American College of Radiology™

September 15, 2025

Electronically submitted

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1834-P
P.O. Box 8010
Baltimore, MD 21244-1850

Re: CMS-1834-P: Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency

Dear Administrator Dr. Oz:

The American College of Radiology (ACR), a professional medical specialty society representing over 41,000 physicians practicing diagnostic radiology, interventional radiology, radiation oncology, and nuclear medicine as well as medical physicists appreciates the opportunity to submit comments to the Centers for Medicare and Medicaid Services' (CMS) calendar year (CY) 2026 proposed rule on Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs.

The ACR provides comments on the following important issues:

1. Proposed APC Placement of Newly Established CPT Codes
2. Proposed APC Placement of Existing CPT/HCPCS Codes
3. Hospital Outpatient Prospective Payment System (HOPPS) Payment for Software as a Service (SaaS)
4. Payment Policy for Diagnostic Radiopharmaceuticals
5. Virtual Direct Supervision of Diagnostic Services Furnished to Hospital Outpatients
6. Proposals for the Hospital Outpatient Quality Reporting (OQR) Program

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Proposed APC Placement of Newly Established CPT Codes

CT Cerebral Perfusion & CT Angiography

The newly established Category I CPT codes 70XX1 and 70XX3 were converted from Category III code 0042T (Cerebral perfusion analysis using computed tomography with contrast administration, including post-processing of parametric maps with determination of cerebral blood flow, cerebral blood volume, and mean transit time).

CPT Code	Short Descriptor	ACR Proposed APC	ACR Proposed Payment	CY2026 Proposed APC	CY2026 Proposed Payment
70XX1	Cta h&n c+ w/noncontrast img	5572 – Level 2 Imaging with Contrast	$357.13	5572 – Level 2 Imaging with Contrast	$358.35
70XX3	Ct cere prfu aly c+wo ct/cta	5572 – Level 2 Imaging with Contrast	$357.13	5571 – Level 1 Imaging with Contrast	$179.73

ACR Perspective and Comments

The ACR recommends that both newly defined services should be paid for under the same APC of 5572 (Level 2 Imaging with Contrast).

CPT code 70XX3 (Computed tomographic (CT) cerebral perfusion analysis with contrast material(s), including image postprocessing performed without concurrent CT or CT angiography of the same anatomy) is clinically similar to 70XX1 with equal to or greater resource use for hospitals providing CT Cerebral Perfusion & CT Angiography. CPT code 70XX3 is not always performed on the same date of service as 70XX1, meaning that in some cases, hospitals must restart work at a later time due to the patient having to return for the adjunctive service. **The ACR recommends that CMS place 70XX3 into APC 5572 with payment of $358.35 for appropriate reimbursement of these services.** Both codes should be placed into the same APC due to their clinical similarity as well as alike resource use.

Radiation Oncology Treatment Delivery

For calendar year 2026, CPT code numbers 77402, 77407 and 77412 are retained but significantly revised, and CPT codes 77385, 77386, 77014 are deleted codes.

Under the new coding structure, radiation treatment delivery with conventional X-ray or electron beams is assigned levels of complexity based on the number of treatment sites

and the complexity of the treatment delivery. The technique (3D, IMRT, or Volumetric Modulated Arc Therapy) does not automatically contribute to complexity level selection. The complexity of intensity-modulated radiation therapy (IMRT) varies depending on the area being treated, the number of targets identified, differential doses delivered, or the technique being used.

CPT Code	Short Descriptor	ACR Proposed APC	ACR Proposed Payment	CY2026 Proposed APC	CY2026 Proposed Payment
77402	Radiation tx delivery lvl 1	5622 – Level 2 Radiation Therapy	$275.34	5621 – Level 1 Radiation Therapy	$107.97
77407	Radiation tx delivery lvl 2	5623 - Level 3 Radiation Therapy	$600.14	5622 – Level 2 Radiation Therapy	$275.34
77412	Radiation tx delivery lvl 3	5623 – Level 3 Radiation Therapy	$600.14	5622 – Level 2 Radiation Therapy	$275.34

