American College of Radiology

American College of Radiology Detailed Summary of Radiology Provisions in the 2025 MPFS Proposed Rule

The Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2025 Medicare Physician Fee Schedule (MPFS) proposed rule on Wednesday, July 10, 2024. In this rule, CMS describes changes to payment provisions and to policies for the Medicare Shared Saving Program, Medicare Prescription Drug Inflation Rebate Program and Medicare Overpayments. There is a 60-day comment period for the proposed rule, ending on September 9.

Conversion Factor and CMS Overall Impact Estimates

CMS estimates a CY 2025 conversion factor of $32.3562 compared to the 2024 conversion factor of $33.2875. This was calculated by removing the 1.25 percent provided by the Consolidated Appropriations Act of 2023 that applied to services furnished from January 1, 2024, through March 8, 2024, and the 2.93 percent payment increase provided by the Consolidated Appropriations Act of 2024 that replaced the previous 1.25 percent increase and applied to services furnished from March 9, 2024, through December 31, 2024. CMS then applied a positive 0.05 percent budget neutrality adjustment.

CMS estimates an overall impact of the MPFS proposed changes to radiology, nuclear medicine and radiation oncology to be a neutral 0 percent, while interventional radiology would see an aggregate decrease of 2 percent if the provisions within the proposed rule are finalized.

Coverage of Computed Tomography Colonography (CTC) for Colorectal Cancer Screening (Page 1127)

CMS is using statutory authority to update and expand coverage for colorectal cancer screening with the following proposals:

- **Adding coverage for CTC,**
- **Removing coverage for the barium enema procedure, and**
- **Expanding a "complete colorectal cancer screening" to include a follow-on screening colonoscopy after a Medicare covered blood-based biomarker CRC screening test (described and authorized in NCD 210.3).**

CMS is using statutory authority under the Balanced Budget Act of 1997 for the Secretary to add additional colorectal cancer screening tests and procedures to its definition of screening tests to propose coverage of CTC for Medicare beneficiaries. The rule states that Section 1861(pp)(1)(D) of the Act authorizes the Secretary to include in the definition of colorectal cancer screening tests "other tests or procedures and modifications to the tests and procedures described under this subsection, with such frequency and payment limits as the Secretary determines appropriate, in consultation with appropriate organizations".

The rule points out that the U.S. Preventative Services Task Force (USPSTF) included CTC as a CRC screening method in their June 2016 revised Final Recommendation Statement and again in

its May 2021 guideline update. CMS issued a non-coverage determination for CTC in 2009. If this proposal is finalized, CMS states that they will address and revise the current non-coverage policy for CTC.

The proposed rule includes discussion of potential harms associated with extracolonic findings as discussed in the 2016 USPSTF recommendations. Citing a study by Dr. Lincoln Berland[1], CMS states, "The potential for extracolonic findings, both clinically significant and insignificant, is an important tradeoff to be considered by the patient and clinician when considering CTC as a CRC Screening option."

Following a discussion of various colorectal cancer screening guidelines and information sources, including RadiologyInfo.org, the proposed rule states, "After considering the above recommendations and guidelines from appropriate organizations, we believe CTC to be reasonable and necessary as CRC screening test, especially for patients and clinicians who seek a direct visualization procedure as a first step in CRC screening that is less invasive and less burdensome on the patient and healthcare system compared to Screening Colonoscopy. Our goal is that the patient and their clinician make the most appropriate choice in CRC screening, which includes considerations of the risks, burdens and tradeoffs for each covered test or procedure. We expect that clinicians who order CTC for CRC Screening will educate their patients on risks and context of radiation exposure and potential extracolonic findings. A shared decision-making tool is not mandated but may be helpful for clinicians and patients to weigh their options for CRC screening."

CMS proposes the following timetables for CTC screening coverage:

- In the case of an individual age 45 or over who is not at high risk of colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 59 months have passed following the month in which the last screening computed tomography colonography or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed.
- In the case of an individual who is at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed.

In accordance with the Affordable Care Act, if the coverage proposal is finalized, CTC will require no Part B coinsurance or deductible when provided as a colorectal cancer screening procedure.

In addition to the proposal to add coverage of CTC, CMS proposes to remove coverage of double contrast barium enema, stating that in the U.S., CTC has largely replaced double contrast barium enema as a radiographic option for colorectal cancer screening. CMS states that in

[1] Lincoln L. Berland, Incidental Extracolonic Findings on CT Colonography: The Impending Deluge and Its Implications, Journal of the American College of Radiology, Volume 6, Issue 1, 2009, Pages 14-20, ISSN 1546- 1440, https://doi.org/10.1016/j.jacr.2008.06.018.

consultation with stakeholder organizations, it has determined that barium enema procedures no longer meet modern clinical standards and are no longer recommended in clinical guidelines. Barium enema was no longer included in the USPSTF 2016 and 2021 recommendations for colorectal cancer screening. CMS also considered the 2017 U.S. Multi-Society Task Force of Colorectal Cancer (MSTF) recommendation statement, which reads, "CT colonography has replaced double-contrast barium enema as the test of choice for colorectal imaging for nearly all indications. CT colonography is more effective than barium enema and better tolerated." Finally, the 2018 American Cancer Society (ACS) Colorectal Cancer Screening for Average-Risk Adults Guideline Update also removed barium enema from recommended screening options.

During the CY 2023 PFS, CMS received a joint public comment from the American College of Gastroenterology (ACG), American Gastroenterological Association (AGA) and the American Society for Gastrointestinal Endoscopy (ASGE) requesting removal of barium enema as a covered colorectal cancer screening option. CMS also stated that in CY 2022, Medicare only paid 72 claims for barium enema for colorectal cancer screening.

Finally, CMS proposes to revise the regulatory text describing a complete CRC screening to state that colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test **or** a Medicare covered blood-based biomarker colorectal cancer screening test returns a positive result. If finalized, this means that beneficiaries who have a positive result on a Medicare covered stool-based or blood-based biomarker screening will not have to pay cost-sharing for the follow-on colonoscopy.

In its proposal CMS states, "We believe our proposal will directly advance health equity by promoting access and removing barriers for much needed cancer prevention and early detection within rural communities and communities of color that are especially impacted by the incidence of CRC. Our proposal to expand colorectal cancer screening directly supports the Administration's Cancer Moonshot Goal of reducing the deadly impact of cancer and improving patient experiences in the diagnosis, treatment, and survival of cancer."

