9794 and C9795 for BgRT. Specifically, HCPCS codes C9794 and C9795 are being deleted and replaced by G0562 and G0563, respectively, to allow for payment in settings other than hospital outpatient departments for CY 2025. The

[1] https://www.gao.gov/assets/gao-15-199.pdf

descriptors for the new G-codes are the same as existing HCPCS codes C9794 and C9795.

Table 22: Final CY 2025 OPPS New Technology APC and Status Indicator Assignments for BgRT

HCPCS	Long Descriptor	Final CY 2025 OPPS SI	Final CY 2025 OPPS APC
G0562 (formerly 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)	S	1521
G0563 (formerly 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	S	1525

Go Deeper
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. The Agency assigned HCPCS code C9794 to APC 1521 (New Technology - Level 21 ($1901-$2000)) and HCPCS code C9795 to APC 1525 (New Technology - Level 25 ($3501-$4000)) for CY 2024.

For CY 2025, the HOPPS payment rates were proposed based on available CY 2023 claims data. As HCPCS codes C9794 and C9795 were effective January 1, 2024, CMS did not have any claims data for the service. Therefore, for CY 2025, it proposed to continue to assign HCPCS code C9794 to APC 1521 (New Technology - Level 21 ($1901-$2000)) with a payment rate of $1,950.50 and HCPCS code C9795 to APC 1525 (New Technology - Level 25 ($3501-$4000)) with a payment rate of $3,750.50.

Applications Received for Device Pass-Through Status for CY 2025
CMS received 14 complete applications for device pass-through status for CY 2025, but only one is of interest to oncology care, generally: Precision GI, a tool that assists with performing a tumor biopsy. CMS determined that it meets the requirements for device pass-through status and approved it, effective January 1, 2025.

Go Deeper
CMS establishes specific criteria for hospitals to receive pass-through payments for devices that offer substantial clinical improvement in treatment of Medicare beneficiaries. Devices must meet the following

criteria: 1) receive FDA approval or clearance; 2) the device is determined to be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part; and 3) the device is an integral part of the service furnished, is used for one patient only, comes in contact with human tissue, and is surgically implanted or inserted, or applied in or on a wound or other skin lesion. Finally, the device must not be an item for which depreciation and financing expenses are recovered and it is not a supply or material furnished incident to a service.

In addition to meeting criteria for pass-through payment, a device must meet specific criteria for CMS to establish a new category of devices. The criteria for establishing a new category of devices require that the device is not appropriately described by any other category; and that it has an average cost that is not insignificant relative to the payment amount for the procedure or service with which the device is associated by demonstrating:

1) The estimated average reasonable costs of devices in the category exceeds 25% of the applicable APC payment amount for the service related to the category of devices;
2) The estimated average reasonable cost of the devices in the category exceeds the cost of the device-related portion of the APC payment about for the related service by at least 25%; and
3) The difference between the estimated average reasonable cost of the devices in the category and the portion of the APC payment amount for the device exceeds 10% of the APC payment amount for the related service.

New Technology APCs

Bronchoscopy with Transbronchial Ablation of Lesion(s) by Microwave Energy

Effective January 1, 2019, CMS established HCPCS code C9751 (Bronchoscopy, rigid or flexible, transbronchial ablation of lesion(s) by microwave energy, including fluoroscopic guidance, when performed, with computed tomography acquisition(s) and 3-D rendering, computer-assisted, image-guided navigation, and endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (e.g., aspiration[s]/biopsy[ies]) and all mediastinal and/or hilar lymph node stations or structures and therapeutic intervention(s)).

There continue to be no new claims for HCPCS code C9751 since 2019. Given the Agency's proposal to maintain current New Technology APC assignments for CY 2025 for New Technology APC services with fewer than 10 claims in the 4-year lookback period applicable for the universal low-volume APC policy, it proposed and is finalizing for CY 2025 to continue to assign HCPCS code C9751 to APC 1562 (New Technology—Level 25 ($3501–$4000)).

Table 26: CY 2025 OPPS APC and Status Indicator for HCPCS Code C9751 Assigned to New Technology APC

HCPCS Code	Long Descriptor	Final CY 2025 OPPS SI	Final CY 2025 OPPS APC
C9751	Bronchoscopy, rigid or flexible, transbronchial ablation of lesion(s) by microwave energy, including fluoroscopic guidance, when performed, with computed tomography acquisition(s) and 3-D rendering, computer-assisted, image-guided navigation, and endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]	T	1562

Liver Histotripsy Service
CPT code 0686T (Histotripsy (i.e., non-thermal ablation via acoustic energy delivery) of malignant hepatocellular tissue, including image guidance) was first effective July 1, 2021, and describes the histotripsy service associated with the use of the HistoSonics system.

For CY 2025, HOPPS payment rates are based on available CY 2023 claims data. CMS identified one claim for CPT code 0686T within the CY 2023 claims data. As the available claims data is below the threshold of 100 claims for a service within a year, CMS proposed to designate CPT code 0686T as a low volume service under the universal low volume APC policy, and use the highest of the geometric mean cost, arithmetic mean cost, or median cost to assign CPT code 0686T to the appropriate New Technology APC. However, because there is only a single claim in the CY 2023 data, CMS has concerns that the universal low volume APC policy calculations do not accurately capture the cost of the service.

Given the aforementioned proposal to maintain current New Technology APC assignments for CY 2025 for New Technology APC services with fewer than 10 claims in the 4-year lookback period applicable for the universal low-volume APC policy, and based on the fact that there have only been 3 claims for CPT code 0686T in the prior 4-year period, CMS will continue to assign CPT code 0686T to APC 1576 (New Technology – Level 39 ($15,001 -$20,000)).

Table 42: CY 2025 OPPS APC and Status Indicator for the Liver Histotripsy Service

HCPCS Code	Long Descriptor	Final CY 2025 OPPS SI	Final CY 2025 OPPS APC
0686T	Histotripsy (i.e., non-thermal ablation via acoustic energy delivery) of malignant hepatocellular tissue, including image guidance	S	1576

Additional information about the 2025 HOPPS proposed rule can be found at the following links:

A display copy of the proposed rule can be found at:
https://public-inspection.federalregister.gov/2024-25521.pdf

The addenda relating to the HOPPS proposed rule are available at:
https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1809-fc

A fact sheet on this proposed rule is available at:
https://www.cms.gov/newsroom/fact-sheets/cy-2025-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0