

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

The Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2025 Medicare Physician Fee Schedule (MPFS) proposed rule on Wednesday, July 10, 2024. In this rule, CMS describes changes to payment provisions and to policies for the Medicare Shared Savings Program, Medicare Prescription Drug Inflation Rebate Program and Medicare Overpayments.

Conversion Factor and CMS Overall Impact Estimates

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

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

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

CMS is using statutory authority under the Balanced Budget Act of 1997 for the Secretary to add additional colorectal cancer screening tests and procedures to its definition of screening tests to propose coverage of CTC for Medicare beneficiaries. The rule points out that the U.S. Preventative Services Task Force (USPSTF) included CTC as a CRC screening method in their June 2016 revised Final Recommendation Statement and again in its May 2021 guideline update. CMS issued a non-coverage determination for CTC in 2009. If this proposal is finalized, CMS states that they will address and revise the current non-coverage policy for CTC.

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

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

Valuation of Imaging Services

CMS is proposing to accept the Relative Value Scale Update Committee (RUC) recommended values and physician times for radiology-related codes, including the six new MR Safety codes. CMS is, however, proposing practice expense (PE) refinements for the MR safety and CT Guidance Needle Placement codes.

Potentially Misvalued Services

Several codes related to radiology were publicly nominated as potentially misvalued:

- CPT code 27279 (*Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed and placement of transfixing device*), which has been re-nominated to request direct PE inputs in the non-facility setting.
- CPT Codes 10021 (*Fine needle aspiration biopsy, without imaging guidance; first lesion*), CPT code 10004 (*Fine needle aspiration biopsy, without imaging guidance; each additional lesion*), CPT code 10005 (*Fine needle aspiration biopsy, including ultrasound guidance; first lesion*) and CPT code 10006 (*Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion*) have been nominated several times in previous years. The nominator states that the methodology for reducing the work relative value units (RVUs) from the RUC-recommended values are flawed.

Clinical Labor Update

In 2022, CMS began its four-year phase in to update the pricing for the clinical labor staff. This is the final year of the phase-in of the updates, and with no new wage data submitted by stakeholders, CMS proposes to finalize the values previously established, by adding the last incremental price increase for CY 2025.

Practice Expense Data Collection/Methodology

CMS shared that the American Medical Association (AMA) expects to complete their new Physician Practice Information Survey (PPIS) analysis and document by the end of CY 2024 and will be sharing the data with CMS when it becomes available. However, CMS still feels it is important to consider challenges to the current PE methodology and to consider other alternatives to improve its stability and accuracy. CMS has started a new contract with RAND to analyze and develop possible alternatives. Additionally, CMS continues to ask for feedback from stakeholders about regular updates to PE inputs for supply and equipment costs with a four-year phase-in. They also want feedback on ways to account for inflation and deflation in supply and equipment costs.

Medicare Economic Index (MEI)

In CY 2023, CMS finalized the rebasing and revising the Medicare Economic Index (MEI). However, due to the AMA's practice expense data collection efforts and some stakeholder

concern about the redistributive impacts of the rebased and revised MEI, CMS decided to delay the implementation in 2023. For those same reasons, CMS is proposing once again not to incorporate the updated 2017-based MEI for CY 2025 at this time. The 2017 data relies primarily on the U.S. Census Bureau's Services Annual Survey (SAS), while the current 2006-based MEI relies on the AMA's 2006 PPIS data. The AMA is currently working on collecting updated PPIS data.

Drugs and Biological Products Paid Under Medicare Part B

Requiring Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts

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

Payment for Radiopharmaceuticals in the Physician Office

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

Medicare Shared Savings Program

As of January 1, 2024, the Medicare Shared Savings Program (MSSP) has 480 accountable care organizations (ACOs) with over 634,000 health care providers and organizations providing care to over 10.8 million assigned beneficiaries in the MSSP. CMS is proposing to allow eligible ACOs with a history of success in the program access to an advance on their earned shared savings, known as prepaid shared savings, to encourage investment in staffing, health care infrastructure, and additional services for people with Medicare, such as nutrition support, transportation, dental, vision, hearing, and Part-B cost-sharing reductions. Additionally, CMS is proposing to further incentivize participation in the MSSP by ACOs that serve people with Medicare who are members of rural and underserved communities by adopting a health equity benchmark adjustment similar to that in the Innovation Center's ACO REACH Model, which has been associated with increased safety net provider participation. CMS is also proposing to move the MSSP towards the Universal Foundation of quality measures, creating better quality measure alignment for providers and driving care transformation. Further, CMS is proposing a

methodology to account for the impact of improper payments when reopening an ACO's shared savings and shared losses calculations.