Financial Impact Discussion (Page 1619)
CMS does not expect its proposal to add coverage of CTC for colorectal cancer screening to have a significant financial impact on the Medicare program. The rule states that CMS expects that utilization of CTC will be modest, considering that it requires bowel preparation and travel to a clinical service site versus stool-based tests that may be administered at home. The rule cites a 2015 study titled "Medicare cost of colorectal cancer screening: CT colonography vs. optical colonoscopy" that concluded that CTC is 29 percent less expensive than colonoscopy (accounting for related procedures) for the Medicare population in the base scenario.[2]

CMS also states that additional utilization will be balanced by avoided utilization of alterative tests in addition to the benefits of increased prevention and early detection of colorectal cancer.

[2] Pyenson, B., Pickhardt, P.J., Sawhney, T.G. et al. Medicare cost of colorectal cancer screening: CT colonography vs. optical colonoscopy. Abdom Imaging 40, 2966–2976 (2015). https://doi.org/10.1007/s00261-015-0538-1.

Procedures Subject to the Multiple Procedure Payment Reduction and the Hospital Outpatient Prospective Payment System (OPPS) Cap (Page 127)
The Deficit Reduction Act of 2005 requires that the technical component of imaging services be paid at the lesser of the MPFS or OPPS payment amount. Imaging services are defined 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."

CMS identified CPT code 74263 (Computed tomographic (ct) colonography, screening, including image postprocessing) among those to be included on the cap list for 2025.

The technical component reimbursement rate for screening CTC under the MPFS is $528 based on the published relative value units (RVUs) and the proposed conversion factor (dollar figure, subject to change). The proposed TC reimbursement rate for the OPPS is $106.30. If finalized as is, the OPPS rate will be the technical component reimbursement rate in both hospital and freestanding settings. The professional component is $104 in both settings.

Adjusting RVUs to Match the PE Share of the Medicare Economic Index (MEI) (Page 29)

In the 2023 MPFS, CMS finalized the rebasing and revising of the Medicare Economic Index (MEI), which is a measure of the relative weights of work, practice, and malpractice in Medicare payment. The purpose of the rebasing and revising of the MEI is to reflect current market conditions, with the latest adjustment made in 2014.

In 2023 and 2024, CMS solicited feedback from stakeholders on when and how to best incorporate the rebased and revised MEI, with many commenters recommending that CMS delay implementation until the American Medical Association (AMA) completes their practice cost survey. As the AMA is currently collecting data through the Physician Practice Information Survey (PPIS), CMS is not proposing to incorporate the updated 2017-based MEI for CY 2025.

Updates to Prices for Existing Direct PE Inputs (Page 36)

Beginning in 2019, CMS worked with a contractor, StrategyGen to make updates to the existing direct practice expense (PE) inputs related to supplies and equipment. The prices for over 2,000 supplies or equipment items were updated over a four-year phase-in period that CMS implemented in order to maintain payment stability. In 2022, with the end of the phase-in of supplies and equipment pricing, CMS began the four-year phase-in for updating the pricing for clinical labor. CY 2025 will be the final year of phase-in.

CMS continues to review and consider invoices they receive for existing direct practice expense (PE) inputs. For CY 2025, CMS is proposing updates to the price of 17 supplies and 1 equipment item as a result of invoice submission from stakeholders.

Invoice Submission (Page 40)

CMS continues to welcome the submission of invoices to assist with the pricing of supplies and equipment. They note that there has been an increase in invoice submission in recent years. While they appreciate the participation, CMS has concerns that this could distort relativity across the fee schedule if only a small subset of supply or equipment items are being reviewed or updated, while the majority of the items are untouched. CMS believes it may be more efficient and accurate to do a more comprehensive review like they did in 2019, perhaps in coordination with clinical labor pricing updates. CMS is soliciting feedback from stakeholders on the possibility of comprehensive review of direct PE inputs in the future.

Supply Pack Pricing Update (Page 41)

In CY 2024, the RUC submitted recommendations for several supply packs that contained pricing discrepancies. Since supply pack pricing was not addressed in the CY 2024 proposed rule, CMS deferred addressing the topic until the CY 2025 rule. For 2025, CMS is proposing to implement the RUC-recommended prices for five supply packs and the deletion of another. Please refer to Table 16 in the proposed rule for a full listing. Eight new supplies are also being created and implemented for CY 2025.

Clinical Labor Pricing Update (Page 44)

Following the end of the supplies and equipment pricing update, CMS began addressing the prices for the clinical labor staff in 2022. The clinical labor rates had not been updated since 2002. Like they did for the supplies and equipment, CMS is also phasing in the updated prices for the clinical staff over four years. 2025 marks the final year of phase-in.
To update the clinical labor wages, CMS utilized data from the Bureau of Labor Statistics, Salary Expert, and/or data provided from stakeholders. While CMS continues to accept wage data submitted from the public, the Agency did not receive any new information for consideration for CY 2025. CMS is proceeding with implementation of the wages as finalized in previous rulemaking, with the incremental increase in this final year of phase-in. Table 5 in the proposed rule details the new rates for CY 2025.

Development of Strategies for Updates to Practice Expense Data Collection and Methodology (Page 51)

In the CY 2023 and CY 2024 MPFS, CMS asked for stakeholder thoughts and feedback on ways to update the PE methodology and inputs that could be repeatable and account for the changes in the health care landscape. The current PE methodology utilizes data from the AMA's 2007/2008 Physician Practice Information Survey (PPIS). The AMA is in the process of collecting updated PPIS data, and many comments have asked CMS to hold off on making any changes to the PE methodology until the new data is available. The AMA expects their analysis to be complete by the end of CY 2024.

In the CY 2025 proposed rule, CMS shares that they do have some concerns about the endorsements the AMA received from many of the national medical specialty societies for their survey and how it may contribute to bias in the data that is collected. Furthermore, CMS states that they have contracted with RAND Corporation to develop other alternative methods for measuring PE. CMS continues to solicit feedback and input from stakeholders on ways to improve the stability and predictability of any future updates, as well as having recurring updates to the PE inputs every four years.

CMS also seeks feedback on ways their methodology could account for inflation or deflation in supply or equipment costs, the impacts of economics of scale, and also how to obtain verifiable and independent data.

CY 2025 Identification and Review of Potentially Misvalued Services (Page 62)

For CY 2025, CMS received five public nominations for potentially misvalued codes. Two of those nominations pertain to codes that are related to radiology.

CPT code 27279 *(Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device)* is currently priced for the facility setting only. This code has been re-nominated for a second time, with the nominator requesting non-facility direct PE inputs for procedures performed in the office. The nominator states that payment in the non-facility setting would allow for increased patient access to this procedure.

