September 12, 2025

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1832-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244–1850

RE: **Medicare and Medicaid Programs; CY 2026 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program**

Dear Administrator 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 & Medicaid Services (CMS) on the calendar year (CY) 2026 Medicare Physician Fee Schedule (PFS) Proposed Rule. In this comment letter, we address the following important issues:

Payment Provisions

- Alternatives Considered for Adjusting relative value units (RVUs) to Match Practice Expense (PE) Share in the American Medical Association's (AMA) Physician Practice Information (PPI) and Clinician Practice Information (CPI) Surveys
- Development of Strategies for Updates to Practice Expense Data Collection and Methodology
- Site of Service Differential
- Efficiency Adjustment
- MR Safety Codes on the Multiple Procedure Payment Reduction (MPPR) List
- Direct Supervision via Use of Two-way Audio/Video Communications Technology
- Comment Solicitation on Payment Policy for Software as a Service (SaaS)
- CY 2026 Identification and Review of Potentially Misvalued Services
- Valuation of Specific Codes for CY 2026

Quality Payment Program (QPP)

- Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) - Proposed Additions and Structure
- Requests for Information (RFIs) Related to MVPs
- MIPS Scoring Overview

PAYMENT PROVISIONS

Alternatives Considered for Adjusting RVUs to Match PE Share in the AMA's PPI and CPI Surveys

Proposal
In PFS rate setting, CMS aligns the aggregate share of the three components of PFS payment (work, PE and malpractice (MP)) with cost share weights currently established as part of the Medicare Economic Index (MEI) and informed by the AMA/Specialty Society PPI survey. To do so, CMS holds the work relative value unit (RVU) constant, and adjusts the PE RVUs, MP RVUs, and the conversion factor to maintain the appropriate balance in RVUs among the PFS components. The current MEI cost shares are 50.9% work RVU, 44.8% PE RVU, and 4.3% MP RVU.

Information derived from the 2024 update of the PPI suggests the cost share weights have substantially changed from the current distribution (established using 2006 data). CMS did not propose to update the cost share weights in rate setting due to concerns with the method used to calculate the updated values. However, the rule discussed alternatives to develop new cost share weights using a revised method to weight specialty-level values reported in the updated PPI/CPI surveys. While Practice Expense per Hour (PE/hr) information from the PPI/CPI surveys are also used in the calculation of PE RVUs, CMS proposed to delay incorporation of data derived from the PPI/CPI surveys and to maintain the current 2006-based MEI cost share weights to allow for public comment.

CMS displays 3 alternatives to provide illustrations of the potential impact of using the updated PPI and CPI survey data in PFS rate setting.

ACR Perspectives and Comments
The ACR supports the AMA's 2024 PPIS data collection process, which collects practice cost information at the department level. **We recommend that CMS implement new MEI cost shares for CY 2026 using the PPI and CPI survey data provided by the AMA and the alternative reweighting methodology displayed in the proposed rule.** As outlined in the proposed rule, this would result in cost shares of 54.4% work RVU, 43.9% PE RVU, and 1.7% MP RVU.

Development of Strategies for Updates to Practice Expense Data Collection and Methodology

Proposal
The AMA PPI survey was introduced in 2007 to collect comprehensive and reliable data on direct and indirect PEs incurred by physicians. The four-year implementation process began in 2010. The current PE methodology utilizes this data, which has not been updated since the 2007 survey.

In recent years, CMS engaged with stakeholders through the rulemaking process, soliciting feedback on ways to improve the PE inputs' accuracy and reliability, asking for public comment on strategies for updating the PE methodology and data collection process, as well as comments on trends in health care business arrangements and the use of technology. CMS also has contracted with the RAND Corporation to develop alternatives to the PE methodology.

The AMA launched an updated PPI and CPI surveys and submitted their data to CMS in time for consideration in the CY 2026 PFS. While CMS shared that they appreciated the AMA's data collection efforts, they expressed concerns about the low response rates and representativeness of the surveys, the small sample size and sampling variation, the lack of comparability to previous survey data, and also missing and incomplete data submission. For these reasons, CMS proposes to not implement the PPI and CPI data into the CY 2026 rate setting. CMS feels that a more efficient and transparent system that could be regularly updated is possible using publicly available administrative data such as Medicare claims data or public tax information.

ACR Perspective and Comments

The ACR supports the AMA's physician practice information survey efforts and believes that it is still the best method for collecting practice cost information at the specialty level. CMS makes several comparisons between the 2007 and 2024 PPI survey data, including response rate, sample size, and missing or incomplete data submission.

The 2007 data was at the physician level, while the 2024 survey was at the practice level, so a direct comparison of the response rate may not be appropriate. The College believes that the new survey provides more accurate and representative cost data for different types of practice types and practice sizes.

Additionally, the small sample size can be attributed to the fact that the sample for 2024 is based on practices, while the 2007 sample was based on individual physicians. Each of the practices in the 2024 sample also included information for several physicians. The 2007 survey included responses from 2,795 physicians while the 2024 survey yielded responses for 18,086 physicians from 380 practices.

With regard to CMS's comment about missing or incomplete data submission, the AMA shared that the independent diagnostic testing facilities (IDTFs) and the American Occupational Therapy Association had a separate contract with Mathematica and were not part of the AMA's PPI data collection effort.

The PPI survey is a very complex and time-consuming project, and we believe the AMA made a concerted effort to acquire accurate financial data from specialties and practices. We believe that the data collected for Radiology was robust and representative. Due to their small sample size, Radiation Oncology data was combined with Radiology in order to estimate the PE/hr, which the College does not agree with. Radiation Oncology has very different practice costs than Radiology.

The ACR encourages CMS to work with the AMA to address any outstanding concerns about the 2024 PPI data and to determine how this data can be utilized in the future to update physician reimbursement.

Site of Service Differential

Proposal

CMS notes that there has been a steady decline of physicians in private practice and that an increased number are being employed by hospitals. The PE methodology allocates the same amount of indirect costs per work RVU regardless of the setting (facility or non-facility), since it was based on the assumption that physicians maintain an office even when practicing in a facility setting. With the increase in physicians working in the facility setting, CMS feels that the indirect costs may now be overstated for physicians who no longer maintain an office. Therefore, CMS proposes to reduce the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility (NF) PE RVUs for each service valued in the facility setting.

CMS is soliciting comment from the public on the specific types and magnitude of indirect PE costs incurred by physicians who practice in part or exclusively in a facility setting. They are also seeking comment on any variables that affect:

- Whether and to what extent a practice would incur these variables
- If the proposal to reduce the facility PE RVUs is an appropriate reduction and/or if a different percentage reduction should be considered for CY2026 or future years
- Whether there are additional data sources to help identify a more precise site of service difference in the allocation of indirect PE RVUs
- If there are ways to improve the allocation of facility and non-facility PE RVUs in the future, and
- How this policy should apply to maternity services and what effect there might be to access to these services.

ACR Perspective and Comments

If this proposal is implemented, the College is concerned about the impacts on physicians who staff hospitals but who still maintain a private office and do their own scheduling. The ACR believes this is the predominant practice pattern for our interventional radiologist members. Additionally, we request clarification on CMS's rationale for selecting the chosen percent reduction (i.e., 50 percent), which appears to be arbitrary. **We recommend that CMS wait to implement this site of service differential until CMS has established a mechanism to identify and exclude office-based physicians who staff hospitals.**

Efficiency Adjustment

Proposal

CMS has relied on the AMA's Relative Value Scale Update Committee (RUC) data to estimate physician time, work intensity, and PE and uses this information to establish RVUs in the PFS. However, CMS continues to express their concerns about the low response rate, large response

range, and possible response bias of the RUC data. Additionally, external data from other sources, such as a study by the Urban Institute in 2016, suggest an overestimation of physician times.

CMS believes non-time-based codes (procedures, radiology services, and diagnostic tests) should become more efficient over time as they become more common, technology improves, and professionals gain experience. CMS also believes these efficiency gains have not been reflected in the work RVUs for these services. Therefore, CMS proposes an efficiency adjustment to the work RVUs, and corresponding updates to the intra-service time, since both the intra-service time and work intensity should decrease as the practitioner develops expertise over time.

CMS believes applying an efficiency adjustment to non-time-based services more broadly, rather than only to certain services more likely to have efficiency gains, will improve the overall accuracy of the valuation of services under the Medicare PFS. For CY 2026, CMS proposes to apply a negative 2.5% MEI productivity adjustment, which is equivalent to applying this adjustment annually over the past five years. Moving forward, CMS proposes to update this efficiency adjustment every three years.

CMS is requesting feedback on several aspects of the proposal, including the initial five-year look back period, possible future modifications to the direct PE inputs related to physician time, the question of whether efficiencies stop accumulating for services after a specific number of years, and the types of data that should be considered valid and reliable empirical evidence, among other topics.

