American College of Radiology

June 9, 2025

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1833-P,
Mail Stop C4-26-05,
7500 Security Boulevard,
Baltimore, MD 21244-1850.

RE: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2026 Rates; Requirements for Quality Programs; and Other Policy Changes

Dear Administrator Oz:

The American College of Radiology (ACR) – a professional association representing more than 40,000 physicians practicing diagnostic radiology, interventional radiology, radiation oncology, and nuclear medicine (NM), as well as medical physicists - appreciates the opportunity to provide comments on the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2026 Rates.

The ACR wishes to address the following issues in these comments:

- Request for information: Unleashing Prosperity Through Deregulation of the Medicare Program Request for Information
    - Treating Physician Rule
    - Supervision of Contrast Administration
    - Deficit Reduction Act
    - 21st Century Cures Act Information Blocking
    - Merit-based Incentive Payment System (MIPS)
    - Protecting Access to Medicare Act (PAMA) Imaging Appropriate Use Criteria
    - No Surprises Act Independent Dispute Resolution (IDR) Process

Streamline Regulatory Requirements

Treating Physician Rule

The ACR requests the Centers for Medicare and Medicaid Services (CMS) take action to remove the burdensome limitation on radiologists in CMS's regulations on treating physicians (42 C.F.R. § 410.32).

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CMS created the treating physician rule through a regulation that defines the circumstances in which ordering diagnostic services is reasonable and necessary.[1] This regulation states that diagnostic tests must be ordered by a treating physician, described as "the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem."[2] The Medicare Benefit Policy Manual states: "A radiologist performing a therapeutic interventional procedure is considered a treating physician. A radiologist performing a diagnostic interventional or diagnostic procedure is not considered a treating physician."[3]

Removing the requirement that a radiologist bill an E&M service to be qualified as the treating physician would help alleviate these barriers and allow radiologists to fully utilize their deep expertise in diagnostic testing to support patients and physicians in other specialties. The ACR believes CMS's policy is based on an antiquated, inaccurate view of the role of radiologists in a patient's continuum of care. Changing the treating physician rule would allow radiologists to track important findings and reduce the exploding data burden on primary care and other physicians and non-physician providers (NPPs).

Inaccurate and unnecessary advanced imaging utilization is a growing national problem that can be attributed, in significant part, to the increased use of NPPs, who order more imaging services than physician providers.[4] Radiologists have extensive expertise in the selection and timing of appropriate imaging studies. Research shows significant decreases in variability and costs in follow-up imaging when radiologist recommendations are followed.[5] To provide the best care to patients, radiologists should be able to change an order to a more appropriate study or less extensive imaging procedure when necessary.

CMS should revise its guidance to clarify that radiologists can order medically necessary tests to manage certain aspects of a patient's care and not impose unique and deleterious restrictions on radiologists. This bureaucratic decision has disrupted and delayed patient care for years and must be eliminated.

Supervision of Contrast Administration

The ACR again requests CMS make permanent the rule adopted during the COVID-19 public health emergency to allow virtual direct supervision of level 2 diagnostic tests via real time audio/video communications.

In 2024 and 2025 rulemaking, the ACR commented in support of CMS's decision to revise regulatory text to allow the virtual direct supervision by a physician (or other practitioner) via audio/video real-time communications technology (excluding audio-only) through December 31, 2025. As previously noted, making the presence of and "immediate availability" of physicians and other practitioners

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1 *See* 62 Fed. Reg. 59,048, 59,057 (Oct. 31, 1997); *see also* Social Security Act (SSA) § 1862(a)(1)(A) (services are not covered by Medicare if they are not reasonable and necessary).

2 42 C.F.R. § 410.32(a)(1).

