American College of Radiology™

September 11, 2026

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1848–P
P.O. Box 8016
Baltimore, MD 21244
Electronically submitted

Dear Administrator Dr. Oz:

The American College of Radiology (ACR), a professional medical specialty society representing over 41,000 physicians practicing diagnostic radiology, interventional radiology, radiation oncology, and nuclear medicine as well as medical physicists, appreciates the opportunity to submit comments on the Centers for Medicare and Medicaid Services (CMS) calendar year (CY) 2027 Payment Policies Under the Physician Fee Schedule (PFS) and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program.

ACR provides comments on the following important issues:

- Determination of Practice Expense (PE) Relative Value Units (RVUs)
- Updates to Prices for Existing Direct PE Inputs
- Updates to PE Methodology – Site of Service Payment Differential
- Efficiency Adjustment
- Procedures Subject to the Multiple Procedure Payment Reduction (MPPR) and the Outpatient Prospective Payment System (OPPS) Cap
- Accounting for Evaluation and Management (E/M) Resource Overlap Between Stand-Alone Visits and Global Periods
- High-Cost Disposable Supplies
- Valuation of Specific Codes for CY 2027
- Potentially Misvalued Services Under the PFS
- Current Procedural Terminology® (CPT®) Request for Information
- Request for Information on Duplicate Laboratory Testing, Imaging, and Result Sharing and Interoperability
- Changes to Primary Care and Care Management Due to Technology and Clinical Artificial Intelligence (AI)
- Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs)
- MVPs Scoring Methodology Request for Information

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- Proposals Directly Applicable to Third-Party Intermediaries (e.g., Qualified Clinical Data Registries (QCDRs) and Qualified Registries)
- Fast Healthcare Interoperability Resources® (FHIR)-Based Digital Quality Measurement in the Quality Payment Program and Other CMS Quality Programs - Request for Information
- MIPS Quality Performance Category

Determination of Practice Expense (PE) Relative Value Units (RVUs)

Proposal
PE RVUs are developed by considering both indirect practice costs such as administrative labor, office expenses, and other expenses, and direct practice costs such as clinical labor staff, medical supplies, and medical equipment per procedure.

In recent years, CMS contracted with RAND Corporation to review the PE methodology and consider alternative methods to improve its accuracy. For 2027, CMS proposes to:

- Use the same allocation methodology for all PFS services and to allocate indirect PE based on both the work RVU and the clinical labor RVU for all services except 010- and 090-day global services,
- Remove the steps in the current PE methodology that rely on the indirect practice cost index (IPCI) from the calculation of the PE RVUs and transition this change over two years,
- Apply a stabilization adjustment to the PE RVUs to reduce volatility by capping any increase or decrease to the PE RVUs at 5 percent each year, and
- Calculate the ratio of allowed charges to the national PFS payment amount for each paid claim line and use the same ratio to adjust time.

ACR Perspective and Comments
ACR appreciates that CMS continues to consider alternative methodologies to stabilize RVUs and reduce large swings in physician reimbursement. For CY 2027, however, CMS is proposing several different changes simultaneously. ACR believes it would be helpful to identify the impact of each proposed change individually and at the CPT code level.

For example, ACR is concerned about the impact on CPT code G0279 *(Diagnostic digital breast tomosynthesis, unilateral or bilateral (list separately in addition to 77065 or 77066)),* which has been subject to RVU reductions for the past several years. The PE RVU for the technical component of CPT code G0279 without the phase-in shows zero, which we strongly believe is incorrect. The value for CPT code G0279 was historically linked to CPT code 77063 *(Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure))*, began diverging in 2024, and now appears to be linked again in the proposed 2027 fully implemented file. ACR requests that CMS provide clarification on this issue.

The College wants to ensure that there is transparency about the potential impacts from the proposed changes to avoid unintended consequences for any specialty or code set. ACR requests that CMS publish a list of which codes receive the stability factor in each year. We agree that any large decreases should be phased in over time.

Updates to Prices for Existing Direct Practice Expense (PE) Inputs

Proposal
CMS proposes to update the price of nine supplies and two equipment items due to public submission of invoices. The following updated supply items are included in radiology codes:

Item Name	CMS Code	Current Price	Updated Price
Dorsal SI Joint Arthrodesis Implant	SD356	$11,500.00	$12,500.00
Varithena admin pack	SA125	$40.00	$55.00
Varithena (foam)	SA324	$3,195.00	$3,495.00

ACR Perspective and Comments
ACR supports the updated pricing for the *Dorsal SI Arthrodesis Implant (SD356)*, *Varithena admin pack (SA125), and Varithena (foam) (SA324).*

Updates to PE Methodology – Site of Service Payment Differential

Proposal
For CY 2026, CMS finalized a policy to allocate half the amount of indirect PE RVUs per work RVU for services furnished in the facility setting compared to those allocated to services in the non-facility setting. This shifted the indirect PE RVUs from the facility setting to the non-facility setting.