ACR Perspective and Comments

CPT codes 77402, 77407, and 77412 for radiation oncology treatment delivery were revised for CY2026 to consolidate services for treatment delivery. Although the CPT code numbers are the same for the remaining three CPT codes in the new treatment delivery family, they represent completely different services. For HOPPS rate setting purposes, CMS should treat 77402, 77407, and 77412 as new codes. Operationally, CMS should assign these three codes to their respective APC with no associated data and use the existing codes for rate setting. CMS did use 77385 and 77386 for rate setting; however, those deleted codes should be used for rate setting in APC 5623 (Level 3 Radiation Therapy). CMS should also utilize existing claims data for CPT code 77412 in ratesetting for APC 5622 (Level 2 Radiation Therapy). The CY 2026 HOPPS proposed rule Addendum B lists no reassignments for CPT Codes 77402, 77407 or 77412, despite the significant revisions to the CPT codes.

Currently, both IMRT treatment delivery codes 77385 (simple) and 77386 (complex) are assigned to APC 5623 Level 3 Radiation Therapy. The geometric mean costs of CPT 77385 and 77386 need to be included in revised Radiation Treatment Delivery codes 77407 and 77412. In addition, the technical component of image guidance and active motion management has been bundled into the revised Radiation Treatment Delivery codes. The

2026 APC assignments should be updated to reflect the coding changes for the Radiation Treatment Delivery code family (codes 77402, 77407, and 77412) to reflect the new coding schema.

The ACR recommends that CMS reassign CPT 77402 to APC 5622 (Level 2 Radiation Therapy) with payment rate of $275.34. The ACR also recommends that CMS reassign CPTs 77407 and 77412 to APC 5623 (Level 3 Radiation Therapy) with payment rate of $600.14 for CY 2026.

Lower Extremity Vascular Procedures – Femoral & Popliteal Vascular Territory
The initial vessel in the femoral and popliteal vascular territory treated with angioplasty alone is reported with 37X10 for straightforward lesions or 37X12 for complex lesions. These newly established codes are replacing deleted code 37224 (Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty).

CPT Code	Short Descriptor	ACR Proposed APC	ACR Proposed Payment	CY2026 Proposed APC	CY2026 Proposed Payment
37X10	Revsc evasc fpvt angio sf 1	5193 – Level 3 Endovascular Procedures	$11,340.57	5192 – Level 2 Endovascular Procedures	$5,880.65
37X12	Revsc evsc fpvt angio cplx 1	5194 – Level 4 Endovascular Procedures	$17,956.72	5192 – Level 2 Endovascular Procedures	$5,880.65
37X14	Revsc evsc fpvt stent sf 1st	5193 – Level 3 Endovascular Procedures	$11,340.57	5193 – Level 3 Endovascular Procedures	$11,873.70
37X16	Revsc evasc fpvt st cplx 1st	5194 – Level 4 Endovascular Procedures	$17,956.72	5193 – Level 3 Endovascular Procedures	$11,873.70

ACR Perspective and Comments
In recent years, technical advancements have fundamentally changed the standard of care for endovascular procedures. The advent of drug eluting technology has been shown to deliver improved long-term vessel patency, using balloons coated with drugs.

Femoropopliteal angioplasty treatment is done with drug-coated balloons which deliver paclitaxel to the intima of the vessel wall, and the vessel must be pre-dilated with a standard low-profile ballon prior to use of the drug-coated balloon. For both

straightforward and complex procedures, the drug-coated balloons can only be used on one segment of vessel (single inflation) and the treatment of a typical femoropopliteal diseased segment requires two drug-coated balloons. **ACR believes it is appropriate for new code 37X10 to be placed in APC 5193 (Level 3 Endovascular Procedures) with a J1 status indicator and payment rate of $11,340.57 for CY2026 due to the complexity of these procedures.**

To treat complex total occlusions (new CPT code 37X12), additional supplies are needed. For example, the use of a crossing catheter and steerable microwire is typical. A stiff, small caliber support wire is also commonly used once the lesion is crossed to deliver the angioplasty balloon through complex occlusions. It is also typical to use a distal protection device to prevent embolization of fibrofatty plaque and thrombus. **Due to the increased clinical complexity as well as the additional resources needed, ACR recommends that CMS place new code 37X12 in APC 5194 (Level 4 Endovascular Procedures) with a J1 status indicator and payment rate of $17,956.72.**

The initial vessel treated with angioplasty and stent placement is reported with code 37X14 for straightforward lesions or 37X16 for complex lesions. These newly established codes are replacing deleted code 37226 (Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed).