3 Medicare Benefit Policy Manual, ch. 15, § 80.6.1.

4 Hughes, D. Jiang, M. Duszak, R. (2015). A Comparison of Diagnostic Imaging Ordering Patterns Between Advanced Practice Clinicians and Primary Care Physicians Following Office-Based Evaluation and Management Visits. *JAMA Internal Medicine*, *175*(1), 101-107

5 *See, e.g.*, Rosenkrantz et al., *Downstream Costs Associated with Incidental Pulmonary Nodules Detected on CT*, 11 Acad. Radiology 798 (2018); Rosenkrantz et al., *Variation in Downstream Relative Costs Associated with Incidental Ovarian Cysts on Ultrasound*, 15 J. Am. College Radiology 958 (2018); Rosenkrantz et al., *Downstream Costs Associated with Incidental Pancreatic Cysts Detected at MRI*, 211 Am. J. Roentgenology 1278 (2018).

through real-time audio and visual interactive telecommunications a permanent part of the definition of direct supervision will help enable afterhours access to radiology services and improve access in rural and underserved areas, where access issues are greater.

For the above reasons, the ACR continues to believe remote direct supervision for level 2 diagnostic imaging tests is appropriate and will ensure patients have access to timely and safe diagnostic imaging.

Deficit Reduction Act (DRA)
The ACR requests the elimination of the Deficit Reduction Act (DRA) cap for imaging services.

Under the DRA, the technical component of certain imaging services paid under the Physician Fee Schedule (PFS) is capped at the amount paid under the Hospital Outpatient Prospective Payment System (OPPS). The DRA defines imaging services as ‘‘imaging and computer-assisted imaging services, including X-ray, ultrasound (including echocardiography), nuclear medicine (including PET), magnetic resonance imaging (MRI), computed tomography (CT), and fluoroscopy, but excluding diagnostic and screening mammography.” The logic behind the DRA provision is that hospital costs should always be greater than physician costs when performing imaging services. This cap assumes that, if a PFS payment is greater than the hospital payment, the PFS payment must be too high rather than the OPPS payment is too low. ACR does not believe this is the case with CT and MRI (and other advanced diagnostic imaging services) where the OPPS payment is well below the resources required to perform the test.

Under section 5102(b)(1) of the DRA of 2005, CMS capped the payment for screening CT colonography (CTC) under APC 5523. Based on the published relative value units (RVUs), the technical component reimbursement for screening CTC is $528 under the PFS but is capped at the OPPS rate of $241.72. The DRA excludes screening and diagnostic mammography from eligibility for the cap. It is unclear why Congress selected only these procedures for exclusion; nonetheless, it seems likely there were concerns about the impact of the cap on screening and diagnostic services to identify breast cancer.

The best long-term solution to this problem is to eliminate the DRA cap for imaging services. This approach would allow for resource-based payment for screening CT colonography and other imaging services when paid under the PFS.

CT and MR Cost Center
ACR again requests that CMS default all costs and charges under the OPPS to a single diagnostic radiology cost center and not use the CT and MRI-specific cost centers for valuing services under the OPPS and the IPPS.

Under the OPPS, CMS uses a highly complex methodology to develop the OPPS relative weights. At its basic level, CMS uses hospital charges on claims reduced to costs using cost-to-charge ratios (CCRs) from hospital cost reports. However, the CCR for advanced diagnostic imaging cost centers, specifically CT and MRI, are the lowest being reported by hospitals.

In the FY 2026 IPPS proposed rule, the CCRs for CT and MRI are 0.032 and 0.066, respectively.[6] This means CMS is assuming a mark-up of 30 times its costs for CT and nearly 15 times its cost for MRI. ACR believes these extremely low CCRs are more likely the result of faulty cost reporting than the actual level of mark-up of hospital charges over cost. The magnitude of these mark-ups appears implausible and dates back to the FY 2009 IPPS, when CMS discussed a contract awarded to Research Triangle International (RTI) to study the effects of charge compression in calculating the relative weights and to consider methods to reduce the variation in the CCRs across services within cost centers.[7] Charge compression describes higher percentage mark-ups on low-cost than high-cost items. Using a single CCR that groups low and high-cost items results in underpayment of high-cost items and overpayment of low-cost items.