When this code was first nominated in the CY 2024 MPFS, there was mixed feedback from stakeholders about the safety of performing this procedure in the office. This led CMS to not nominate this code as potentially misvalued. For CY 2025, CMS received additional literature to support the nominator's assertion that this procedure could be safely performed in the office and has a relatively low complication rate. However, CMS notes that the studies submitted by the nominator also reported heterogenous safety outcomes, leading CMS to once again not nominate this code as potentially misvalued. CMS is soliciting more stakeholder feedback and input on whether this code should be priced in the non-facility or office setting.

CPT codes 10021 *(Fine needle aspiration biopsy, without imaging guidance; first lesion)*, 10004 *(Fine needle aspiration biopsy, without imaging guidance; each additional lesion (List separately in addition to code for primary procedure))*, 10005 *(Fine needle aspiration biopsy, including ultrasound guidance; first lesion)*, and 10006 *(Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion (List separately in addition to code for primary procedure))* were nominated as potentially misvalued. This family of fine needle aspiration (FNA) codes have been nominated several times in the previous years and addressed by CMS in previous rulemaking.

The nominator encouraged CMS to accept the values previously recommended by the RUC and cited several reasons why they do not agree with the reduced work RVUs assigned by CMS. The nominator expressed concern about the crosswalk code, 36640 *(Push transfusion, blood, 2 years*

or younger), that CMS applied, stating that is a rarely utilized pediatric procedure requiring less experience and training to perform compared to fine needle aspiration of the thyroid, which is a much more complex and high-risk procedure. The nominator also stated that the reduction in payment for these procedures has led to a decrease in practices and physicians who are willing to perform them and is therefore limiting patient access to this specialized service.

While the nominator provided supporting information from a self-conducted survey about practitioners' experiences related to FNA procedures, CMS noted that no peer-reviewed medical literature or nationally representative survey data was provided to support their claims.

CMS disagrees with the nominator that this code family is potentially misvalued. However, they acknowledge that there may be significant changes to how these services are being delivered since their last review at the October 2017 and January 2018 RUC meetings. While CMS does not believe the family is potentially misvalued, they are requesting stakeholder feedback on whether a re-review by the RUC is appropriate based on the nominator's comments.

Valuation of Specific Codes for CY 2025 (Page 130)

MRI-Monitored Transurethral Ultrasound Ablation of Prostate (CPT codes 5X006, 5X007, and 5X008) – (Page 144)

- **5X006** *(Insertion of transurethral ablation transducers for delivery of thermal ultrasound for prostate tissue ablation, including suprapubic tube placement during the same session and placement of an endorectal cooling device, when performed)*
- **5X007** *(Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation)*
- **5X008** *(Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation; with insertion of transurethral ultrasound transducers for delivery of the thermal ultrasound, including suprapubic tube placement and placement of an endorectal cooling device, when performed)*

Three new CPT codes, 5X006, 5X007, and 5X008, were approved for MRI-monitored transurethral ultrasound ablation (TULSA). While CMS is proposing to accept the RUC-recommended values, the Agency notes concerns about the experience of the survey respondents and the intra-service times provided in the survey data. CMS welcomes additional data that could be considered in the valuation of the work and direct PE inputs for these CPT codes. In the meantime, CMS is proposing the RUC-recommended work RVU of 4.05 for CPT code 5X006, a work RVU of 9.80 for CPT code 5X007, and a work RVU of 11.50 for CPT code 5X008.

CMS is also proposing to accept the RUC-recommended direct PE inputs for all three codes without refinement.

Percutaneous Radiofrequency Ablation of Thyroid (CPT codes 6XX01 and 6XX02) - (Page 146)

- **6XX01** *(Ablation of 1 or more thyroid nodule(s), one lobe or the isthmus, percutaneous, including imaging guidance, radiofrequency)*
- **6XX02** *(Ablation of 1 or more thyroid nodule(s), additional lobe, percutaneous, with imaging guidance, radiofrequency (List separately in addition to code for primary service)*

CMS is proposing to accept the RUC-recommended work RVU of 5.75 for CPT code 6XX01 and a work RVU of 4.25 for add-on code CPT 6XX02.

CMS is also proposing to accept the RUC-recommended direct PE inputs for both codes without refinement.

Magnetic Resonance Examination Safety Procedures (CPT codes 7XX00, 7XX01, 7XX02, 7XX03, 7XX04, and 7XX05) - (Page 152)

- **7XX00** *(MR safety implant and/or foreign body assessment by trained clinical staff, including identification and verification of implant components from appropriate sources (e.g., surgical reports, imaging reports, medical device databases, device vendors, review of prior imaging), analyzing current MR conditional status of individual components and systems, and consulting published professional guidance with written report; initial 15 minutes)*
- **7XX01** *(MR safety implant and/or foreign body assessment by trained clinical staff, including identification and verification of implant components from appropriate sources (e.g., surgical reports, imaging reports, medical device databases, device vendors, review of prior imaging), analyzing current MR conditional status of individual components and systems, and consulting published professional guidance with written report; each additional 30 minutes (List separately in addition to code for primary procedure)*
- **7XX02** *(MR safety determination by a physician or other qualified health care professional responsible for the safety of the MR procedure, including review of implant MR conditions for indicated MR exam, analysis of risk versus clinical benefit of performing MR exam, and determination of MR equipment, accessory equipment, and expertise required to perform examination with written report)*
- **7XX03** *(MR safety medical physics examination customization, planning and performance monitoring by medical physicist or MR safety expert, with review and analysis by physician or qualified health care professional to prioritize and select views and imaging sequences, to tailor MR acquisition specific to restrictive requirements or artifacts associated with MR conditional implants or to mitigate risk of non-conditional implants or foreign bodies with written report)*
- **7XX04** *(MR safety implant electronics preparation under supervision of physician or other qualified health care professional, including MR-specific programming of pulse generator and/or transmitter to verify device integrity, protection of device internal*

circuitry from MR electromagnetic fields, and protection of patient from risks of unintended stimulation or heating while in the MR room with written report)

- **7XX05** *(MR safety implant positioning and/or immobilization under supervision of physician or qualified health care professional, including application of physical protections to secure implanted medical device from MR-induced translational or vibrational forces, magnetically induced functional changes, and/or prevention of radiofrequency burns from inadvertent tissue contact while in the MR room with written report)*

Six new codes were created to describe magnetic resonance (MR) examination safety procedures and to capture the physician work involving patients with implanted medical devices that require access to MR diagnostic procedures. CPT codes 7XX00 and 7XX01 are PE only, while the other four codes (CPT codes 7XX02, 7XX03, 7XX04, and 7XX05) capture the associated physician work and PE in performing these services.