ACR Perspective and Comments

The ACR reiterates our support for the AMA RUC process and commends the Relativity Assessment Workgroup (RAW) for their efforts to help identify potentially misvalued codes for RUC review.

The College strongly opposes CMS's proposed 2.5% "efficiency" adjustment for non-time-based procedures, such as radiology services. Advancements in imaging technology have allowed for an increase in diagnostic capabilities inherent in higher resolution acquisitions. While these advancements are giant leaps forward for patient care, CMS is incorrect in its assumption that these advancements have created efficiencies. First, higher resolution images require more time and intensity to review and interpret by radiologists. For example, higher resolution images now allow identification and diagnosis of tiny cartilage fissures and microtrabecular fractures on high resolution musculoskeletal Magnetic Resonance Imaging (MRI) after trauma and subtle cortical dyplasias on high resolution brain MRI in seizure patients. The reviewing radiologist must have the skills to identify and diagnose these subtle findings. Second, newer technologies, including artificial intelligence (AI) software, frequently generate substantially more images, including multiplanar reformatted images, and sequences than were previously available. A Computed Tomography (CT) study that once consisted of 40 images now frequently contains 400 or more images, which the interpreting radiologist must spend time reviewing. Third, AI tools often highlight or flag findings that require further physician review, confirmation, or correlation with

other studies. This process adds uncompensated time and cognitive effort to the physician's workload. Far from creating net efficiencies, these innovations can increase the interpretive and documentation burden.

The proposal also overlooks the unique demands of providing radiology services. Radiology is a specialty that provides continuous, 24/7/365 coverage to meet urgent patient needs. Radiologists routinely interpret emergent imaging studies during evenings, overnight shifts, weekends, and holidays. By applying the efficiency adjustment to radiology, but exempting specialties whose services are largely confined to predictable daytime hours, the proposal inadvertently undervalues the commitment required to maintain constant availability for patients.

Off-hour work is not simply "more of the same" done at a different time; it frequently involves high-acuity cases that require rapid, accurate interpretation to guide immediate clinical decisions. Maintaining this readiness and availability requires significant resources, staffing, and expertise, which should be appropriately recognized in payment policy.

By reducing payment in the face of increasing demands, CMS risks undervaluing the expertise required for accurate, high-quality image interpretation and discourages the adoption of emerging technologies, most notably AI, before they can deliver their full potential benefits to patients and the health system.

The ACR is also concerned about the broader impact of this proposal. Payment reductions of this nature may hinder recruitment and retention of radiologists, particularly for off-hour coverage, and ultimately affect timely patient access to advanced diagnostic imaging.

Compounding these concerns, 2026 will mark the 17th consecutive year without a positive update for diagnostic radiology in the Medicare Physician Fee Schedule impact tables—paired with an overall update from 1992 through 2023 that has been less than the MEI by an aggregate 32 percentage points.

Any adjustment to a code's time and value should be carefully considered and based on appropriate specialty-specific data. Technologies and clinical processes do not improve at an equal pace for all specialties or procedures. This efficiency adjustment also should not be applied unilaterally every three years to all codes, as any efficiencies will eventually stop. The College is deeply concerned that these additional payment reductions will limit patient access to timely imaging, hinder recruitment and retention of radiologists, and ultimately compromise care. We strongly urge CMS to weigh the theoretical benefits against the real-world impacts and reject this well-intentioned but ultimately harmful proposal.

MR Safety Codes on the Multiple Procedure Payment Reduction (MPPR) List

The ACR met with CMS in April 2025 to discuss several MR Safety codes that we believe are inappropriately on the MPPR list. The MPPR is applied to diagnostic radiology services under Medicare when multiple services are provided by the same physician to the same patient in the same session.

Current Procedural Terminology® (CPT) codes 76017 *(MR safety medical physics examination customization, planning and performance monitoring by medical physicist or MR safety expert, with review and analysis by physician or other 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)*, 76018 *(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)*, and 76019 *(MR safety implant positioning and/or immobilization under supervision of physician or other 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)* were recommended by both the CPT Editorial Panel and the RUC to be modifier -51 exempt and are indicated as such in the CPT manual.

The RUC discussed this topic at the January 2024 meeting and determined there was no overlapping work and requested these codes be modifier -51 exempt. These procedures can be performed with another procedure but may also be stand-alone procedures not always performed with other specified procedures. The value, time, and practice expense for these codes are separate from the work of other MR codes; there is also no overlap in pre-service work.

Additionally, to be consistent with other modifier -51 exempt codes, the multiple procedure indicator should be updated to 0 *(no payment adjust rules for multiple procedures apply. If you report the procedure on the same day as another procedure, payment is based on the lower of the actual charge or the fee schedule amount for the procedure).* Similarly, the diagnostic imaging family indicator should be updated to 99 *(concept does not apply).*

CPT code 76016 *(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 examination, analysis of risk vs clinical benefit of performing MR examination, and determination of MR equipment, accessory equipment, and expertise required to perform examination, with written report)* is appropriately included on the MPPR list.

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

Proposal

Under Medicare Part B, certain types of services, including diagnostic tests described under § 410.32 and services incident to a physician's professional service described under § 410.26 (incident-to services), are required to be furnished under specific minimum levels of supervision by a physician or other practitioner. In the March 31, 2020, COVID-19 interim final rule with comment period (IFC), CMS changed the definition of "direct supervision" during the public

health emergency (PHE) for COVID-19 as it pertains to supervision of diagnostic tests, physicians' services, and some hospital outpatient services. This change allows the supervising professional to be immediately available through virtual presence using two-way, real-time audio/video technology, instead of requiring their physical presence. The ACR has previously supported CMS's extension of this policy. CMS proposed 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.

ACR Perspective and Comments

Previously, the ACR commented 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, 2025. 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.**

Contrast Material Administration

In 2022, the ACR aligned the ACR–SPR Practice Parameter for The Use of Intravascular Contrast Media[1] to comply with the ACR Manual on Contrast Media. The ACR Drugs and Contrast Media Committee has now updated its statement[2] on the supervision of contrast material administration. The committee statement is designed to afford facilities latitude in their operations while upholding safety standards. In instances where a physician offers direct oversight for the study, whether on-site or remotely, the requirement for direct supervision is deemed fulfilled. The ACR's primary concern is ensuring the presence of a qualified individual on-site capable of managing contrast reactions. These on-site individuals may encompass roles such as Nurse Practitioners (NPs), Registered Nurses (RNs), or other qualified personnel. Deliberately, the Committee abstained from delineating specific professional designations for contrast management, recognizing the substantial variability in institutional protocols and local regulations, including state laws and policies. As long as individuals possess the competencies outlined in the contrast statement, they may render the service on-site, provided facilities adhere to pertinent local statutes and regulations.

On-site Personnel for Patient Safety

The ACR supports the presence of qualified on-site personnel during diagnostic imaging procedures involving contrast media. These individuals must be capable of appropriately managing adverse reactions. Rather than specific roles, the ACR emphasizes qualifications of

[1] https://gravitas.acr.org/PPTS/GetDocumentView?docId=142

[2] https://www.acr.org/Advocacy/Position-Statements/Supervision-of-Contrast-Material-Administration

on-site personnel to accommodate variations in state and local regulations and remain adaptable to future changes in scope of practice. Relevant qualifications are outlined in the ACR's Statement from the Drugs and Contrast Media Committee on Supervision of Contrast Material Administration.

Radiologist-Led Teams
To ensure diagnostic quality and minimize radiation exposure, imaging services must be supervised by professionals who can assess image quality related to equipment capabilities and clinical needs. On-site personnel should remain integral to radiologist-led teams. The ACR urges CMS to continue supporting physician-led models, where Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs) collaborate under physician supervision to uphold patient safety and care standards.

Ensuring Access to Care
The ACR supports making the definition of direct supervision to include real-time audio-visual telecommunications permanent. This approach ensures continued access to radiology services after-hours, improves availability in rural and underserved areas, and strikes a necessary balance between patient safety and access to care.

Policies to Improve Care for Chronic Illness and Behavioral Health Needs
Comment Solicitation on Payment Policy for Software as a Service (SaaS)

Proposal
CMS stated there have been rapid developments in the use of software-based technologies to support clinical decision-making in the outpatient and physician office settings. These advancements may include devices that require clearance, approval, or authorization by the Food and Drug Administration (FDA). CMS has considered most computer software and associated analysis and licensing fees to be indirect costs tied to expenses related to associated hardware considered to be medical equipment. CMS has included several distinct issues when evaluating SaaS technologies. CMS has observed wide variations in the purported costs of clinically similar SaaS technologies. Manufacturers consider various costs, including research and development and software maintenance, when pricing their technologies; these costs are often not publicly verifiable. Additionally, due to the novel and evolving nature of these technologies, there are rarely existing medical items or services to use for comparison when determining clinical and resource similarity. Lastly, CMS stated that, while there has been a rapid increase in the development and coding of services incorporating these technologies in recent years, there is a very limited amount of Medicare claims data. CMS is seeking to understand how the use of SaaS and AI technology affects services and how to incorporate these costs into their current strategy for paying for evolving models of care delivery, such as Advanced Primary Care Management and risk-based payment arrangements generally.