The CCRs for selected CT and MR procedures also show a significant number of CCRs close to zero. These near zero CCRs indicate that even when hospitals create standard cost centers, they likely cannot accurately re-allocate many costs already allocated across hospital departments to new CT and MR departmental cost centers. For these hospitals, the CCRs probably reflect allocations of staffing and dedicated departmental expenses, while the costs of equipment, some costs associated with physical space (e.g., lead in walls), and other administrative costs remain spread across all hospital departments. The presence of these nearly zero CCRs contributes to underestimated costs used in rate setting, pulling rates for CT and MR procedures down below their actual cost and further eroding payment accuracy.

Since 2021, CMS has set the imaging APC payment rates at 100 percent of the payment rate using the standard payment methodology.[8] ACR has repeatedly requested that CMS estimate cost using a single diagnostic radiology cost center rather than CT and MRI-specific cost centers. The benefits of this approach include consistent reporting across hospitals, proper accounting of high-cost medical equipment, simplification and standardization of cost reporting within the diagnostic radiology cost center, elimination of partial allocation of costs to CT and MR cost centers, and reduced reporting burden. While we believe this approach would solve the inaccurate reporting of costs for CT and MR services, CMS has chosen not to adopt, this method.

In contrast to the OPPS where CMS uses this flawed cost reporting data, the PFS payment methodology for practice expenses utilizes micro-costing to determine the direct practice expense share of the total payment with an algorithm for allowing indirect costs. As described above, ACR believes CMS should default all costs and charges to a single diagnostic radiology cost center and eliminate the CT and MRI-specific cost centers for valuing services under the OPPS and the IPPS.

[6], Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2026 Rates; Quality Programs Requirements; and Other Policy Changes, public display copy released on April 30, 2024, page 219

[7] Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates, Final Rule, August 19, 2008, page 48451.

[8] CY 2022 final rule, page 61152.

Opportunities to Reduce Administrative Burden of Reporting and Documentation

21st Century Cures Act Information Blocking

The ACR continues to recommend that HHS leverage enforcement discretion to focus the HHS Office of Inspector General (OIG) investigations and application of provider disincentives on clearly intentional, repetitive, and objectively anti-competitive "bad faith" behaviors by major actors.

The ACR supports appropriate access, exchange, and use of electronic health information (EHI) by providers and patients. The 21st Century Cures Act[9] was designed to help patients and providers quickly and easily access their electronic health information to make informed decisions about patient care in an appropriate amount of time. The Cures Act required healthcare organizations to have the capability to release electronic health information, such as clinical notes and test results, to patients as soon as the information is finalized.

Section 4004 of the 21st Century Cures Act (2016) expanded the authority of the U.S. Department of Health and Human Services (HHS) to investigate and penalize information blocking practices that impede legally permissible requests for certain healthcare data. The statutory definition of "information blocking" by a provider-actor requires the actor to know the practice is both unreasonable and a likely interference, prevention, or material discouragement of EHI access, exchange, or use**.** Radiology providers must proactively comply by not engaging in information blocking practices, which can be inclusive of internal policies that delay access by patients or other providers. Still, some patients may prefer to receive communication about EHI with life-changing and/or complex observations directly from their referring provider rather than via email or text message of a radiology report.

The ACR continues to support patients' access to EHI in an appropriate time and setting, while ensuring providers are not unduly penalized by the HHS Information Blocking rules. The ACR continues to recommend that HHS focus on clearly intentional, repetitive, and objectively anti-competitive "bad faith" behaviors by major actors when investigating and penalizing information blocking practices.

Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs)

The ACR supports changes to MIPS so the program better applies to physicians, like radiologists, who do not fit neatly into MIPs or APMs due to the nature of how they practice medicine.