CMS is proposing to accept the RUC-recommended 0.60 work RVU for CPT code 7XX02, 0.76 work RVU or CPT code 7XX03, 0.75 work RVU for CPT code 7XX04, and0.60 work RVU for CPT code 7XX05.

However, CMS is proposing several refinements to the direct PE inputs recommended by the RUC:

- For CPT codes 7XX00, 7XX01, 7XX02, 7XX04, and 7XX05, CMS is proposing to refine the clinical labor for the CA034 activity (*Document procedure (nonPACS) (e.g. mandated reporting, registry logs, EEG file, etc.)*) from 2 minutes to 1 minute. This refinement is based on 1 minute being allotted to a similar clinical activity for the reference CPT code, 70543 *(Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s), followed by contrast material(s) and further sequences).CPT code 7XX03 also has 1 minute of time for CA034, and CMS noted that they wanted to maintain consistency in the family.*
- For CPT code 7XX01, CMS is proposing to refine the clinical labor for the CA021 activity (*Perform procedure/service---NOT directly related to physician work time*) from 27 minutes to 14 minutes. The descriptor for 7XX00 is for the "initial 15 minutes" and the descriptor for 7XX01 is for "each additional 30 minutes." Given that 7XX00 contains 7 minutes for this clinical activity, CMS believes that the associated activity for 7XX01 should be double the time of CPT code 7XX00. This proposed refinement would also result in a reduction to the equipment time for the Technologist PACS workstation (ED050) from 45 minutes to 32 minutes.
- For CPT code 7XX03, the RUC recommended 13 minutes of time for the Professional PACS Workstation (ED053) listed as a Facility PE input. The Agency believes this was an error and are proposing to remove this time.
- For CPT code 7XX04 and 7XX05, CMS is proposing to reduce the clinical labor time for the CA024 activity (*Clean room/equipment by clinical staff*) from 2 minutes to 1 minute. Since only the new equipment,EQ412 (*Vitals monitoring system (MR Conditional)*), is being cleaned and not the entire room, CMS believes that 1 minute would be typical and

appropriate. CMS's refinement also results in a reduction to the equipment time for EL008 (*room, MR*) for both of these codes.

- For CPT code 7XX05, CMS is proposing to remove supply item SL082 (*impression material, dental putty (per bite block)*). The Agency believes this was an error since the PE recommendations did not list SL082 as one of the included supplies for CPT code 7XX05 and it does not appear as a supply input for any of the other codes in the family.

Ultrasound Elastography (CPT codes 76981, 76982, and 76983) - (Page 155)

- **76981** *(Ultrasound, elastography; parenchyma (eg, organ))*
- **76982** *(Ultrasound, elastography; first target lesion)*
- **76983** ***(****Ultrasound, elastography; each additional target lesion (List separately in addition to code for primary procedure))*

This code family was flagged for re-review by the new technology/new services screen as a result of the increased utilization of code 76981, which triggered a review of the code family. CMS is proposing to accept the RUC-recommended work RVUs of 0.59 for CPT code 76981, 0.59 for CPT code 76982, and 0.47 for CPT code 76983.

CMS is also proposing to accept the RUC-recommended direct PE inputs for all three codes without refinement.

CT Guidance Needle Placement (CPT code 77012) - (Page 155)

- **77012** (*Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation*)

This code was reviewed following updates to the clinical vignette to describe the typical patient for this procedure as a result of coding changes in 2019.

CMS is proposing to accept the RUC-recommended 1.50 work RVU for CPT code 77012.

CMS is proposing to refine the equipment time for the CT room (EL007) to maintain the current time of 9 minutes. CPT code 77012 is a radiological supervision and interpretation (RS&I) code, and CMS has a longstanding convention for assigning 9 minutes of room time for RS&I codes. In previous rulemaking, commenters have made the distinction that while there is precedent for 9 minutes to be assigned to the room time for RS&I codes, it is specific to angiographic rooms. CMS disagrees, citing other RS&I codes with 9 minutes for CT room time.

There are 38 other RS&I codes and CMS believes that it will affect the relativity of these code to change the room time minutes for CPT code 77012 without addressing the remaining codes. CMS is proposing to accept the other PE inputs as recommended by the RUC.

Transcranial Doppler Studies (CPT codes 93886, 93888, 93892, 93893, 93X94, 93X95, 93X96, and 93890) - (Page 170)

- **93886** *(Transcranial Doppler study of the intracranial arteries; complete study)*
- **93888** (*Transcranial Doppler study of the intracranial arteries; limited study)*
- **93892** *(*T*ranscranial Doppler study of the intracranial arteries; emboli detection without intravenous microbubble injection)*
- **93893** *(Transcranial Doppler study of the intracranial arteries; venous-arterial shunt detection with intravenous microbubble injection)*
- **93X94** *(Vasoreactivity study performed with transcranial Doppler study of intracranial arteries, complete)*
- **93X95** *(Emboli detection without intravenous microbubble injection performed with transcranial Doppler study of intracranial arteries, complete)*
- **93X96** *(Venous-arterial shunt detection with intravenous microbubble injection performed with transcranial Doppler study of intracranial arteries, complete)*
- **93890** *(Transcranial Doppler study of the intracranial arteries; vasoreactivity study)*

Three new add-on codes were created to report when additional studies are performed on the same date of services as a complete transcranial Doppler study. The RUC reviewed these three new add-on codes, as along with the base codes, 93886, 93888, 93892 and 93893. As a result of this new code structure, CPT code 93890 is being deleted.

CMS is proposing the RUC-recommended work RVU for all seven codes in the Transcranial Doppler Studies code family: 0.90 RVU for CPT code 93886, 0.73 RVU for CPT code 93888, 1.15 RVU for CPT code 93892, 1.15 RVU for CPT code 93893, 0.81 RVU for CPT code 93X94, 0.73 RVU for CPT code 93X95, and 0.85 RVU for CPT code 93X96.

CMS is also proposing to accept the RUC-recommended work RVUs for all seven codes in this family without refinement.

CMS further states that the billing instructions for this code family needs to specify that the three new add-on codes should be used in conjunction with CPT code 93886, and that CPT code 93888 should not be used in conjunction with CPT codes 93886, 93892, 93893, 93X94, 93X95, and 93X96. CMS also suggests that the CPT Editorial Panel should state more explicitly that CPT code 93X95 should not be used in conjunction with CPT code 93892 and that CPT code 93X96 should not be used in conjunction with CPT code 93893.