For CY 2027, CMS continues to examine its policy and consider additional refinements to the methodology. CMS is seeking comment on:

- Differences in PE costs for physicians and other professionals based not only on whether they practice in part or exclusively in a facility setting, but also on how their costs vary when they are employed by health systems, hospitals, or other entities.
- The amount of indirect PE incurred by hospital-employed physicians when they furnish care within a facility and the accuracy of the 50% indirect PE allocation.
- Whether and how to define and identify physicians and professionals who are employed by hospitals, health systems, or other entities to ensure the services they furnish are not inappropriately consuming PE RVUs that would be more appropriately assigned to services furnished by professionals incurring comparatively greater practice expenses.
- Whether a new Healthcare Common Procedure Coding System (HCPCS) modifier for employed physicians would be a reasonable way to identify and reduce facility PE from the services performed in the facility setting or if other methods should be considered.
- What primary variables should be considered to improve the data sources, allocation methodologies, and payment rates and best reflect the resources required for professionals and suppliers to furnish PFS services across different settings of care in a complex marketplace.

ACR Perspective and Comments
As we stated last year, ACR is concerned about the impact of this policy on physicians who staff hospitals, but also have a private office and do their own scheduling, which is typical for many interventional radiologists. **ACR recommends that CMS pause implementation of this policy**

until the agency has established a mechanism to identify and exclude office-based physicians who staff hospitals, perhaps with a G-code, or until additional information is available on the appropriateness of a 50% reduction.

Efficiency Adjustment

Proposal
For CY 2026, CMS implemented an efficiency adjustment of 2.5 percent to the work RVUs and physician intraservice time for non-time-based services. CMS will be applying an efficiency adjustment every three years.

For CY 2027, CMS clarified that refinements were made to Relative Value Scale Update Committee (RUC)-recommended values where the values were based on, or crosswalked to, pre-adjusted work RVUs. CMS stated that this only impacted a small number of codes reviewed for 2027.

ACR Perspective and Comments
ACR remains strongly opposed to the unilateral application of a 2.5% efficiency adjustment to all non-time-based procedures. We reiterate our belief that any adjustment to a code's time and value should be carefully considered and based on appropriate specialty-specific data. While there have been advancements in imaging technology, this does not necessarily translate into efficiency. For example, technological improvements may result in higher resolution images or a greater number of images, which would require more physician time for review and interpretation.

We are concerned that these continued payment reductions will harm practices and limit patient access to care across all specialties. ACR recommends that CMS pause this policy to thoroughly evaluate potential negative impacts on patient care and explore more targeted solutions for efficiency.

Procedures Subject to the Multiple Procedure Payment Reduction (MPPR) and the Outpatient Prospective Payment System (OPPS) Cap

Three new Magnetic Resonance Angiography (MRA) head and neck codes were identified by CMS as "imaging services" and are proposed for inclusion in their OPPS cap list.

CPT Code	Descriptor
70XX4	*Magnetic resonance angiography, head and neck, including image postprocessing; without contrast material(s)*
70XX5	*Magnetic resonance angiography, head and neck, including image postprocessing; with contrast material(s)*
70XX6	*Magnetic resonance angiography, head and neck; without contrast material(s) in one or both body regions, followed by contrast material(s) and further sequences in one or both body regions, including image postprocessing*

ACR Perspective and Comments
ACR agrees that it is appropriate for the three MRA head and neck codes, 70XX4, 70XX5, and 70XX6, to be on the MPPR list.

Accounting for Evaluation and Management (E/M) Resource Overlap Between Stand-Alone Visits and Global Periods

Proposal
CMS believes that there is likely a duplicative payment under the current PE methodology when the same physician provides an office/outpatient (O/O) E/M service for the same patient in conjunction with a procedure with a 0-, 10- or 90- day global period. Therefore, CMS is proposing to pay the most expensive service at 100 percent and reduce all other surgical procedure(s) or E/M visit(s) by 50 percent.

ACR Perspective and Comments
ACR does not support CMS's proposal to apply a 50 percent reduction in payment when a physician performs an O/O E/M on the same patient and day as a surgical procedure, which is identified through the application of modifier -25. To avoid duplicative reimbursement, any potential overlap in resources and time is already considered as part of the American Medical Association's (AMA's) RUC valuation process.