ACR Perspective and Comments

The ACR appreciates CMS inviting public and stakeholder feedback on the role of SaaS and AI in healthcare. This is a timely and important step toward ensuring 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.

The ACR also urges CMS to align its terminology with that used by other federal agencies to promote regulatory consistency. For example, the 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.

Factors CMS should consider when paying for these technologies should include how such technologies are used in clinical practice, the improvements they can make for patient outcomes, and their potential for increasing physician work. For example, as discussed above, SaaS and AI technologies that are newly available to radiologists represent advances in care for patients. Still, such technologies can also place a greater work burden on clinicians. When using these technologies to advance patient care, CMS should recognize and appropriately value the corresponding increases in clinician work.

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.

CY 2026 Identification and Review of Potentially Misvalued Services

Proposal

For CY 2026, CMS received 11 public nominations for potentially misvalued codes. One of the code families nominated pertains to radiology - Fine Needle Aspiration:

CPT CODE	LONG DESCRIPTOR
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
10006	Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion(List separately in addition to code for primary procedure)

A vested party requested that CMS reconsider the CPT codes listed above, citing significant undervaluation since 2019. This family of fine needle aspiration (FNA) codes have been nominated several times in previous years and addressed by CMS in previous rulemaking.

The nominator suggested payment changes have created negative outcomes that are currently impacting the care of patients with thyroid nodules and cancer.

The nominator provided comprehensive information, data, recent research, and detailed analysis on trends relating to this procedure. The nominator continues to encourage CMS to accept the values previously recommended by the RUC and strongly disagrees with CMS's methodology of crosswalking or comparing these codes to a neonatal blood transfusion code.

CMS acknowledges the potential site of service variance in recent years. However, CMS states these changes are not substantial enough to prompt revaluation. CMS will continue to monitor the site of service trends closely. CMS is soliciting public comment regarding whether these codes should be re-reviewed considering the detailed information submitted by the nominator.

ACR Perspective and Comment
The ACR continues to urge CMS to accept the values previously approved by the RUC. We do not believe this family requires additional RUC review, as the codes are undervalued as a result of a double-counting of the utilization for the new codes that included imaging guidance. We believe correction of this mathematical error and the acceptance of the previously recommended RUC values will resolve any issues related to the potential misvaluation of these codes. The College also strongly disagrees with the methodology CMS used to refine the values for the codes, by using intra-service time ratios and then applying clinically inappropriate crosswalks.

Valuation of Specific Codes for CY 2026

Lower Extremity Revascularization (37XX1, 37X02, 37X03, 37X04, 37X05, 37X06, 37X07, 37X08, 37X09, 37X10, 37X11, 37X12, 37X13, 37X14, 37X15, 37X16, 37X17, 37X18, 37X19, 37X20, 37X21, 37X22, 37X23, 37X24, 37X25, 37X26, 37X27, 37X28, 37X29, 37X30, 37X31, 37X32, 37X33, 37X34, 37X35, 37X36, 37X37, 37X38, 37X39, 37X40, 37X41, 37X42, 37X43, 37X44, 37X45, and 37X46)

Proposal
In Fall 2018, three CPT codes (37225, 37227, and 37229) were flagged by the RAW's high-cost supplies screen. This resulted in a deep dive into the lower extremity revascularization (LER) family. Ultimately, the CPT Editorial Panel created four new subsections and 46 new codes to replace the existing 16 codes. These codes were presented at the September 2024 RUC meeting.

CMS expressed some reservations about the survey process, including the abbreviated survey instrument, small sample size, and variations in responses. Nonetheless, CMS proposes to accept the RUC's recommended work RVUs for all 46 codes. Please see the table below.

CPT CODE	LONG DESCRIPTOR	PROPOSED CY 2026 WORK RVU
37XX1	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel	7.30
37X02	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	3.00
37X03	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel	10.75
37X04	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	3.89
37X05	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel	8.75
37X06	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for	4.00

	accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	
37X07	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	12.69
37X08	Revascularization, endovascular, open or percutaneous, iliac vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel.	4.25
37X09	Intravascular lithotripsy(ies), iliac vascular territory, including all imaging guidance and radiological supervision and interpretation necessary to perform the intravascular lithotripsy(ies) within the same artery (List separately in addition to code for primary procedure)	3.00
37X10	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel	7.75
37X11	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	3.00
37X12	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the	10.50

	artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel	
37X13	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel	4.00
37X14	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel (List separately in addition to code for primary procedure)	8.75
37X15	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	3.73
37X16	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	14.75
37X17	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral;	5.00

	complex lesion, each additional vessel (List separately in addition to code for primary procedure)	
37X18	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel	9.00
37X19	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel	4.00
37X20	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	12.63
37X21	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	5.50
37X22	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel	11.00

37X23	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	4.25
37X24	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	15.00
37X25	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	6.00
37X26	Intravascular lithotripsy(ies), femoral and popliteal vascular territory, including all imaging guidance and radiological supervision and interpretation necessary to perform the intravascular lithotripsy(ies) within the same artery (List separately in addition to code for primary procedure)	4.00
37X27	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel	9.80
37X28	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the	3.00

	artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel	
37X29	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel (List separately in addition to code for primary procedure)	12.31
37X30	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	4.26
37X31	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel	10.00
37X32	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	3.34
37X33	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	13.46

37X34	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	5.00
37X35	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel	13.50
37X36	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	4.75
37X37	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	17.00
37X38	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	6.50

37X39	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, initial vessel	15.00
37X40	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	6.50
37X41	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel	18.00
37X42	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal stent placement, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the stent placement, atherectomy, and angioplasty when performed, within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	8.16
37X43	Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, initial vessel	11.00

37X44	Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; straightforward lesion, each additional vessel (List separately in addition to code for primary procedure)	4.00
37X45	Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, initial vessel	13.70
37X46	37X46 - Revascularization, endovascular, open or percutaneous, inframalleolar vascular territory, with transluminal angioplasty, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the angioplasty within the same artery, unilateral; complex lesion, each additional vessel (List separately in addition to code for primary procedure)	5.00

CMS proposes to accept all the PE recommendations from the RUC, with several revisions to address discrepancies that were noted. Please see Attachment A for an itemized list of the refinements.

Additionally, CMS is soliciting comments on whether they should create G-codes to describe the use of high-cost disposable supplies or use the Hospital Outpatient Prospective Payment System (OPPS) mean unit cost data (MUC) to price these services based on how the supplies are paid for in the hospital setting.

ACR Perspective and Comments

The ACR appreciates CMS's proposal to accept the physician work RUC recommendations for all 46 lower extremity revascularization codes. The survey process was a large undertaking involving multiple specialty societies. We performed a full survey on 11 of the codes, representing all four territories, and then two groups of abbreviated surveys to account for the remaining 35 codes. We believed this would alleviate any survey fatigue and increase the survey response rate. We do feel we collected sufficient responses for all of the codes, with over 100 responses for each of the 11 anchor codes and over 40 for the abbreviated surveys.

We also have comments on several of the Agency's proposed PE refinements for this family; our feedback and rationale are enclosed in Attachment A.

The ACR recommends that CMS create Healthcare Common Procedure Coding System (HCPCS) codes to separately identify and pay for high-cost disposable supplies over $500. These supplies and their prices should be reviewed annually and updated appropriately.

Irreversible Electroporation of Tumors (4001X and 5XX11)

Proposal
CPT codes 4001X and 5XX11 were created for reporting of percutaneous irreversible electroporation ablation of one or more tumors. CMS proposed to accept the RUC-recommended work RVUs for both codes. Please see the table below.

CPT CODE	LONG DESCRIPTOR	PROPOSED CY 2026 WORK RVU
4001X	Ablation, irreversible electroporation, liver, 1 or more tumors, including imaging guidance, percutaneous	9.41
5XX11	Ablation, irreversible electroporation, prostate, 1 or more tumors, including imaging guidance, percutaneous	13.50

While CMS proposed to accept the RUC-recommended PE inputs for CPT code 5XX11, they are recommending refinements to some of the inputs for CPT code 4001X. CMS disagrees with the use of the standard 90-day global pre-service clinical labor times in the Facility setting for CPT code 4001X since this is a 0-day global procedure. Instead, CMS proposed the standard 000/010 global day extensive pre-service clinical labor times in the Facility setting. Please see Attachment A for an itemized list of the refinements.