The Merit-based Incentive Payment System (MIPS) was authorized under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Pub. L. No. 114-10, § 101(c), 129 Stat. 87 (2015). In 2015, MACRA legislation consolidated several physician quality reporting programs into a single system, MIPS, designed to offer simplified, flexible participation options. Despite MACRA's aim to streamline Medicare's value-based payment programs and reduce participation burdens for clinicians billing for Medicare part B services, these CMS regulations have largely done the opposite while simultaneously failing to demonstrate better patient outcomes or avoid unnecessary spending.

The MIPS program requires extensive, ongoing efforts to maintain compliance and avoid decreases of up to 9% in reimbursement for Medicare services. CMS formalized this process in the CY 2019 PFS Final Rule (83 FR 59452) and codified it in 42 CFR § 414.1330(c), resulting frequent and unpredictable updates, which placed increased administrative and financial strain on medical practices.

[9] https://www.federalregister.gov/documents/2020/05/01/2020-07419/21st-century-cures-act-interoperability-information-blocking-and-the-onc-health-it-certification

Practices must continually reevaluate workflows, retrain staff, and update templates annually to comply. As a result, practices invest years building systems, processes, and training around specific measures. A 2023 ACR analysis estimated the average annual cost of MIPS compliance at $12,881 per physician and 200 staff hours. For practices with 15 to 30 radiologists, costs rise to $193,215–$386,430 annually. When measures are removed, these investments are lost.

As part of the MIPS program, outdated or redundant measures were removed, and registry measure use was promoted with the intent to streamline reporting. This change has disproportionately impacted radiology, leaving few clinically relevant measures for radiologists to meet MIPS reporting requirements.

When making payment determinations based on quality program participation, CMS should also compare like clinicians. Comparing a radiologist to a cardiologist on MIPS scoring does not reflect a true difference in quality based on the current structure of the MIPS program. The approach of comparing similar physicians would better inform the public of the quality of care.

In addition, Medicare should recognize the contributions of teams of caregivers rather than individuals by focusing on patient outcomes resulting from the efforts of the multiple different specialty clinicians involved. Radiologists and other non-patient facing physicians treat high volumes of beneficiaries yet rarely have control over patient management. Maintaining an adequate fee-for-service payment method is critical, especially for those specialties, like radiology, that do not fit neatly into MIPS or APMs.

Finally, the current MIPS methodology, in which lower performers fund the bonus payments for higher performers, encourages practices to choose measures in which they already perform well. Instead of this pay-for-performance model, the ACR encourages a pay-for-improvement program, where clinicians and practices have an incentive to choose measures in which they are not already performing at a high level. These practices could then be rewarded for improvement in QI measures within the same performance year and longitudinally. In addition, as a result of this payment model, small, rural, and underserved radiology practices face disproportionate penalties due to their limited resources to support and fund their efforts to successfully participate in MIPS.

In summary, the ACR requests changes to address the shortcomings of the current Medicare value-based payment programs (such as MIPS and APMs) to address the extensive, ongoing efforts required to comply with frequently changing measures, the paucity of clinically relevant measures for radiologists, comparison of physicians from different specialties, lack of recognition of the contribution of teams of caregivers, and use of pay-for-performance methodologies that do not provide incentives to meaningfully improve patient care.

Identification of Duplicative Requirements

Protecting Access to Medicare Act of 2014 (PAMA) Imaging Appropriate Use Criteria

The ACR proposes that CMS revisit the PAMA AUC program and make necessary changes to address the challenges associated with its implementation.

Section 218(b) of PAMA required CMS to establish a program mandating consultation of physician-developed appropriate use criteria (AUC) before physicians and other providers refer Medicare Part B beneficiaries for advanced diagnostic imaging services beginning on January 1, 2017. Through the Medicare Physician Fee Schedule rulemaking process, the CMS Coverage and Analysis Group (CAG)

staff worked with stakeholders, including the ACR, to develop and implement the PAMA AUC program.