Strategies for Improving Global Surgery Payment Accuracy (Page 337)

Approximately 41,000 physicians' services are coded and valued under the MPFS as global surgical packages or single codes valued to include all services provided during a certain period (i.e. 0-day, 10-day, or 90-day globals), including the surgical procedure itself, post-operative evaluation and management (E/M) visits, pre-operative visits on the day of and/or day prior to the procedure, and services provided during the post-operative period. Global packages,

including the pre-operative, day-of, and post-operative visits associated with the surgical procedure, are valued using the annual MPFS rulemaking process.

Beginning in 2015, CMS has expressed concerns with the accuracy of valuation of the global packages under the MPFS. Findings from multiple OIG reports suggest that practitioners perform fewer post-operative visits than are expected and accounted for in the valuation of the global packages. In addition, CMS feels that the current valuation process does not consider scenarios where the surgical procedure and follow-up care are provided by different practitioners in different group practices.

Over the past 9 years, CMS has collected data on post-operative E/M visits, including frequency and complexity of these visits as well as information on the prevalence of transfer of care modifiers for surgical care, post-operative management and pre-operative management. CMS notes that although they have received many comments in opposition to eliminating global packages, commenters have not proposed specific alternative strategies to revalue global surgical packages.

In this rule, CMS focuses on transfer of care modifiers. Specifically, CMS proposes beginning for services furnished in 2025, to broaden the applicability of the transfer of care modifiers for the 90-day global packages by requiring the use of the appropriate transfer of care modifier (modifier -54, -55, or -56) for all 90-day global surgical packages in any case when a practitioner plans to furnish only a portion of a global package (including but not limited to when there is a formal, documented transfer of care as under current policy, or an informal, non-documented but expected, transfer of care). Practitioners billing for a global package procedure code with modifier -54 and other practitioners in the same group practice as that practitioner would still be able to bill during the global period for any separately identifiable E/M services they furnish to the patient that are unrelated to the global package procedure. To do so, the practitioner would append modifier -24 to the claim line for the E/M service. This proposal would prevent duplicative Medicare payment for post-operative care because the global surgical package payment would be adjusted based on the appended modifier, and payment for post-operative care would not be made both as part of a global surgical package and through separately billed E/M visits.

CMS also proposes a new add-on code to be billed with an office/outpatient E/M visit for post-operative follow-up care during the global period of a global package to capture additional resources associated with practitioners who were not involved in furnishing the surgical procedure. This follow-up care may include, but is not limited to, obtaining and reviewing the surgical notes and surgical history, monitoring for signs and symptoms of infection, taking into account any considerations from the surgical procedure that may affect the medical care, and monitoring for any potential post-operative complications that may arise. This new code would be billed by the practitioner who furnishes the post-operative office/outpatient E/M visits when that practitioner is not the proceduralist and is not in the same specialty or group practice as the proceduralist. Documentation in the medical record must justify use of the add-on code.

CMS notes that the impact of the conversion factor on this proposed reduction in spending associated with these policies is redistributed across the PFS via an increase in the budget neutrality adjustment to the conversion factor. CMS is soliciting comments from interested parties on this postoperative transfer of care policy.

Drugs and Biological Products Paid Under Medicare Part B

Requiring Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts (Page 1581)
In rulemaking over the last few years, CMS has finalized policies which established a refund for discarded amounts of certain single-dose container or single-use package drugs. CMS is reviewing an application for increased applicable percentage for CY 2025 and proposing to clarify several policies implemented in CY 2023 and CY 2024, including: exclusions of drugs for which payment has been made under Part B for fewer than 18 months from the definition of refundable single-dose container or single-use package drug; and identifying single-dose containers. Also, CMS is proposing to require the JW modifier if a billing supplier is not administering a drug, but there are discarded amounts discarded during the preparation process before supplying the drug to the patient.

Payment for Radiopharmaceuticals in the Physician Office (Page 1591)
To alleviate confusion from Medicare Administrative Contractor (MACs) and other interested parties about which exact methodologies are available to MACs for pricing of radiopharmaceuticals in the physician office setting, CMS is proposing to clarify that, for radiopharmaceuticals furnished in a setting other than a hospital outpatient department, MACs shall determine payment limits for radiopharmaceuticals based on any methodology used to determine payment limits for radiopharmaceuticals in place on or prior to November 2003.

Direct Supervision via Use of Two-way Audio/Video Communications Technology

Proposal to Extend Definition of "Direct Supervision" to Include Audio-Video Communications Technology through 2025 (Page 105)

In the March 31, 2020, COVID-19 IFC, CMS changed the definition of "direct supervision" during the PHE for COVID-19 as it pertains to supervision of diagnostic tests, physicians' services, and some hospital outpatient services, to allow the supervising professional to be immediately available through virtual presence using two-way, real-time audio/video technology, instead of requiring their physical presence. CMS has previously extended the virtual supervision flexibility through rulemaking. The ACR has previously supported CMS's extension of this policy. CMS acknowledge the utilization of this flexibility and recognized that many practitioners have stressed the importance of maintaining it, however CMS continues to seek additional information regarding potential patient safety and quality of care concerns. CMS noted that an immediate reversion to the pre-PHE definition of direct supervision would prohibit virtual direct supervision, which may present a barrier to access to many services, such as incident-to services, and that physicians and/or other supervising practitioners, would need time

to reorganize their practice patterns established during the PHE to reimplement the pre-PHE approach to direct supervision without the use of audio/video technology.

CMS believes an incremental approach is warranted, particularly in instances where unexpected or adverse events may arise for procedures which may be riskier or more intense. Considering these potential safety and quality of care implications, and exercising an abundance of caution, CMS is extending this flexibility for all services on a temporary basis only. **CMS is proposing to continue to define direct supervision to permit the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2025.**

Proposal to Permanently Define "Direct Supervision" to Include Audio-Video Communications Technology for a Subset of Services

CMS is proposing to adopt a definition of direct supervision that allows "immediate availability" of the supervising practitioner using audio/video real-time communications technology (excluding audio-only), but only for the following subset of incident-to services described under § 410.26: (1) services furnished incident to a physician or other practitioner's service when provided by auxiliary personnel employed by the billing practitioner and working under their direct supervision, and for which the underlying HCPCS code has been assigned a PC/TC indicator of '5'; and (2) services described by CPT code 99211 (Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional).