ACR Perspective and Comments
The ACR agrees with CMS's proposal to accept the RUC-recommended work RVU values for CPT codes 4001X and 5XX11. We also appreciate CMS's proposal to accept the RUC-recommended direct PE inputs for CPT code 5XX11.

The ACR has comments on several of the Agency's proposed PE refinements for CPT code 4001X; our feedback and rationale are enclosed in Attachment A. **The ACR urges CMS to accept the direct practice expense inputs for 4001X as recommended by the RUC without refinement.**

Prostate Biopsy Services (55705, 55706, 5XX00, 5XX01, 5XX02, 5XX03, 5XX04, 5XX07, 5XX08, 5XX09, 5XX10, and 76872)

Proposal
This family was identified by the RAW screen for services performed 75% of the time or more by the same physician on the same date of service. The societies developed an action plan that referred the family to the CPT Editorial Panel for revision. As a result, CPT code 55700 was deleted, CPT codes 55705 and 75872 were revised, and 9 new codes were created. CMS

proposed to accept the RUC-recommended work RVUs for all 12 codes. Please see the table below.

CPT CODE	LONG DESCRIPTOR	PROPOSED CY 2026 WORK RVU
55705	Biopsy, prostate; any approach, nonimaging-guided	1.93
55706	Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance	4.27
5XX00	Biopsy, prostate, transrectal, ultrasound-guided (ie, sextant), ultrasound-localized	2.63
5XX01	Biopsy, prostate, transrectal, ultrasound-guided (ie, sextant) with MRI-fusion guidance	3.39
5XX02	Biopsy, prostate, transperineal, ultrasound-guided (ie, sextant), ultrasound-localized	3.23
5XX03	Biopsy, prostate, transperineal, ultrasound-guided (ie, sextant) with MRI-fusion guidance	3.81
5XX04	Biopsy, prostate, transrectal, MRI-ultrasound-fusion guided, targeted lesion(s) only	2.61
5XX07	Biopsy, prostate, transperineal, MRI-ultrasound-fusion guided, targeted lesion(s) only, first targeted lesion	3.10
5XX08	Biopsy, prostate, in-bore CT- or MRI-guided (ie, sextant), with biopsy of additional targeted lesion(s), first targeted lesion	4.00
5XX09	(Biopsy, prostate, in-bore CT- or MRI-guided targeted lesion(s) only, first targeted lesion	3.62
5XX10	(Biopsy, prostate, each additional, MRI-ultrasound fusion or in-bore CT- or MRI-guided targeted lesion (List separately in addition to code for primary procedure	1.05
76872	Ultrasound, transrectal	0.67

CMS is also proposing to accept the RUC-recommended direct PE inputs for this code family without refinement.

ACR Perspective and Comments
The ACR agrees with CMS's proposal to accept the RUC-recommended values and PE inputs for all 12 codes associated with prostate biopsy services.

Endovascular Therapy with imaging (61624, 61626, 75894 and 75898)

Proposal
Based on action plans developed in correspondence with the April 2022 RUC meeting, CPT codes 61624, 61626, 75894, and 75898 were sent to the CPT editorial panel to evaluate for potential code bundling. While CMS proposes to accept the RUC-recommended RVUs for CPT codes 75894 and 75896, they have concerns about the survey data due to variations in the intra-

service times and work values in the responses collected. CMS is seeking public comments on the proposed work RVUs for these two codes.

CMS disagrees with the RUC-recommended values for CPT codes 61624 and 61626. The Agency proposes to crosswalk CPT code 61624 to CPT code 49622 *(Repair of parastomal hernia, any approach (that is, open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; incarcerated or strangulated),* with a work RVU of 17.06. CMS feels that this lower work RVU reflects the significant decrease in both the intra-service time and total time of CPT code 61624.

For CPT code 61626, CMS proposes to crosswalk CPT code 61624 to CPT code 49594 *(Repair of anterior abdominal hernia[s] [that is, epigastric, incisional, ventral, umbilical, spigelian], any approach [that is, open, laparoscopic, robotic], initial, including implantation of mesh or other prosthesis when performed, total length of defect[s]; 3 cm to 10 cm, incarcerated or strangulated),* with a work RVU of 13.46. CMS feels that this lower work RVU reflects the significant decrease in both the intra-service time and total time of CPT code 61626. See the table below.

CPT CODE	LONG DESCRIPTOR	RUC-Recommended WORK RVU	PROPOSED CY 2026 WORK RVU
61624	Transcatheter permanent occlusion or embolization [for example, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation], percutaneous, any method; central nervous system [intracranial, spinal cord]	20.00	17.06
61626	Transcatheter permanent occlusion or embolization [e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation], percutaneous, any method; non-central nervous system, head or neck [extracranial, brachiocephalic branch]	15.31	13.46
75894	Transcatheter therapy, embolization, any method, radiological supervision and interpretation)	2.25	2.25
75898	Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis	1.85	1.85

CMS proposes to accept the RUC-recommended PE inputs for CPT codes 61624, 75894, and 75898 without refinement. However, CMS proposes some refinements to the PE inputs for CPT code 61626. Please see Attachment A for an itemized list of the refinements.

While CMS is not proposing refinements to the PE inputs for 75894 and 75898, they are requesting public comments to clarify the 60 minutes for 75894 and 45 minutes for 75898 that are attributed to CA021 (Perform procedure/service - NOT directly related to physician work

time). The Agency would like feedback on what intra-service clinical labor times would be typical for these procedures when they are performed in the absence of CPT codes 61624 and 61626.

ACR Perspective and Comments

The ACR supports CMS's proposal to accept the RUC-recommended values for CPT codes 75894 (2.25 RVUs) and 75898 (1.85 RVUs). CMS expressed concerns about the validity of the survey data due to variations in the work values and the intra-service times reported by respondents. However, the College stands behind the survey data and the RUC process in determining the appropriate value for these procedures, which have never been valued by the RUC. We also believe that the RUC-recommended time of 60 minutes for 75894 and 45 minutes for 75898 for CA021(Perform procedure/service - NOT directly related to physician work time) is appropriate. The Vascular Interventional Technologist is working closely with the physician during that time to ensure the imaging is appropriate, the contrast necessary to identify and review the fine detail of vessels is accomplished, and appropriate documentation of the images is acquired.

The ACR disagrees with CMS's refinement of the work values for CPT codes 61624 and 61626. The RUC-recommended values for both codes were based on robust survey data and comparisons to key reference codes.

CPT code 61624 should be labeled CMS/Other, as it has never been addressed by the RUC, making its current physician times unreliable for comparison purposes. Instead, CMS proposes to crosswalk the value for CPT code 61624 to code 49622 based on the comparison of the intra-service time and not any clinical criteria or consideration of the RUC survey data. These two procedures are fundamentally different with 61624 involving precise catheter-base embolization of cranial or spinal arteries, while 49622 is an open abdominal procedure. CMS uses two other codes, 33224 *(Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or implantable defibrillator pulse generator (including revision of pocket, removal, insertion, and/or replacement of existing generator))* and 93590 *(Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve)*, to support their crosswalk proposal, but these procedures also do not match the level of complexity and precision as that required of CPT code 61624.

CPT code 61626 should be labeled CMS/Other, as it has never been addressed by the RUC, making its current physician times unreliable for comparison purposes. Instead, CMS proposes to crosswalk the value for CPT code 61626 to code 49594 based on the comparison of the intra-service time and not any clinical criteria or consideration of the RUC survey data. These two procedures are not comparable due to fundamental anatomical, technical, and resource disparities. CMS uses two other codes, 55881 *(Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation;)* and 93580 *(Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant)*, to support their

crosswalk proposal, but these procedures also do not match the level of complexity and precision as that required of CPT code 61626.

The ACR urges CMS to accept the RUC-recommended values for CPT codes 61624 (20.00 RVUs) and 61626 (15.31 RVUs).

The ACR has comments on several of the Agency's proposed PE refinements for CPT code 61626; our feedback and rationale are enclosed in Attachment A.

Percutaneous Decompression of Median Nerve (647XX)

Proposal
The CPT Editorial Panel created new CPT code 647XX to report the percutaneous decompression of the median nerve at the carpal tunnel using ultrasound guidance and a balloon dilation device while transecting the transcarpal ligament. While CMS notes they received external input suggesting a higher 6.00 work RVU, their review of procedures with similar times does not support a higher work RVU. Therefore, CMS proposes to accept the RUC-recommended RVU for this service. Please see the table below.