In complex cases where a total occlusion is treated with angioplasty and stent placement (new CPT code 37X16), it is typical to enter the subintimal space and require a reentry device to gain wire access across the occlusion. Covered stents are preferred in lieu of uncovered metal stents to improve patency for these long segment chronic total occlusions. Two covered stents are necessary for the typical length of chronic total occlusions in the femoropopliteal segment.

Additional supplies, such as a crossing catheter, steerable microwire, and small caliber support wire, are used once the lesion is crossed to deliver the angioplasty balloon and stent through complex occlusions. It is also typical to use a distal protection device to prevent embolization of fibrofatty plaque and thrombus in these cases. **ACR recommends that 37X16 be placed in APC 5194 (Level 4 Endovascular Procedures) due to its increased complexity and resource use over straightforward lesions in the same vascular region.**

Proposed APC Placement of Established CPT/HCPCS Codes

Medical 3D Printing Services

Category III codes 0559T-0562T were established in 2019 to report the creation of a 3D printed anatomical model from medical imaging data.

CPT Code	Long Descriptor	ACR Proposed APC	ACR Proposed Payment	CY 2026 Proposed APC	CY 2026 Proposed Payment
0559T	Anatomic model 3D printed from image data set(s): first individually prepared and processed component of an anatomic structure	5735 – Level 5 Minor Procedures	$451.59	5733 – Level 3 Minor Procedures	$60.59
0561T	Anatomic guide 3D printed from image data set(s): first anatomic guide	5735 – Level 5 Minor Procedures	$451.59	5733 – Level 3 Minor Procedures	$60.59

ACR Perspective and Comments

The ACR believes that codes 0559T and 0561T for 3D printing services are not appropriately reimbursed under the HOPPS. These codes have historically shown low utilization within the HOPPS system, leading to a lack of reliable claims data for ratesetting purposes. For example, a 2024 multicenter 3D printing publication included 20 sites over 3 years (June 2020-June 2023) and reported on 2,637 patients. Yet, the CY 2026 HOPPS NRPM cost statistics files showed reporting of only 16 total frequency claims for 0559T and 84 total frequency claims for 0561T.[1]

Since the implementation of these codes in 2019, reimbursement levels have remained insufficient to cover the actual costs of delivering these services to Medicare beneficiaries in many hospitals. As a result, numerous institutions face financial disincentives to provide these services. For example, the costs for what are considered basic 3D printing services have been benchmarked[2]. Of the costs reported in this publication, the cost per patient when separated is $1762 for the technical component, and $975 for the professional component with a total cost of ($2737/ per patient). More complex patients have higher costs. Due to the significant gap between service costs and reimbursement rates, some hospitals have chosen to limit availability, and others have refrained from adopting 3D

[1] https://www.sciencedirect.com/science/article/abs/pii/S1546144024006847?via%3Dihub

[2] https://www.jacr.org/article/S1546-1440(22)00552-X/fulltext

printing technologies altogether. This results in reduced access to these services for patients who would benefit from this care.

The ACR believes codes 0559T and 0561T should be placed into APC 5735 with payment rate of $451.59 because the resources and supplies needed to provide this service are greater than the current reimbursement rate. The proposed CY 2026 geometric mean costs for 0559T and 0561T, which dictate their current APC placement, are not indicative of the true costs of providing this service. Also, these services share more clinical similarities and resource homogeneity with other services within APC 5735, providing for an appropriate reimbursement. The proposed geometric mean for APC 5735 more closely aligns with the codes 0559T and 0561T for 3D printing services.