The AUC program is an effective, evidence-based program founded on physician-developed guidelines. AUCs are intended to optimize patient care by guiding providers to order the most appropriate advanced imaging study. Programs that utilize AUC within an Electronic Medical Record via clinical decision support (CDS) technology have demonstrated improvement in ordering the correct imaging study in hundreds of institutions over many years. Use of these AUC programs has also shown reductions in unnecessary utilization of imaging studies, producing savings to both payers and patients. In the 2024 Medicare Physician Fee Schedule final rule, CMS estimated implementation of the PAMA imaging provisions would save Medicare approximately $700,000,000 annually. Despite these potential benefits and cost savings, CMS encountered difficulties implementing the program and suspended its work to fulfill this statutory mandate.

The ACR has proposed that CMS revisit the PAMA AUC program by making the following technical changes to the original program.

- ***In lieu of the requirement to report AUC consultation information on each claim for advanced diagnostic imaging services prospectively, ordering providers would instead self-attest to this consultation. Qualified clinical decision support mechanisms would then collect the AUC consultation information (as was previously required of the mechanism).***
- ***This information would then be provided to CMS for retrospective review. Audits could then be performed only as needed.***
- ***The current language should also be amended to exempt small and rural practices and practices participating in clinical trials.***

The ACR feels CMS has the authority to make these changes. Thus, with minimal effort, the PAMA program could finally be implemented. We believe this technology will evolve and improve with use, can be applied to other services besides imaging, and will generate significant savings to the Medicare program.

Additional Recommendations

No Surprises Act (NSA) Independent Dispute Resolution (IDR) Process

The ACR requests the administration consider swift release of the IDR Operations final rule (CMS-9897)[10].

The NSA was signed into law by President Trump in 2020 to protect patients from unexpected medical bills resulting from out-of-network care, particularly in emergencies or when they unknowingly receive care from out-of-network providers at in-network facilities. The development of the IDR process was robust and extensive. When drafting the law, Congress worked to ensure fairness between providers and insurers in payment disputes. The factors that would be considered during the IDR arbitration process were carefully crafted.[11] By establishing a framework for resolving payment disputes between insurers and providers, the NSA ensured patients are not financially penalized for circumstances beyond their control.

[10] https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=202404&RIN=0938-AV15

[11] U.S. Representative Richard Neal, Press Release: Neal Opening Statement at Hearing on Implementation of the No Surprises Act, September 19, 2023, https://neal.house.gov/news/documentsingle.aspx?DocumentID=3797.

The ACR strongly supports the NSA "hold harmless" provisions, removing patients from reimbursement disputes between insurers and providers. In addition, the ACR appreciates the NSA's intended balanced approach with respect to insurance companies and medical practices. The law was designed to end the problem of surprise medical billing while preserving access to care by protecting good-faith negotiations between insurance companies and provider groups, giving neither side unbalanced leverage in network contract negotiations.

Unfortunately, the previous administration did not implement the law as intended, resulting in legal action to correct problematic regulations and much higher usage of the IDR process than anticipated. The IDR Operations proposed rule was published in the *Federal Register* on November 3, 2023, with public comments initially due on February 5, 2024. The final rule, which was expected to be released in early-to-mid summer 2024, has not yet been issued. The new regulations include vital reforms that would greatly improve efficiency and decrease unnecessary utilization of the IDR process. The anticipated changes would also be easily implemented as stakeholders have already provided public comment.

The rule is currently listed on the Administration's Unified Agenda for potential August 2025 action. Given the lengthy delays and ongoing concerns of physicians seeking fair reimbursement from health insurer underpayments under the process laid out by the statute signed into law by President Trump, the ACR urges the Administration to issue a final rule as soon as possible.

Conclusion

The ACR appreciates the opportunity to comment on the FY 2026 IPPS proposed rule. We hope these comments provide valuable input for your consideration. The ACR is available to provide clarification and guidance regarding areas identified for simplification. If you have any questions, please do not hesitate to contact Christina Berry, Team Lead Economic Policy at cberry@acr.org .

Regards,

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Chief Executive Officer

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