CPT CODE	LONG DESCRIPTOR	PROPOSED CY 2026 WORK RVU
647XX	Decompression; median nerve at the carpal tunnel, percutaneous, with intracarpal tunnel balloon dilation, including ultrasound guidance	2.70

CMS is also proposing to accept the RUC-recommended direct PE inputs for CPT code 647XX without refinement.

ACR Perspective and Comments
The ACR agrees with CMS's proposal to accept the RUC-recommended values and PE inputs for CPT code 647XX.

Cerebral Perfusion & CT Angiography-Head & Neck (70496, 70498, 70XX1, 70XX2 and 70XX3)

Proposal
The CPT Editorial Panel created three new codes for Cerebral Perfusion and CT Angiography (CTA) of the Head and Neck. These codes were surveyed for the September 2024 RUC meeting, along with the existing standalone codes for CTA head and CTA neck. CMS proposes to accept the RUC-recommended work RVUs for the five codes. Please see the table below.

CPT CODE	LONG DESCRIPTOR	PROPOSED CY 2026 WORK RVU
70496	Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing	1.75
70498	Computed tomographic angiography, neck, with contrast material(s),including noncontrast images, if performed, and image postprocessing	1.75
70XX1	Computed tomographic angiography (CTA), head and neck, with contrast material(s), including noncontrast images, when performed, and image postprocessing	2.50
70XX2	Computed tomographic (CT) cerebral perfusion analysis with contrast material(s), including image postprocessing performed with concurrent CT or CT angiography of the same anatomy (List separately in addition to code for primary procedure)	0.77
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	1.00

CMS is also proposing to accept the RUC-recommended direct PE inputs for this code family without refinement.

ACR Perspective and Comments
The ACR agrees with CMS's proposal to accept the RUC-recommended values and PE inputs for all five codes associated with Cerebral Perfusion & CT Angiography of the Head and Neck.

Coronary Atherosclerotic Plaque Assessment (75XX6)

Proposal
The CPT Editorial Panel created a new Category I CPT code, 75XX6, to describe Coronary Atherosclerotic Plaque Assessment and deleted four existing Category III CPT codes associated with the procedure. CMS proposed to accept the RUC-recommended work RVU and practice expense for CPT code 75XX6. Please see the table below.

CPT CODE	LONG DESCRIPTOR	PROPOSED CY 2026 WORK RVU
75XX6	Quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, derived from augmentative software analysis of the data set from a coronary computed tomographic angiography, with interpretation and report by a physician or other qualified health care professional	0.85

While CMS proposes to accept the RUC-recommended direct PE inputs without refinement, the Agency notes that the new supply item, Plaque Characterization Analysis Software, has a per-patient cost of $1,500 for the plaque data analysis summary generated by the vendor. CMS continues to have concerns that software analysis fees are not well accounted for in the direct PE methodology, but they recognize that it is a significant part of the resource costs associated with this procedure. Therefore, CMS proposed to crosswalk the PE RVU for CPT code 75XX6 to the PE RVU for CPT code 77373 *(Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions)*, which is a PE-only code with no work RVU and which closely approximates the OPPS assignment employed by Category III code 0625T *(Automated quantification and characterization of coronary atherosclerotic plaque to assess severity of coronary disease, using data from coronary computed tomographic angiography; computerized analysis of data from coronary computed tomographic angiography)*, which was previously used to report this service. Crosswalking the PE RVU allows CMS to recognize the costs that practitioners are incurring and would not otherwise be recognized under the current PE methodology.

ACR Perspective and Comments

The ACR agrees with CMS's proposal to accept the RUC-recommended values and PE inputs for CPT code 75XX6. The ACR supports CMS's proposal to crosswalk the PE RVU for CPT code 75XX6 to the PE RVU for CPT code 77373, allowing for the software analysis fee to be captured. This is consistent with the methodology CMS has implemented previously for CPT code 75580, fractional flow reserve with CT.

Use of the Relationship Between OPPS Ambulatory Payment Classification (APC) Relative Weights to Establish PE RVUs for Radiation Oncology Treatment Delivery (CPT codes 77387, 77402, 77407, 77412, and 77417)

Proposal

In the proposed rule, CMS details the differences in practice expense for radiation oncology services in the physician office (non-facility setting) and the hospital (facility setting). Radiation Oncology services in the facility setting typically exceed the Medicare payment for the same service in the physician office. CMS has received comments from interested parties that the facilities are shouldering a heavy burden of cost compared to non-facilities due to items such as overhead to maintain the facility 24 hours a day 7 days a week and caring for a higher acuity patient that will need additional support services. CMS notes they received voluntary submission of "resource costs" via invoices, but these submissions are proving hard to verify and even to obtain.

In the CY 2016 rule, CMS maintained the HCPCS G-codes under the PFS to report radiation treatment delivery services instead of the new CPT codes, while adopting the CPT codes for use under OPPS. Outpatient radiation therapy services have been reported to Medicare using two different sets of HCPCS codes depending on whether they are provided in a facility or non-facility setting.

The CPT Editorial Panel has revised the radiation treatment delivery codes for CY 2026. If CMS were to adopt the CPT codes under the PFS and utilize the RUC-recommended PE inputs, this could lead to volatility in their payment. Therefore, CMS has determined that identifying an alternative, more routinely updated and standardized data source would improve the accuracy of the codes' valuation.

To develop PE RVUs for these radiation oncology services, CMS proposed to use the OPPS cost data and apply the CY 2026 proposed APC relative weights to the codes. The Agency is also proposing to value the MP RVUs for these services through their usual methodology for PE-only services. CMS calculated the RVUs for these codes so that the overall PE and MP RVUs for these services represent the same share of total PE and MP RVUs in 2025 and 2026. For CY 2026, CMS approximated the direct costs for these services and allocated indirect PE RVUs per the standard methodology to both arrive at PE RVUs based on the proposal described and maintain relativity within the PE RVUs across the fee schedule. The direct PE input public use file does not include the proxy inputs. CMS is seeking comments on this aspect of the methodology, as they want to maintain transparency in rate setting.

CMS is also seeking comments on their proposal to use the relative relationship between the proposed OPPS APC relative weights to establish the PE RVUs.

ACR Perspective and Comments
The ACR appreciates CMS's recognition of the high equipment costs for radiation treatment delivery services in a non-facility setting compared to other services performed in the non-facility, stating that the costs align more closely with facility costs. The College supports CMS's proposal to use cost data from hospital cost reports, which can lead to more payment stability and price transparency. The ACR agrees with using OPPS data to set rates for some technical-only radiation oncology services.

Radiation Oncology Treatment Delivery (CPT codes 77387, 77402, 77407, 77412, and 77417)

Proposal
The CPT Editorial Panel revised CPT codes 77402, 77407, and 77412 to establish a technique-agnostic family of codes and to bundle imaging into the three codes. They also deleted CPT codes 77385, 77386, and 77014.

CMS has been using 17 G-codes for payment of these services under the PFS. For CY 2026, in conjunction with their proposal to utilize OPPS cost data to establish PE RVUs, CMS proposes to delete the 17 G-codes and recognize the newly revised CPT codes for payment.

CMS proposes to accept the RUC-recommended work RVU for CPT code 77387, which is the only code with a physician work component. See the table below.

CPT CODE	LONG DESCRIPTOR	PROPOSED CY 2026 WORK RVU
77387	Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed	0.70
77402	Radiation treatment delivery; Level 1 (for example, single electron field, multiple electron fields, or 2D photons), including imaging guidance, when performed	-
77407	Radiation treatment delivery; Level 2, single isocenter (eg, 3D or IMRT), photons, including imaging guidance, when performed	-
77412	Radiation treatment delivery; Level 3, multiple isocenters with photon therapy (for example, 2D, 3D, or IMRT) OR a single isocenter photon therapy (eg, 3D or IMRT) with active motion management, OR total skin electrons, OR mixed electron/photon field(s), including imaging guidance, when performed	-
77417	Therapeutic radiology port image(s)	-

CMS proposes to assign Procedure Status "B" to the technical component of CPT code 77387 to maintain consistency with OPPS payment. This code is packaged into payment for the treatment delivery codes (CPT codes 77402, 77407, and 77412) and is not separately payable under OPPS. For CPT code 77387, CMS proposes the PE and total RVU for the global service will equal the PE and total for the professional component only since the technical component is not separately payable under the PFS. CMS is seeking feedback on whether displaying the global service equal to the professional component is problematic and if it would be preferable to eliminate the global code and display only the professional and technical components in Addendum B.

CMS proposes a similar Procedure Status "B" assignment to CPT code 77417, which is PE-only and also packaged into the payment for the treatment delivery codes, CPT codes 77402, 77407, and 77412.

ACR Perspective and Comments

The ACR agrees with CMS's proposal to accept the RUC-recommended value for CPT code 77387.