CMS is proposing an incremental approach whereby they will adopt without any time limitation the definition of direct supervision permitting virtual presence for services that are inherently lower risk: that is, services that do not ordinarily require the presence of the billing practitioner, do not require direction by the supervising practitioner to the same degree as other services furnished under direct supervision, and are not services typically performed directly by the supervising practitioner**. For all other services required to be furnished under the direct supervision of the supervising physician or other practitioner, CMS is proposing, as described above, to continue to define "immediate availability" to include real-time audio and visual interactive telecommunications technology only through December 31, 2025.**

<u>Medicare Shared Savings Program</u> (Page 667)

As of January 1, 2024, the Medicare Shared Savings Program (MSSP) has 480 Accountable Care Organizations (ACOs) with over 634,000 health care providers and organizations providing care to over 10.8 million assigned beneficiaries in the Medicare Shared Savings Program (MSSP). CMS states changes to MSSP regulations are meant to advance Medicare's value-based care strategy of growth, alignment, and equity and includes changes to allow for timely improvements to program policies and operations.

Summary of Shared Savings Program Proposals
CMS is proposing modifications to the MSSP to require ACOs, beginning in performance year 2025 and subsequent performance years, to report the APM Performance Pathway (APP) Plus quality measure set. The APP Plus quality measure set would incrementally grow to comprise of eleven measures, consisting of the six measures in the existing APP quality measure set and five newly proposed measures from the Adult Universal Foundation measure set that would be incrementally incorporated into the APP Plus quality measure set over performance years 2025 through 2028.

CMS is proposing to establish a new "prepaid shared savings" option to assist eligible ACOs with a history of earning shared savings. CMS is proposing to allow eligible ACOs with a history of success in the program access to an advance on their earned shared savings to encourage investment in staffing, health care infrastructure, and additional services for people with Medicare, such as nutrition support, transportation, dental, vision, hearing, and Part-B cost-sharing reductions. CMS would require that at least 50 percent of prepaid shared savings would be reserved to be spent on direct beneficiary services not otherwise payable in Traditional Medicare, such as meals, dental, vision, hearing, and Part B cost-sharing support. Additionally, up to 50 percent of the prepaid shared savings can be spent on staffing and infrastructure. CMS is also proposing refinements to advance investment payment policies to allow ACOs receiving advance investment payments to voluntarily terminate from the payment option while remaining in the MSSP, and to specify that if CMS terminates an ACO's participation agreement, the ACO must repay any outstanding advance investment payments it received.

CMS is proposing modifications to the MSSP's financial methodology to encourage ACO participation in the MSSP by removing barriers for ACOs serving underserved communities, and by providing greater specificity and clarification on how CMS would perform certain financial calculations. CMS would ensure the benchmarking methodology includes sufficient incentive for ACOs serving underserved communities to enter and remain in the program through the application of a proposed health equity benchmark adjustment. CMS is proposing to specify a calculation methodology to account for the impact of improper payments in recalculating expenditures and payment amounts used in MSSP financial calculations. CMS is proposing to establish a methodology for excluding payment amounts for HCPCS and CPT codes exhibiting significant, anomalous, and highly suspect billing activity during CY 2024 or subsequent calendar years that warrant adjustment. Additionally, CMS is proposing to further incentivize participation in the MSSP by ACOs that serve people with Medicare who are members of rural and underserved communities by adopting a health equity benchmark adjustment similar to that in the Innovation Center's ACO REACH Model, which has been associated with increased safety net provider participation. CMS is also proposing to move the MSSP towards the Universal Foundation of quality measures, creating better quality measure alignment for providers and driving care transformation.

Eligibility Requirements and Application Procedures
CMS is proposing changes to eligibility requirements and application procedures. To better align program policies with CMS's goal of increasing the number of beneficiaries in an accountable care relationship with a health care provider, CMS is proposing to sunset the requirement that

CMS terminates the participation agreement if the ACO's population is not at least 5,000 by the end of the performance year specified by CMS in its request for a Corrective Action Plan (CAP) while continuing to require ACOs to meet the minimum threshold of 5,000 assigned beneficiaries to begin a new agreement.

Updates to the Quality Payment Program (QPP)

MIPS Value Pathways (MVPs)

In this proposed rule, CMS introduced two new Requests for Information (RFI), *Building upon the MIPS Value Pathways (MVPs) Framework to Improve Ambulatory Specialty Care* and *Transforming the Quality Payment Program*, which focus on the full implementation of MVPs into MIPS and the eventual sunsetting of traditional MIPS.

RFI: Building upon the MIPS Value Pathways (MVPs) Framework to Improve Ambulatory Specialty Care (Page 1105)

In this proposed rule, CMS addresses the concern that Medicare beneficiaries' health care is increasingly fragmented because they see more specialists with greater frequency over several visits, while primary care provider encounters remain consistent. CMS explains that an ambulatory specialty care MVP would address the quality of care coordination and support care continuity for these beneficiaries.

This RFI invites public comment on the design of a future ambulatory specialty model. CMS is exploring this MVP to increase the engagement of specialists in value-based payment and encourage interaction with primary care providers. MIPS-eligible clinicians participating in this MVP would receive a payment adjustment according to their performance on a set of clinically relevant MVP measures and comparing the participant's final score against a limited pool of clinicians (other model participants of their same specialty type and clinical profile, who are also required to report on those same clinically relevant MVP measures). CMS expects such a strategy to produce scores and payment adjustments that are more reflective of participants' performance. CMS also anticipates that this approach would provide better insight into the clinical decisions and processes (i.e., care coordination) affecting patient outcomes. In addition to other comments and questions, the RFI asks explicitly for feedback on this MVP's definition of participants, performance assessment, and payment methodology. Input is also requested on care delivery and incentives for partnerships with accountable care entities and integration with primary care, health information technology and data sharing, health equity, and multi-payer alignment.

RFI: Transforming the Quality Payment Program (Page 1187)

In this RFI, CMS requests feedback on approaches for achieving full MVP adoption and subgroup participation. As described in the proposed rule, CMS is identifying ways that the transition from traditional MIPS to MVPs would ensure the availability of applicable MVPs for all clinicians, including the broadly applicable MVPs, guidance for multispecialty groups to

assign clinicians into subgroups for reporting relevant MVPs, and MIPS policies for eventually sunsetting traditional MIPS in the 2029 performance year/2031 MIPS payment year.