3D Surface Mesh Printing

In the January 2025 HOPPS Quarterly update, CMS created the new HCPCS code C8001 for the 3D anatomical segmentation imaging intended as software for preoperative surgical planning, and as software for the intraoperative display of these multi-dimensional digital images. In the April HOPPS update, CMS revised the APC placement from APC 5521 to APC 5721. In the CY 2026 HOPPS PR, CMS proposes for HCPCS code C8001 to remain in APC 5721 with a payment rate of $132.89.

CPT Code	Long Descriptor	ACR Proposed APC	ACR Proposed Payment	CY 2026 Proposed APC	CY 2026 Proposed Payment
C8001	3d anatomical segmentation imaging for preoperative planning, data preparation and transmission, obtained from previous diagnostic computed tomographic or magnetic resonance examination of the same anatomy	5723 - Level 3 Diagnostic Tests and Procedures	$381.96	5721 - Level 1 Diagnostic Tests and Procedures	$132.89

ACR Perspective and Comments

While the ACR appreciates the revised APC placement of newly established HCPCS code C8001 in the April 2025 HOPPS update, we believe this service should be placed into APC 5723 (Level 2 Diagnostic Tests and Procedures) based on the technical expertise required by the technologist and the additional hardware and software costs associated with these procedures.

Colorectal Cancer (CRC) Screening Services

In the CY2025 HOPPS final rule, CMS added coverage for computed tomography colonography (CTC) services, assigning a Status Indicator of S to CPT code 74263 to indicate separate payment. In this proposed rule, CMS proposes to place 74263 in APC 5523 (Level 3 Imaging without Contrast) with payment rate $245.72.

CPT Code	Long Descriptor	ACR Proposed APC	ACR Proposed Payment	CY 2026 Proposed APC	CY 2026 Proposed Payment
74263	Computed tomographic (CT) colonography (i.e., virtual colonoscopy), screening, including image postprocessing	5524 – Level 4 Imaging without Contrast	$562.07	5523 – Level 3 Imaging without Contrast	$245.72

ACR Perspective and Comments

The ACR would like to thank CMS for the opportunity to provide feedback on the reimbursement of CT colonography screening services. This minimally invasive colorectal cancer screening option saves Medicare beneficiary lives by detecting pre-cancerous polyps and/or identifying cancer at an early stage. Prior to 2025, CTC was an untapped resource that broadens screening options and mitigates access issues for Medicare beneficiaries. CTC provides a proven, safe and minimally invasive exam to both screen for precursor polyps and colorectal cancer and save lives. Unfortunately, low reimbursement rates for CTC make it financially unviable for many imaging practices.

Screening CT colonography is currently assigned to APC 5523 (Level 3 Imaging without Contrast). **An alternative APC assignment would be APC 5524 (Level 4 Imaging without Contrast) that has a proposed 2026 OPPS payment amount of $562.07.**

Again, ACR requests CMS consider the public policy implications of assigning screening CT colonography to a higher paying APC. Given the impact of screening services on public health, the ACR encourages their provision on a recommended schedule supported by public health research. The proposed payment of $245.72 would continue to discourage many imaging practices from offering screening CT colonography. This reimbursement level is likely to disproportionately affect underserved communities and exacerbate disparities in early diagnosis and treatment of colorectal cancer. A payment of $562.07 will encourage the provision of screening CT colonography and positively contribute to early identification and treatment of colon cancer.

Hospital Outpatient Prospective Payment System (HOPPS) Payment for Software as a Service (SaaS)

Comment Solicitation on Payment Policy for Software as a Service (SaaS)

CMS currently does not have a payment methodology specifically for SaaS. As these technologies have continued to evolve and diversify, some interested parties have stated that the lack of a consistent payment policy for SaaS reduces patient access to these services, which are otherwise approved by the FDA.