The ACR agrees that the Agency's proposal to apply the APC relative weights to the codes within the radiation oncology treatment delivery family is the most accurate method for capturing the OPPS cost data for these procedures under the PFS.

The current HOPPS APC assignment for the codes are:

- **CPT code 77402 -** APC 5621 (level 1 radiation therapy)
- **CPT codes 77407 and 77412** – APC 5622 (level 2 radiation therapy)
- **CPT codes 77385 and 77386 –** APC 5623 (level 3 radiation therapy)

With the deletion of codes 77385 and 77386 and the other CPT code numbers in the family being revised to describe different services, the ACR acknowledges the difficulty in APC assignments for this restructured code family. We are proposing the following CY 2026 APC assignments:

- **CPT code 77402 -** APC 5622 (level 2 radiation therapy)
- **CPT codes 77407 and 77412** – APC 5623 (level 3 radiation therapy)

We also recommend that CMS:

- Use existing 77412 data in APC 5622 for rate setting.
- Use 77385 and 77386 data in APC 5623 for rate setting.

Since CMS proposed to assign procedure status "B" to the technical component for CPT code 77387, the ACR recommends that CMS display only the professional component for CPT code 77387 and not the global code to avoid billing confusion. We also suggest updating the Medicare Claims Processing Manual to include language explaining CPT codes 77387-26 should be reported regardless of the POS, when performed.

Since CMS proposed to assign procedure status "B" to the PE-only code 77417, which is also packaged into the payment for the treatment delivery codes (CPT codes 77402, 77407, and 77412), the ACR requests that CMS closely review the utilization mapping for this code to ensure the PE RVUs for code 77417 are put into the treatment delivery family for redistribution.

Superficial Radiation Treatment (CPT codes 77X05, 77X07, 77X08, and 77X09)

Proposal

The CPT Editorial Panel created four new codes, 77X05, 77X07, 77X08, and 77X09, to describe surface radiation therapy. These codes will replace CPT code 77401 *(Radiation treatment delivery, superficial and/or ortho voltage, per day)* and HCPCS code G6001 *(Ultrasonic guidance for placement of radiation therapy fields).*

For the two codes with physician work (CPT codes 77X05 and 77X09), CMS proposes to accept the RUC-recommended work RVUs. See the table below.

CPT CODE	LONG DESCRIPTOR	PROPOSED CY 2026 WORK RVU
77X05	Surface radiation therapy; superficial or orthovoltage, treatment planning and simulation-aided field setting	0.77
77X07	Surface radiation therapy; superficial, delivery, <150 kV, per fraction (eg, electronic brachytherapy)	-
77X08	Surface radiation therapy; orthovoltage, delivery, >150-500 kV, per fraction	-
77X09	Surface radiation therapy; superficial or orthovoltage, image guidance, ultrasound for placement of radiation therapy fields for treatment of cutaneous tumors, per course of treatment (list separately in addition to	0.30

	the code for primary procedure) (use 77x09 in conjunction with 77x07, 77x08)	

For PE RVUs, CMS proposes an approach similar to what was used for the radiation oncology treatment delivery codes. They are proposing to use the relationship between the relative weights of the OPPS APCs to which the codes in this family are assigned to more accurately reflect the actual costs of these services.

CMS proposes to utilize the relationship between the proposed OPPS APC assignments for APCs 5621 and 5732 to inform the valuation of PE-only CPT codes 77X07 and 77X08, and for the technical component of CPT code 77X05 when paid under the PFS.

CMS proposes to assign Procedure Status "B" to the technical component of CPT code 77X09 to maintain consistency with OPPS payment for this code, which is packaged into payment for CPT codes 77X07 and 77X08. CMS is seeking feedback on whether displaying the global service equal to the professional component is problematic and if it would be preferable to eliminate the global code and display only the professional and technical components in Addendum B.

ACR Perspective and Comments
The ACR is providing comment only on CPT code 77X08, as we believe that dermatology will be the dominant providers for the other codes (77X05, 77X07, and 77X09). The College supports CMS's proposal to utilize the relationship between OPPS APC 5621 to inform the valuation of CPT code 77X08.

Proton Beam Treatment Delivery (CPT codes 77520, 77522, 77523, and 77525)

Proposal
Proton beam treatment delivery PFS payments are currently determined by local Medicare Administrative Contractors (MACS). These services do not have previously established RVUs due to the unique nature of their equipment costs when compared to other capital costs addressed by CMS's usual PE methodology. With the discussion of the new radiation oncology and superficial radiation treatment delivery services codes, CMS is seeking feedback on whether they should adopt a similar approach to establishing RVUs for these proton beam treatment delivery services.

CPT CODE	LONG DESCRIPTOR
77520	Proton treatment delivery; simple, without compensation
77522	Proton treatment delivery; simple, with compensation
77523	Proton treatment delivery; intermediate
77525	Proton treatment delivery; complex

CMS is specifically seeking comments on how they can establish national pricing and total RVUs for these services to maintain relativity within the PFS. They pose the questions:

- Would using the overall ratio between OPPS and PFS payment for radiation oncology treatment services to establish initial year RVUs for proton beam delivery services accurately reflect the relative resources involved?
- Would it be more appropriate to consider the overall difference between the OPPS and Medicare payments currently determined by the MACs for these services, or are there other alternative methods that CMS should consider?

ACR Perspective and Comments

The ACR supports CMS's proposal to consider using OPPS relative weights to establish pricing for proton beam treatment delivery. We believe this would allow for more stability in the payment methodology, as carrier pricing may vary. However, the ACR recommends that CMS work closely with the American Society for Radiation Oncology to establish the appropriate cost structure for this code family, as it may be complex. We further recommend that CMS include a detailed proposal in the CY 2027 rulemaking cycle to allow for public comment.

QUALITY PAYMENT PROGRAM

MIPS Value Pathways (MVPs) – Proposed Additions and Structure

Proposal

In the proposed rule for the 2026 Medicare Physician Fee Schedule, CMS introduced two new MIPS Value Pathways (MVPs) specifically for radiology; these are anticipated to be voluntary for reporting starting in the 2026 performance year.

1. The Diagnostic Radiology (DR) MVP, designed for practices that focus on imaging interpretation, includes quality measures like follow-up imaging for incidental findings, the use of dose-reduction techniques, and timely communication of critical results. Improvement activities support participation in clinical data registries, the use of decision support tools, and peer review. CMS continues to recognize that non-patient-facing radiologists may be exempt from the Promoting Interoperability category requirements. CMS may apply the Medicare Spending Per Beneficiary (MSPB) cost measure to some practices, but for those with limited evaluation and management (E/M) billing, cost performance could be reweighted to other categories, unless an exemption is granted.
2. The Interventional Radiology (IR) MVP is devised for procedural-based, image-guided interventions across various clinical areas. It reflects the distinct nature of interventional radiology and includes measures focused on procedural safety, outcomes, and efficiency.

ACR Perspective and Comments

The ACR appreciates CMS's efforts to propose the new DR and IR MVPs for use beginning with the 2026 MIPS performance year. We recognize that adopting MVPs before the traditional MIPS sunset will provide practices with the time needed to change or build an infrastructure that supports participation in this newer method. While larger or well-resourced groups may already have the infrastructure and staff capacity to adapt quickly, significant investments will likely be required from many practices preparing for MVP participation in 2026.

We are concerned that the limited list of quality measures proposed in the MVPs may not provide enough participation opportunities for smaller practices. In addition, incurring penalties instead of participating may outweigh the cost of staff training, workflow updates, and technology adjustments to enable participation. Practices may need to work with vendors to ensure systems can support MVP-specific reporting. In addition, multispecialty groups will need to manage subgroup registration. Implementing improvement activities and reviewing performance feedback will also demand ongoing attention. While costs will vary by practice size and infrastructure, the transition will involve both staff and financial resources, which many groups may not be able to afford. This shift may be especially challenging for smaller practices, as the added administrative complexity, technological demands, and operational disruptions could strain limited staff and budgets without a clear short-term return on investment. **Therefore, the ACR requests that traditional MIPS not be sunset until there are a larger number and greater spectrum of quality measures included in the MVPs.**

Diagnostic Radiology MVP

In October 2024, the ACR was invited to review CMS's Draft DR Candidate MVP alongside agency leadership and contractors. The inclusion of Qualified Clinical Data Registry (QCDR) measures in the draft underscored the value of specialty-specific metric. Still, the ACR continued to advocate for the addition of further QCDR measures to better represent the field.

In its response, the ACR emphasized the importance of aligning the MVP with the clinical realities of diagnostic radiologists. Key recommendations included:

- Minimizing administrative burden for resource-limited practices.
- Maintaining flexibility in reporting, particularly through continued support for non-patient-facing exemptions.
- Offering clear guidance for subgroup registration and data submission.
- Ensuring that MVP participation does not interfere with clinical workflows or compromise patient care.