According to CMS, MVPs simplify MIPS participation, align the MIPS performance categories, and encourage clinicians to report on relevant measures to their practice. Voluntary reporting of MVPs began in the 2023 performance period, with CMS continuing to incrementally include new MVPs supporting its projected complete transition to MVPs. There are currently 16 MVPs available for use in MIPS, with CMS proposing the adoption of six more for the 2025 performance year. If these six proposed MVPs are adopted, 80% of specialties participating in MIPs could submit applicable MVPs. Unfortunately, at present time, there are no applicable MVPs for radiologist participation. CMS stated its goal of ensuring opportunities for specialists within multispecialty groups to submit MVPs, especially since the 2026 performance period marks mandatory subgroup reporting for multispecialty groups that participate in MIPS as MVP participants. CMS defines and ultimately determines whether a group is multispecialty if there are two or more specialty types according to practices' claims data. CMS is interested in approaches encouraging multispecialty groups to report more than one MVP. It is also considering using information on Medicare claims data to create subgroup composition restrictions and making an exception to the mandatory subgroup multispecialty reporting requirement for small practices (TINs consisting of 15 or fewer eligible clinicians).

Interested in learning what constitutes meaningful MIPS participation for clinicians who, after the sunset of traditional MIPS, may not have an applicable MVP, the RFI explicitly questions whether CMS should develop a more global MVP with broadly applicable measures or consider flexibilities or alternative policies, such as non-patient-facing clinician changes. CMS recognizes that gaps in quality and cost measures, among other requirements, hinder the development of non-patient-facing clinician MVPs.

Within the RFI, CMS requests input on addressing measure gaps and making MVPs more widely available. CMS is researching the flexibilities included in the Act to develop new MVPs for non-patient-facing MIPS-eligible clinicians. However, in the proposed rule, it is emphasized that flexibilities explored must support CMS' overall MIPS goals; reweighting a performance category, for example, would mean that the quality or cost performance category could be reweighted in an MVP but would not support performance measurement to drive value or provide comparable information for patients selecting clinicians or care teams. CMS explains that the Act requires that non-patient-facing professionals' circumstances be considered where feasible and appropriate, including alternative measures or activities that fulfill the goals of the applicable performance category. **The Act also requires CMS to consult with such professionals, with CMS highlighting diagnostic radiologists facing several challenges to participating in existing MVPs.** CMS requests input to explore alternative measures and activities to measure non-patient-facing MIPS-eligible clinicians' performance.

CMS proposes developing MVPs based on multiple specialty measure sets for those specialties that do not currently have MVP coverage. This approach would serve as a bridge until new measures are available to support the organization of individual MVPs for clinicians without an MVP specific to their specialty, patient populations served, or the primary conditions treated.

MVP Scoring (Page 1214)

CMS proposes several updates to MVP scoring, including the policy for population health measures using the highest score of available population health measures, aligning MVP scoring with traditional MIPS policies by cross-referencing the MVP Cost performance category scoring policies to traditional MIPS for scoring cost measures, and by removing references to high and medium-weighted IAs in MVPs for consistency with the proposed removal of such weighting under traditional MIPS. Other proposals for MVP scoring comprise the provision of full credit (i.e., 40 points) for the Improvement Activities (IA) performance category for MVP participants who report one IA and an extension to the 2025 performance period and beyond the requirement that subgroups submit their affiliated group's data for the PI performance category.

MIPS Category Weighting (Page 1176)

The proposed category weights for the 2025 performance year are Quality: 30%, Cost: 30%, Promoting Interoperability (PI): 25%, and Improvement Activities (IA): 15%. These are the same values finalized for the 2022 performance year and are unlikely to change in future years. The proposed rule continues to offer category reweighting for physicians who cannot submit data for one or more performance categories or who fall under special statuses such as small, rural, or non-patient-facing. In most cases, the weight of these categories will continue to be redistributed to the Quality category.

CMS has proposed a new reweighting policy for clinicians using third-party intermediaries to submit MIPS data to CMS on their behalf. **In this new proposal, which would go into effect for the 2024 MIPS performance year, a group or individual clinician could request that CMS reweight a performance category if their third-party intermediary failed to report MIPS data to CMS within the mutually agreed-upon timeframe due to circumstances beyond the control of the clinician.** Whether CMS agrees to reweight a performance category will depend upon the following criteria:

- Did the MIPS-eligible clinician know or have reason to know that there was an issue with the third-party intermediary's CMS submission?
- Did the MIPS clinician take reasonable action to attempt to correct the issue?
- Did the issue between the MIPS clinician and their third-party intermediary cause no data to be submitted for the performance category by the applicable deadline? (p. 1185)

If this proposal is adopted, clinicians would have until November 1 of the year before the applicable MIPS payment year to make this appeal to CMS. In other words, if a clinician intended to request this type of reweighting for the 2024 MIPS performance year, they would have until November 1, 2025, to submit their request to CMS.

MIPS Performance Threshold and Incentive Payments (Page 1184)

The MIPS performance threshold is the value that determines whether MIPS participants will receive a positive, negative, or neutral payment adjustment during the associated MIPS payment year. Beginning with the 2022 performance years, CMS was statutorily required to set the MIPS performance threshold based on the mean or median value derived from a previous year's scoring data. Using the mean from 2017 MIPS scoring data, CMS set the performance threshold at 75 points in 2022 and has remained at 75 points through the 2024 performance year. **For the 2025 performance period, CMS proposes to maintain the 75-point performance threshold.** CMS finalized the minimum and maximum payment adjustment of +/- 9% for performance years 2020 and beyond. No changes are proposed to the MIPS adjustment.

In the proposed rule, CMS commented that they recognize certain medical specialties—such as diagnostic radiology—are at a disadvantage due to fewer available quality measures and more measures being topped out and capped at seven points. Many of these specialties are also exempt from the Promoting Interoperability and Cost categories, thus giving their Quality score a higher weight relative to their overall MIPS score. Assuming a Quality category weight of 85%, a group or individual scoring perfectly on six measures capped at seven points would still not achieve the 75-point neutral adjustment threshold. **To mitigate this, CMS has proposed to identify, on an annual basis, a selection of topped-out measures for which the seven-point cap will be removed and replaced with an adjusted benchmark that allows for up to 10 achievement points.**

The proposed benchmark for the selected measures would look like this:

Measure Achievement Points	Performance Rate
1 – 1.9	84 – 85.9%
2 – 2.9	86 – 87.9%
3 – 3.9	88 – 89.9%
4 – 4.9	90 – 91.9%
5 – 5.9	92 – 93.9%
6 – 6.9	94 – 95.9%
7 – 7.9	96 – 97.9%
8 – 8.9	98 – 99.9%
10	100%

Please note that this new benchmark excludes the ninth decile. CMS' rationale is that this would still cap the score at the eighth decile for groups and individuals scoring less than 100% performance on a measure but would allow top performers to achieve 10 full points (page 1370).