In an effort to promote the adoption of high-value, cost-effective care, CMS has welcomed public comment as they consider how to appropriately pay for these services, determine that Medicare payments truly reflect the value of the technologies to medical practice, and ensure any payment policies demonstrate fiscal responsibility and good stewardship

ACR Perspective and Comments

The ACR appreciates the CMS for inviting public and stakeholder feedback on the role of software-as-a-service (SaaS) and artificial intelligence (AI) in healthcare. This timely and important step will ensure emerging digital health technologies are integrated into care delivery in a safe, effective, and equitable manner.

As a leader in AI governance, the ACR has developed a robust framework of tools, resources, and guidance to support informed decision-making and responsible adoption of AI across clinical settings. The rapid evolution of digital health technologies—including digital therapeutics, AI-enabled diagnostics, and systems ranging from augmentative to fully autonomous—has generated growing interest among physicians seeking to enhance patient care through innovation.

For these technologies to be meaningfully adopted and made available to patients, however, CMS must establish a clear and consistent pathway to payment. Reimbursement clarity is essential to support clinical integration, encourage innovation, and ensure equitable access to these tools.

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. Because hospital charges are adjusted using CCRs, the resulting geometric means and respective Medicare payment rates will be significantly lower or higher than the corresponding charge amounts.

Hospitals vary widely in how they report their charges and costs to CMS. Because of the difficulty accurately calculating all the capital costs associated with SaaS codes, most hospitals underreport this cost to CMS. The inconsistencies between the actual costs of SaaS tools and the geometric means calculated by CMS are concerning.

The ACR believes that, rather than assigning SaaS codes to radiology or other existing cost centers, CMS should consider establishing a new revenue cost center specifically for AI to allow more granular data to be obtained. This new cost center should only be applicable to SaaS codes that are augmentative (i.e., enhance patient care by performing tasks for which physicians are not already reimbursed). This would only be applicable to codes with an "S" status indicator deeming separate reimbursement.

In the meantime, CMS should maintain current APC placements for existing SaaS codes. The ACR supports the broad use of SaaS codes at an appropriate reimbursement rate so they may be adopted and utilized more widely by clinicians. The ACR believes CMS should allow adequate time for appropriate claims data to accrue before reassigning SaaS codes to new APCs. Refinements and exclusions based on low claims volumes should be applied consistently throughout the current fee schedule and across years. This would allow for more stability within the HOPPS with constantly emerging AI technologies.

The ACR also urges CMS to align its terminology with that used by other federal agencies to promote regulatory consistency. For example, the Food and Drug Administration (FDA) uses the term "software as a medical device" (SaMD) to describe many of these technologies. Harmonizing language across agencies will reduce confusion and facilitate more streamlined policy development.

The College believes CMS should clarify in the HOPPS final rule that the SaaS codes were designed by The American Medical Association (AMA) Current Procedural Technology (CPT) to be vendor neutral. As a result, these codes do not belong to any single vendor or represent any single vendor's services. To focus on a single commercial platform for a code is not accurate, confuses the applicability of the code, and limits adoption of other tools for which the code was intended. By removing the current language that these codes are "associated with" a specific service, we anticipate an increase in claims, allowing CMS to gain a more accurate understanding of the actual costs associated with these services.

The ACR looks forward to continued collaboration with CMS as it navigates this complex and rapidly evolving landscape. We are ready to contribute our expertise to support thoughtful policy solutions that advance patient-centered care through responsible innovation.

Payment Policy for Diagnostic Radiopharmaceuticals

Separate Payment for Diagnostic Radiopharmaceuticals

In the CY 2025 HOPPS final rule, CMS finalized a policy to pay separately for any diagnostic radiopharmaceutical with a per day cost greater than $630 for 2025. Those at or below this threshold will remain policy packaged.

For CY 2026, CMS proposes to continue this policy finalized in CY 2025. CMS proposes to update the CY 2025 $630 threshold amount by the four-quarter moving average PPI levels for Pharmaceuticals for Human Use, Prescription to trend the $630 threshold forward.

CMS proposes for CY 2026 to continue with the current policy to pay qualifying diagnostic radiopharmaceuticals with per day costs above the diagnostic radiopharmaceutical packaging threshold, based on their arithmetic mean unit cost (MUC), which would be derived from calendar year 2024 claims data. CMS continues to encourage manufacturers to submit Average Sales Price (ASP) information for diagnostic radiopharmaceuticals, if possible.