Throughout CMS's 45-day public comment period, the ACR remained actively engaged, urging expansion of both Clinical Quality Measures (CQMs) and QCDR measures to more accurately reflect the subspecialized and diverse nature of diagnostic radiology. The ACR cautioned CMS that implementing such a limited measure set could disrupt workflows, increase administrative demands, and contribute to clinician burnout through a lack of engagement and an inability to participate in relevant measures.

To enhance relevance and feasibility, the ACR recommended several QCDR measures, including those focused on CT pulmonary angiogram (CTPA) interpretation, coronary calcium scoring, Thyroid Imaging Reporting and Data System (TI-RADS) utilization, and Dual-energy X-ray Absorptiometry (DEXA) fracture risk assessment. Citing the wish to reduce the overall number of QCDR measures, however, CMS instead removed several QCDR measures originally included in the Draft DR Candidate MVP from the DR MVP being proposed in the CY 2026 PFS proposed rule. The measures removed include:

- ACRad34: Multi-strata weighted average for 3 CT Exam Types
- ACRad41: Use of Quantitative Criteria for Oncologic FDG PET Imaging
- QMM17: Appropriate Follow-up Recommendations for Ovarian-Adnexal Lesions using O-RADS
- QMM18: Use of Breast Cancer Risk Score on Mammography

We encourage CMS to include these measures in the proposed DR MVP beginning with the 2026 MIPS performance year.

Additionally, the ACR is deeply concerned that CQM ID 494: *Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT* has been added to the Diagnostic Radiology MVP in place of ACRad 34: *Multi-strata weighted average for 3 CT Exam Types*. CMS has stated that the two measures are duplicative and CQM ID 494 supersedes ACRad 34. While both measures address CT radiation safety, the National Quality Forum's Measure Applications Partnership (MAP) report for the 2023 rulemaking cycle clarifies that they are complementary, not competing.[3]

Further, CQM ID 494 has been the subject of extensive feedback from the ACR and other stakeholders, i.e. radiology groups and hospitals, citing substantial implementation challenges, including the need for proprietary software, complex data workflows, and system integrations for which practices may be dependent on support from hospitals where they provide services. These barriers limit its feasibility across diverse practice settings. In contrast, ACRad 34 supports similar safety and quality goals but is more practical to adopt, as many practices have done. For this reason, **we recommend reinstating ACRad 34 in the MVP to ensure broader participation, measure choice, and sustained progress in radiation dose optimization.**

Compared to the initial candidate version, the substantial changes CMS now proposes for the DR MVP raise significant questions about alignment with stakeholder input. Many of the previously included measures were expected to support meaningful and successful participation for radiologists. Their removal not only undermines the value of the public comment process but also limits radiologists' ability to engage with the MVP in a manner that reflects their clinical practice. Without access to relevant, subspecialty-specific measures, large portions of the radiology community would be excluded from MVP participation or forced to report on measures that are not applicable to their scope of work.

The ACR would like to highlight the misconception among CMS and its contractors that reducing the number of measures in MVPs will lessen the reporting burden. Instead, the real burden arises from complex reporting requirements and program regulation, not from the number of measures themselves. To genuinely support physicians and enhance care, CMS should provide a comprehensive set of meaningful quality measures that reflect real clinical scenarios and drive

[3] Measure Applications Partnership (MAP). (2022). *MAP Clinician: 2022–2023 Measures Under Consideration (MUC) Cycle Measure Specifications Manual*. Centers for Medicare & Medicaid Services. https://www.cms.gov

improvement. We understand CMS may intend to streamline measure selection. Nonetheless, eliminating clinically relevant, specialty-specific measures forces radiologists to report on metrics that are less applicable to their practice, if even they are feasible to report. This shift conflicts with the goal of MVPs to provide meaningful, tailored pathways for participation and instead creates additional complexity, reduces flexibility, and may discourage engagement. **The ACR calls for CMS to broaden measure sets within an MVP of both MIPS and QCDR measures that reflect real-world clinical care and enable accurate performance assessment.**

The ACR appreciates CMS's confirmation that the category reweighting used in traditional MIPS—such as for Promoting Interoperability due to diagnostic radiologists' non-patient-facing status—will carry forward to MVP reporting.

Interventional Radiology MVP

Similar to its feedback on the DR MVP, the ACR submitted comments for the IR MVP during the 45-day public comment period. ACR's comments highlighted the lack of broadly applicable quality measures across interventional radiology subspecialties. Most proposed measures were narrowly focused, leaving many IR clinicians without viable reporting options. The ACR recommended ten additional measures, raised concerns about inappropriate cost measure attribution, and urged CMS to explore alternatives and clarify reweighting within the MVP framework. While CMS retained the proposed measures, structural changes may now allow broader participation, including vascular, oncologic, and pain management IRs. For more details, refer to the ACR's comments on the IR MVP submitted on January 24, 2025.

Proposal

CMS states that both the DR and IR MVPs are part of its ongoing efforts to make MIPS more relevant to clinical practice, reduce the reporting burden, and support performance improvement tailored to each specialty. To achieve this, CMS proposed categorizing all existing and future MVPs into CMS-assigned clinical groups, each associated with a unique set of quality and cost measures and improvement activities that reflect the services provided by the specified clinicians. For example, the DR MVP has been divided into three clinical groupings: General Radiology, Body Imaging (with a focus on thoracic and abdominal imaging), and Advancing Health and Wellness. In contrast, the IR MVP has not yet been categorized. CMS explains that assigning clinical groupings ensures measures and activities are aligned with the actual work clinicians perform, making reporting more relevant and manageable, enabling more accurate comparisons among similar providers, and supporting subgroup reporting in multispecialty practices.

ACR Perspective and Comments

The ACR is interested in learning more about CMS's MVP-assigned clinical groupings. We request clarity on the formation of these groups, specifically their role in practices' participation, and the Agency's plans for expanding the list of measures for each grouping.

The ACR questions whether CMS plans more groupings to accommodate measures for additional subspecialties. For instance, the DR MVP includes the Body Imaging grouping,

focusing on thoracic and abdominal radiology subspecialties. CMS must understand that these subspecialties comprise only a portion of the diagnostic radiologists participating in the MIPS program. As of now, the remaining subspecialists are left to report measures in the General Diagnostic Radiology and Advancing Health and Wellness categories, which substantially limits their reporting choices, may be inordinately burdensome to implement, or are not meaningful to these practices. **The ACR suggests that CMS introduce additional radiology subspecialty groupings, such as neuroradiology and musculoskeletal imaging, as clinical categories.**

The ACR agrees that including preventive screening measures is critical for supporting population health. Given CMS's introduction of clinical groupings, we encourage the inclusion of additional screening measures in the proposed DR MVP under the *Advancing Healthcare and Wellness* category. These additional measures could include ACRad 43: *DXA: Improving Reporting of True Change in Bone Mineral Density*, a screening measure that improves the accuracy of reporting changes in bone mineral density from DXA scans, which are commonly used to screen for osteoporosis. Helping clinicians distinguish between actual changes and measurement variability supports better decision-making in preventive care and enhances the effectiveness of ongoing bone health screenings. We also recommend including QMM 23: *Low-Dose Cancer Screening Recommendation for CT of Chest with Diagnosis of Emphysema*, as it promotes the inclusion of lung cancer screening recommendations in chest CT reports for patients diagnosed with emphysema, a known risk factor for lung cancer. By encouraging radiologists to identify and flag eligible patients for low-dose CT screening, the measure supports early detection efforts and enhances the preventive value of routine imaging in high-risk populations.

Additionally, we encourage CMS to include QMM 28: *Reporting Breast Arterial Calcification (BAC) on Screening Mammography* in the MVP, as it leverages routine breast cancer screening to identify women at increased risk for cardiovascular disease. By encouraging breast radiologists to report BAC, the measure supports early identification of patients who may benefit from further cardiovascular evaluation. Given that the DR MVP currently includes just one breast imaging measure, adding QMM 28 would provide another meaningful opportunity for breast imagers to contribute to quality reporting and population health improvement.

The ACR similarly requests that CMS expand the list of measures in the *Advancing Health and Wellness* clinical grouping to include ACRad 36: *Incidental Coronary Artery Calcification Reported on Chest CT* in the DR MVP. This measure would align with the MVP's thoracic imaging focus, as chest CT interpretation is typically performed by thoracic or body radiologists. It would also complement other screening measures, such as QMM 23, and provide another meaningful opportunity for radiologists to contribute to preventive care through routine imaging.

Proposal

CMS proposed a significant change to subgroup reporting for multispecialty practices participating in MVPs. Beginning with the 2026 performance year, multispecialty groups will no longer be allowed to report MVPs as a single group. Instead, MIPS-eligible clinicians within these groups must either report as a defined subgroup or as an individual.