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

In the March 31, 2020, COVID-19 interim final rule with comment, 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, to allow the supervising professional to be immediately available through virtual presence using two-way, real-time audio/video technology, instead of requiring their physical presence. CMS has previously extended this flexibility through rulemaking, [supported](#) by the ACR. CMS acknowledges the utilization of this flexibility and recognized that many practitioners have stressed the importance of maintaining it, however CMS continues to seek additional information regarding potential patient safety and quality of care concerns.

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

Quality Payment Program (QPP)

Notably, the proposed rule includes significant changes to the scoring of the Merit-based Incentive Payment System (MIPS) Quality performance category, likely to benefit radiologists.

MIPS Value Pathways (MVPs)

In this proposed rule, CMS introduced a new request for information (RFI), building upon the MIPS Value Pathways (MVPs) Framework to Improve Ambulatory Specialty Care. This RFI invites public comment on the design of a future ambulatory specialty model. CMS is exploring this MVP to increase the engagement of specialists in value-based payment and encourage interaction with primary care providers. MIPS-eligible clinicians participating in this MVP would receive a payment adjustment according to their performance on a set of clinically relevant MVP measures and comparing the participant's final score against a limited pool of clinicians (other model participants of their same specialty type and clinical profile, who are also required to report on those same clinically relevant MVP measures).

CMS proposes developing MVPs based on existing Specialty Measure Sets for specialties that do not have MVP coverage. This approach would serve as a bridge until new measures are available to support the creation of individual MVPs for clinicians without an MVP specific to their specialty, patient populations served, or the primary conditions treated. Further, CMS is

researching the flexibilities found in the Act to develop new MVPs for clinicians eligible for non-patient-facing MIPS.

MIPS Scoring Overview

The category weights for the 2025 performance year will remain the same as the 2022 weights: **Quality – 30%, Cost – 30%, PI – 25%, and IAs – 15%**. These percentages will likely remain fixed for the future of the MIPS program. Previously established reweighting formulas for non-patient-facing clinicians and small practices are set to continue with no proposed changes. **CMS proposes maintaining the performance threshold at 75 points for 2025.** This figure is based on the rounded mean final score from the 2017 performance year. The same threshold was used in performance years 2023 and 2024.

CMS finalized the payment adjustment of +/- nine percent for performance years 2020 and beyond. No changes have been proposed to the MIPS adjustment. Additionally, CMS has proposed a new reweighting policy, which could potentially go into effect with the 2024 performance year. In this proposal, groups or individuals could request reweighting of a performance category if a third-party intermediary to whom they delegated the responsibility of submitting their MIPS data failed to submit their data within the required timeframe (p. 1185). CMS will maintain the small practice bonus of 6 points for the Quality performance category score and all previously finalized considerations for small practices.

Quality Category

CMS has proposed significant changes to the scoring of the Quality category to mitigate the difficulty that certain specialties—such as radiology—face due to the increasing number of measures being removed from the program or capped at seven points. Specifically, CMS has proposed eliminating the seven-point cap on measures deemed to come from specialty sets with a limited number of measures available. The proposal would include all the topped-out Diagnostic Radiology measures (360, 364, 405, and 406). CMS proposes an annual review to determine which topped-out measures should be given this scoring adjustment.

CMS notes in the proposed rule that the following measure was previously finalized for **removal**:

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

Measure #436 will be replaced with the following measure (#494), which was previously finalized for **addition** to the program in 2025:

- #494: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults
As previously finalized, the quality measure data completeness threshold will remain at 75% for 2025.

Improvement Activities

CMS has proposed simplifying the scoring of the Improvement Activities category by eliminating the weights associated with activities. Previously, activities were identified as either high-weight or medium-weight. With this new proposal, all activities would be weighted equally. Standard MIPS participants will be required to report two activities, while small, rural, and non-patient-facing clinicians and MVP participants will be required to report one activity.

CMS has also proposed adding a new Population Management Improvement Activity titled “Implementation of Protocols and Provision of Resources to Increase Lung Cancer Screening Uptake”.

Cost Performance Category

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

CMS published Fact Sheets on the overall [MPFS proposed rule](#), the [Quality Payment Program](#), the [Shared Savings Program](#) and a [Press Release](#).

ACR staff will review the entire MPFS proposed rule in the coming weeks and will provide a comprehensive summary of the rule. The ACR will also submit comments to CMS by the comment period deadline.