ACR Perspective and Comments
We appreciate CMS's engagement with stakeholders on this topic in past years and the opportunity to comment on this important issue in this year's proposed rule. **While ACR supports separate payment under the MUC methodology for products without ASP, we recommend that CMS allow for payment rates based on ASP, which has a more transparent methodology and reflects the widely available market price.** Stakeholders continue to have concerns that hospital outpatient claims data for certain products is limited and could result in fluctuations in payment from the average acquisition costs.

As with other drugs and biological products, the ASP methodology provides the most accurate reflection of the prevailing market price across widely available sources. Using ASP where available would be consistent with CMS precedent of pass-through payment status for drugs and biologicals. In conclusion, we strongly support CMS setting separate payment for advanced diagnostic radiopharmaceuticals based on ASP data where available.

Virtual Direct Supervision of Diagnostic Services Furnished to Hospital Outpatients
In the CY 2023 OPPS/ASC final rule with comment period, CMS extended the end date of the flexibility allowing for the virtual supervision. This change allows for the flexibility of virtual supervision of outpatient diagnostic services through audio/video real-time communications technology from the end of the PHE to the end of the calendar year in which the PHE ends. In the CY 2024 OPPS/ASC final rule this was once again extended to December 31, 2024. In the CY 2025 HOPPS final rule, CMS again revised the definition of direct supervision at § 410.32(b)(3)(ii) to extend the availability of virtual direct supervision of therapeutic and diagnostic services under the PFS through December 31, 2025.

In addition to desiring uniformity under the Physician Fee Schedule (PFS) and OPPS in how regulations are applied to similarly situated clinicians and providers, CMS states that the approach proposed in the PFS proposed rule strikes the appropriate balance between

recognizing that virtual supervision of diagnostic services has been available and widely utilized since the beginning of the PHE and ensuring quality of care and patient safety.

Consequently, CMS proposes to revise § 410.27(a)(1)(iv)(B)(1) and § 410.28(e)(2)(iii) to make the availability of the direct supervision of CR, ICR, PR services and diagnostic services via audio-video real-time communications technology (excluding audio-only) permanent, except for diagnostic services that have a global surgery indicator of 010 or 090.

ACR Perspective and Comments
Previously, the ACR commented[3] in support of CMS's decision to revise regulatory text to allow the presence of the physician (or other practitioner) including virtual presence through audio/video real-time communications technology (excluding audio-only) through December 31, 2024. The ACR reaffirms our previous comments requesting that CMS make the rule that allows virtual direct supervision of level 2 diagnostic tests via real time audio/video communications permanent**. The ACR remains supportive of CMS's decision to permanently adopt a definition of direct supervision that allows "immediate availability" of the supervising practitioner using audio/video real-time communications technology (excluding audio-only), for all services described under § 410.26, except for services that have a global surgery indicator of 010 or 090.**

<u>Proposals for the Hospital Outpatient Quality Reporting (OQR) Program</u>
The following summarizes the proposed updates to the Hospital Outpatient Quality Reporting (OQR) Program and Rural Emergency Hospital Quality Reporting (REHQR) Program, and the Request for Information (RFI) on new measure concepts.

Measure Concepts Under Consideration for Future Years in the Hospital OQR, REHQR, and ASCQR Programs – Request for Information
In the Cross-Program Measures section of the RFI, CMS is seeking feedback on the broad expansion of digital quality measures (dQM) in outpatient settings through the implementation of electronic Clinical Quality Measures (eCQMs) in the Hospital Outpatient Quality Reporting (OQR) and Rural Emergency Hospital Quality Reporting (REHQR). CMS states that these changes are intended to modernize data collection, reduce provider burden, and improve the accuracy and timeliness of quality reporting. To support the transitions, the RFI outlines technical requirements for eCQM reporting that also comply with the Office of the National Coordinator's (ONC) standards and submission of data.