ACR Perspective and Comments
With the anticipated shift to mandatory subgroup reporting for multispecialty groups beginning in the 2026 performance year, the ACR is examining how this transition will impact radiology practices. While it is expected that radiologists in these groups will report through the DR or IR MVPs, there is concern whether these MVPs are sufficiently designed to reflect the unique nature of radiology practice and accurately capture radiologists' contributions to patient care.

Radiologists face unique challenges in subgroup reporting due to the consultative nature of their work. Most MIPS measures are designed for patient-facing specialties that manage patient care directly, limiting their relevance for radiology. Further, radiology-specific data, such as imaging findings and modality metrics, can be hard to isolate within shared electronic health record (EHR) systems, complicating subgroup analysis. The limited representation of radiology subspecialties in current MVPs, especially in areas like breast imaging, nuclear medicine, and interventional radiology, restricts meaningful participation. These factors make standardized subgroup reporting under the MVP framework less reflective of radiologists' contributions and potentially more burdensome.

The ACR urges CMS to:

- **Reconsider the removal of key QCDR measures from the DR MVP to preserve meaningful participation opportunities for diagnostic radiologists;**
- **Introduce additional radiology subspecialty groupings, such as neuroradiology and musculoskeletal imaging, as clinical categories in the DR MVP;**
- **Finalize and clarify the process for cost category reweighting within MVPs;**
- **Exclude the MSPB measure from application to diagnostic radiologists participating in the DR MVP until such guidance is in place;**
- **Delay mandatory subgroup reporting for multispecialty groups.**

<u>Requests for Information (RFIs) Related to MVPs</u>
Core Elements in an MVP

Proposal
CMS states it is working to enhance transparency and comparability among MVPs by standardizing certain components, including population health measures, patient-reported outcomes, and interoperability requirements. To support this initiative, the Agency is considering a structural change in MVP composition by designating a percentage of measures as "core." For instance, CMS proposes that 25 percent of the measures within each MVP be classified as core, which would require reporting groups to select at least one core measure along with three additional measures. This strategy aims to promote alignment across MVPs and facilitate more accurate comparisons of clinician performance.

ACR Perspective and Comments
Standardizing core elements across all MVPs, such as population health measures, patient-reported outcomes, and interoperability requirements, would present unique challenges for radiologists. Unlike other specialties, radiologists often work in a consultative role, interpreting

imaging studies ordered by other clinicians, with limited direct patient interaction. As a result, measures like patient-reported outcomes and current population health metrics may not align with the nature of radiology workflows or the data typically available in imaging systems.

Interoperability requirements based on clinical data exchange standards might not fully address the complexities of imaging data. This type of data is typically stored in separate systems, such as Picture Archiving and Communication System (PACS) and Radiology Information System (RIS), and requires specific formats and metadata for effective management. Without tailored guidance or exemptions, radiology practices could face significant barriers to meaningful participation in MVPs structured around these standardized elements. Moreover, layering these core elements onto the MVP framework introduces additional complexity and burden to an already challenging and resource-intensive reporting program. **To ensure MVPs are relevant and practical for radiology, the ACR advises that CMS explore adaptable implementation strategies that consider the specialty's distinct clinical roles, data landscape, and reporting abilities.**

Further, CMS's consideration of designating a percentage of measures within each MVP as "core," such as requiring reporting groups to select at least one core measure along with three others, raises significant issues for radiology. While this structure may work for specialties with a large and diverse set of measures, the proposed radiology MVPs comprise far fewer options. For example, the DR MVP contains only nine measures, making it difficult to identify two that would be broadly applicable across all radiology practices. This lack of measure availability, combined with the wide variation in radiology practice types, means a rigid core measure requirement could limit meaningful participation and increase reporting burden. Unlike specialties such as ophthalmology, which have 23 measures across five clinical groupings, radiology lacks the depth and diversity needed to support a core element framework. Before implementing such a policy**, CMS must expand the measure portfolio and ensure that any core designation reflects the realities of radiology practice.**

Procedural Codes for MVP Assignment

Proposal
CMS is considering the use of procedural codes (e.g., CPT, HCPCS) to automatically assign clinicians to MVPs, reflecting their scope of practice. This could streamline reporting and ensure that clinicians are evaluated using relevant measures. Comments are being requested on how CMS should define procedural thresholds or assessment logic.

ACR Perspective and Comments
Using procedural codes to match clinicians with the most suitable MVP may benefit radiology by aligning reporting requirements with actual services delivered. This method could simplify participation and minimize confusion, especially in multispecialty practices where radiologists often serve in consultative roles. However, there are potential downsides.

Radiology CPT codes might not provide the necessary detail to differentiate between subspecialties or capture the complete range of diagnostic work, which could result in assigning clinicians to MVPs that are not relevant to their practice. In addition, automatically assigning MVPs based on procedural codes may remove the flexibility for clinicians to choose the pathway that best aligns with their clinical focus and reporting capabilities, potentially limiting meaningful participation. To make this strategy effective, **the ACR recommends that CMS create a detailed mapping framework that incorporates input from specialists and allows practices the flexibility to adjust or override automatic assignments as needed.**

Transition Toward Digital Quality Measurement

Proposal
As CMS continues to pursue a shift toward digital quality measurement (dQM), the Agency is requesting feedback on the use of Fast Healthcare Interoperability Resources (FHIR)-based Application Programming Interfaces (APIs), EHR integration, and automated data capture to support real-time, interoperable reporting.

ACR Perspective and Comments
We appreciate CMS's ongoing effort towards dOM. There are, however, substantial barriers in diagnostic radiology that it must understand. The use of FHIR-based APIs for digital quality measurement (dQM) in diagnostic imaging contains significant barriers to adoption due to the lack of promotion of US Core Data for Interoperability (USCDI) Level 2 elements into final text, the reluctance of implementers to move beyond FHIR R4 while FHIR R6 promises to be normative, and the lack of a CMS dQM Implementation Guide (IG), which would allow profiles to be published publicly for use in data capture and reporting.

Currently, USCDI requires only information about the type of test (e.g., CT head or chest radiograph) and the imaging report available. Although the report may represent the final work of the radiologist, numerous factors related to the quality of the procedure, its appropriateness, and follow-up care should be considered for quality measurement. Access to order information, which involves using the service request and imaging accession number, is necessary. Also, data about the imaging study, including the parameters utilized and captured during the procedure, can only be extracted from the images through image reference. Without these data elements, it is not possible to fully develop and report accurate quality measures in radiology. These items are crucial as they connect to the rest of the EHR to a radiology encounter and the patient's care plans. This is particularly important when following guidelines such as BI-RADS or Lung-RADS.

The FHIR R4 standard imaging lacks the ImagingSelection resource, which is vital for linking findings to specific locations in imaging studies, limiting effective tracking. R4 is a normative version designed for production use, but further development is necessary in specific areas, including imaging.

To promote transparency in how data is captured and used for reporting digital quality measures, CMS should publish a dedicated FHIR implementation guide that outlines standardized protocols for data extraction and submission. Aligning this guide with the Clinical Registry Extraction and Data Submission (CREDS) IG would help ensure consistency across registries and reporting systems. The current Quality Measure IG, built on FHIR R4, lacks the necessary support for key diagnostic imaging elements, making it insufficient for radiology-specific quality reporting.

MIPS Scoring Overview

Proposal
CMS proposes to extend the new topped out measure scoring policy, in which point-capped measures from certain "at-risk" measure sets are allowed to achieve up to 10 points, to MVPs.

ACR Comments and Perspective
The ACR supports CMS's proposal to extend this measure scoring policy to MVPs.

Proposal
CMS proposes to maintain the MIPS neutral performance threshold at 75 points through the 2028 performance year.

ACR Comments and Perspective
The ACR supports CMS's proposal to maintain the threshold at 75 points.

Proposal
CMS proposes to change the Total Per Capita Cost (TPCC) measure by refining how candidate events are identified and attributed. Specifically, the proposal would allow the exclusion of candidate events initiated by advanced practice providers (APPs) when all other non-APP clinicians within the same Tax Identification Number (TIN) are excluded based on existing specialty exclusion criteria.

ACR Comments and Perspective
The ACR strongly supports this proposal. Several radiology practices over recent years have been negatively affected by the misattribution of the TPCC measure. We are grateful CMS has proposed a remedy to this problem. Knowing this is a serious and correctable problem, we strongly urge CMS to make this policy retroactive for the 2025 performance year.

Conclusion

The ACR appreciates the opportunity to provide comments on the CY 2026 PFS 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 dialogue 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 Angela Kim at akim@acr.org.

Respectfully Submitted,

D Smetherman

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