Quality Measures Proposed for Addition and Removal (Page 1892)

In the 2024 MPFS final rule, CMS finalized their proposal to remove the following Diagnostic Radiology measure:

- #436: Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques

This measure is being removed as it is considered duplicative of the following newly added measure in the Diagnostic Radiology set:

- #494: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults

Notably, this new Diagnostic Radiology measure is an eCQM, which means it will not be reportable as a traditional MIPS CQM. See below for details about this newly proposed measure:

- *Description:* This measure provides a standardized method for monitoring the performance of diagnostic CT to discourage unnecessarily high radiation doses, a risk factor for cancer while preserving image quality. It is expressed as a percentage of out-of-range CT exams based on either excessive radiation dose or inadequate image quality relative to evidence-based thresholds based on the clinical indication for the exam. All diagnostic CT exams of specified anatomic sites performed in inpatient, outpatient, and ambulatory care settings are eligible. This eCQM requires additional software to access primary data elements stored within radiology electronic health records and translate them into data elements that this eCQM can ingest.
- *Denominator:* All CT scans in adults aged 18 years and older at the start of the measurement period that have a CT Dose and Image Quality Category and were performed during the measurement period.
- *Numerator:* Calculated CT size-adjusted dose greater than or equal to a threshold specific to the CT dose and Image Quality Category, or Calculated CT Global Noise value greater than or equal to a threshold specific to the CT Dose and Image Quality Category.

Quality Data Completeness Requirements (Page 1270)

In the 2024 MPFS final rule, CMS signaled that it intended to raise the quality measure data completeness requirement to 75% for the 2024 and 2025 performance periods. This number defines the minimum subset of patients within a measure denominator that must be reported. CMS proposes to maintain this threshold through the 2027 and 2028 MIPS performance periods.

Cost Performance Category (Page 1182)

CMS proposes adding several new episode-based cost measures that are unlikely to be attributed to radiology groups but may contain imaging in the cost calculations: Chronic Kidney Disease, End-Stage Renal Disease, Kidney Transplant Management, Prostate Cancer, and Rheumatoid Arthritis, and Respiratory Infection Hospitalization.

CMS also proposes to adopt the following set of criteria to guide the future removal of cost measures (page 1321):

- It is not feasible to implement the measure specifications.
- A measure steward is no longer able to maintain the cost measure.
- The implementation costs or negative unintended consequences associated with a cost measure outweigh the benefit of its continued use in the MIPS cost performance category.
- The measure specifications do not reflect current clinical practice or guidelines.

- The availability of a more applicable measure, including a measure that applies across settings, applies across populations, or is more proximal in time to desired patient outcomes for the particular topic.

CMS proposes adopting a new cost measure exclusion policy beginning with the 2025 performance period to provide scoring flexibility in instances where changes during a performance period impede the effective measurement of cost. If data used to calculate a score for a cost measure is impacted by significant changes during the performance period, such that calculating the cost measure score would lead to misleading or inaccurate results, the affected cost measure is excluded from the MIPS-eligible clinician's or group's cost performance category score. "Significant changes" are those external to the care provided and contain rapid or unprecedented changes to service utilization. CMS would determine if those may lead to misleading or inaccurate results and would be empirically assessed by CMS to determine the extent to which the changes impact the calculation of a cost measure score that reflects clinician performance (page 1397).

Improvement Activities Performance Category (Page 1332)

CMS has proposed changes to simplify the Improvement Activities performance category scoring by removing the weight previously assigned to all activities. Since the beginning of the MIPS program, every improvement activity has been assigned either medium or high weight. A medium-weighted activity is worth 10 points, and a high-weighted activity 20, with a maximum total score of 40, is required for full credit in the category. For small, rural, or non-patient-facing clinicians, activities counted for twice as many points, meaning that participants could achieve a full score by submitting either one high-weighted or two medium-weighted activities.

With the new proposal, all activities would be assigned the same weight. Regular MIPS clinicians would be required to submit two activities for full category credit, while small, rural, and non-patient-facing clinicians would only be required to submit one activity.

Improvement Activities Proposed for Removal

Activity ID	Activity Name	Rationale for Removal
IA_EPA_1	Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record	CMS considers this activity to be obsolete due to high utilization of EHRs.
IA_PM_12	Population Empanelment	CMS considers this activity obsolete due to the wide acceptance of empanelment.
IA_CC_1	Implementation of Use of Specialist Reports Back to Referring Clinician or Group to Close Referral Loop	This activity is considered duplicative and is also highly utilized.

IA_CC_2	Implementation of Improvements that Contribute to More Timely Communication of Test Results	This activity is considered obsolete due to the wide adoption of EHRs and patient portals.
IA_ERP_4	Implementation of a Personal Protective Equipment (PPE) Plan	This activity is considered obsolete; since the COVID-19 pandemic, clinicians are well-prepared in PPE safety and this activity is unlikely to drive further improvements.
IA_ERP_5	Implementation of a Laboratory Preparedness Plan	This activity is considered obsolete; since the COVID-19 pandemic, clinicians are well-prepared in COVID-19-related patient safety and laboratory-preparedness enhancements have been made throughout patient care settings.
IA_BMH_8	Electronic Health Record Enhancements for BH Data Capture	There is now an alternative activity available (IA_BMH_7: Implementation of Integrated Patient Centered Behavioral Health Model) which has a stronger relationship to quality care or improvements.
IA_PSPA_27	Invasive Procedure or Surgery Anticoagulation Medication Management	This activity is considered duplicative of IA_CC_15: Perioperative-Surgical Home Care Coordination

Promoting Interoperability Performance Category (Page 1254)

CMS proposes to allow eligible clinicians to request to reweight the Promoting Interoperability performance category if issues were encountered with a third-party intermediary contracted to submit data on their behalf, and the data is no longer accessible and submittable to CMS by the eligible clinician.

CMS proposes to no longer accept incomplete submissions of Promoting Interoperability performance category participation. The proposed policy is intended to prevent accidental and unintended submissions, which previously negated automatic reweighting of the category's score even in scenarios where only a date was submitted to CMS.

Additionally, for those participating in this performance category, CMS proposes to use the highest score when multiple data submissions are provided. Previously, multiple submissions with conflicting data resulted in a zero score.

CMS has requested information on challenges and opportunities with the "Public Health and Clinical Data Exchange" objective, including soliciting ideas on how to advance information exchange in the future while avoiding overburdening participants.

CMS published Fact Sheets on the overall MPFS proposed rule, the Quality Payment Program, the Shared Savings Program and a Press Release. The ACR will submit comments to CMS by the September 9 comment period deadline.