[3] https://www.acr.org/-/media/ACR/Files/Advocacy/AIA/091323-ACR-24-MPFS-PR-Comment-Letter-Final.pdf

ACR Perspective and Comments

ACR appreciates the inclusion of this RFI in the CY 2026 HOPPS Proposed Rule, which is consistent with similar requests in the MPFS and IPPS proposed rules and reflects CMS's broader Digital Quality Measurement Strategy to transition to fully digital, interoperable reporting systems.

While ACR supports these goals, implementing standardized digital reporting presents distinct challenges for radiology, especially in hospital outpatient departments and imaging facilities. Radiologists typically work in a consultative capacity, interpreting studies ordered by other clinicians, with limited direct patient contact. As a result, core components of many dQMs—such as patient-reported outcomes and population health metrics – do not align with radiology workflows or the data available in imaging systems.

Some hospital outpatient departments may be better positioned to support eCQM reporting due to centralized EHR infrastructure. Also, some subspecialties (like breast imaging and interventional radiology) may have more direct patient interaction, which makes certain measures more readily applicable. Still, interoperability requirements may not fully account for the complexity of imaging data stored in systems like PACS and RIS, which operate independently of EHRs and rely on unique formats and metadata. Without clear guidance, radiology departments could face significant technical and operational barriers to participating in eCQM reporting under the Hospital OQR program.

To ensure DQM is practical for radiology, CMS should consider flexible implementation strategies that reflect the specialty's clinical role and data environment. These strategies could include developing radiology-specific eCQMs, clarifying expectations for imaging system interoperability, and offering technical support for integration across platforms. These steps would help ensure the transition to DQM under the HOQR program applies to and is practical for radiology providers.

Hospital Outpatient Quality Reporting (OQR) Program and Rural Emergency Hospital Quality Reporting (REHQR) Program

In the CY 2024 OPPS/ASC final rule, CMS finalized adoption and voluntary reporting of the *Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults* eCQM in the Hospital OQR and REHQR programs starting in 2025. Mandatory reporting was planned in CY 2027. In response to public comments highlighting significant burdens and resource challenges, particularly for facilities lacking the necessary infrastructure, CMS is now proposing to repeal the mandatory reporting requirement for both programs and keep voluntary reporting of the Excessive Radiation Dose eCQM indefinitely.

ACR Perspective and Comments

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The ACR has long led efforts to advance radiation safety, offering a broad range of resources, from guidelines and accreditation to initiatives like Image Gently and Image Wisely, to help hospitals and imaging facilities deliver safe, high-quality care. We also support the adoption of practical tools that promote appropriate imaging and optimize patient exposure through dose index monitoring, such as the Dose Index Registry currently used by thousands of hospitals in the U.S. to monitor clinical performance and usage of radiation dose.

The College appreciates and strongly supports CMS's proposal to maintain voluntary reporting for the Excessive Radiation eCQM in the Hospital OQR and REHQ programs. ACR has received feedback about the substantial financial and operational challenges of implementing and maintaining this eCQM, particularly the difficulty of converting CT imaging data into standardized formats compatible with eCQM specifications from many members, imaging facilities, hospital radiology departments, radiology practices affiliated with hospitals, and other entities. This decision appropriately addresses these ongoing concerns.

ACR would like to emphasize that implementation of the Excessive Radiation Dose eCQM in the REHQR program is especially problematic and could strain already limited resources for rural emergency hospitals (i.e. those designated as Critical Access Hospitals (CAH) or a rural hospital with 50 or fewer beds). These facilities may have even greater challenges obtaining the advanced imaging systems and technical support needed to report the measure.

The ACR appreciates the opportunity to provide comments on the CY 2026 HOPPS proposed rule. We encourage CMS to continue to work with physicians and their professional societies through the rulemaking process to create a stable and equitable payment system and promote an equitable delivery system. The ACR looks forward to continued dialogues with CMS officials about these and other issues affecting radiology and radiation oncology. If you have any questions or comments on this letter or any other issues with respect to radiology or radiation oncology, please contact Kimberly Greck (kgreck@acr.org) or Christina Berry (cberry@acr.org).

Respectfully submitted,

D Smetherman

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