ACR is concerned that this proposal could have a negative impact on interventional radiologists and other physicians who work in independent, office-based practices. Interventional radiologists often perform separately identifiable E/M services on the same patient in the same day; this does not mean there is duplicative work. Appropriate coding and compliance can be addressed through continued education or medical review rather than a unilateral payment reduction on presumed duplication of work. We request that CMS not implement this policy and provide additional information to support the agency's proposed 50 percent payment reduction.

High-Cost Disposable Supplies

ACR Perspective and Comment
ACR continues to recommend that CMS create HCPCS codes to separately identify and reimburse for high-cost disposable supplies over $500. These supplies and their prices should be reviewed annually and updated appropriately.

As new technologies make more minimally invasive procedures available in physician office settings, Medicare payment must accurately reflect the significant costs of the required supplies. When the cost of a disposable device represents a substantial portion of the total payment, inadequate reimbursement can create challenges for physician practices and may unintentionally shift care to higher-cost hospital settings. Creating separate supply codes would improve transparency, allow CMS to more accurately track and update supply pricing, and help ensure that payment keeps pace with innovation. In addition, separate coding would provide greater oversight of these supplies and support more accurate, accountable reimbursement across care settings.

Valuation of Specific Codes for CY 2027

Fine Needle Aspiration (CPT codes 10005 and 10006)

CPT Code	Descriptor	Proposed CY 2027 Work RVU
10005	Fine needle aspiration biopsy, including ultrasound guidance; first lesion	1.35
10006	Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion	1.00

At the RUC's January 2026 meeting, two fine needle aspiration (FNA) biopsy codes with ultrasound guidance, 10005 and 10006, were re-reviewed at the request of a specialty society.

Proposal
CMS proposes to adopt the RUC-recommended work RVUs for both codes.

CMS proposes to accept the RUC-recommended PE inputs for CPT codes 10005 and 10006 but does not support increasing the price of the existing portable ultrasound equipment (EQ250). Instead, CMS proposes creating a new equipment item, Fine Needle Aspiration portable ultrasound (ER130), priced at $83,750, for use with CPT codes 10005 and 10006 at the recommended equipment times of 37 and 17 minutes, respectively.

ACR Perspective and Comment
ACR supports CMS's proposal to adopt the RUC-recommended work RVUs and PE modification for CPT codes 10005 and 10006. We also support CMS's proposal to create a new equipment item, Fine Needle Aspiration portable ultrasound (ER130).

Ablation Therapy – Bone Tumors (CPT code 209XX)

CPT Code	Descriptor	Proposed CY 2027 Work RVU
209XX	Ablation therapy for reduction or eradication of bone tumor, including adjacent soft tissue when involved by tumor extension, cryoablation, open	2.70

Proposal
In February 2025, the CPT Editorial Panel approved new Category I add-on code 209XX to describe cryoablation performed during an open surgical procedure after tumor resection, where remaining bone tissue is treated by freezing.

The code was initially reviewed at the April 2025 RUC meeting, where the specialty society recommended an interim value. It was subsequently resurveyed at the September 2025 RUC meeting, and revised recommendations were submitted to CMS.

CMS proposes to adopt the RUC-recommended work RVU for CPT code 209XX. The RUC did not recommend any direct PE inputs for this code.

ACR Perspective and Comment
ACR supports CMS's proposal to adopt the RUC-recommended work RVU of 2.70 for CPT code 209XX.

Intraosseous Fiducial Marker Placement (CPT codes 209X1 and 209X2)

CPT Code	Descriptor	Proposed CY 2027 Work RVU
209X1	Placement of localization marker(s) (e.g., fiducial marker[s]), intraosseous, percutaneous, including imaging guidance, when performed; first target site	3.00
209X2	Placement of localization marker(s) (e.g., fiducial marker[s]), intraosseous, percutaneous, including imaging guidance, when performed; each additional target site	1.76

Proposal
At the May 2025 CPT Editorial Panel meeting, two new CPT codes (209X1 and 209X2) were approved to report percutaneous intraosseous fiducial marker placement for the first site and each additional target site. The specialty societies noted that the codes describe existing services rather than new technology and were created to improve coding specificity.

CMS proposes to adopt the RUC-recommended work RVUs and direct PE inputs for both codes without refinement.

ACR Perspective and Comment
ACR supports CMS's proposal to adopt the RUC-recommended work RVUs and PE inputs for CPT codes 209X1 and 209X2.

Sacroiliac (SI) Joint Arthrodesis (CPT codes 27278 and 27279)

CPT Code	Descriptor	Proposed CY 2027 Work RVU
27278	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive, including imaging guidance, unilateral; placement of intra-articular structural bone graft, metal and/or synthetic device(s) without cortical piercing, including use of osteopromotive material and/or obtaining bone graft, when performed	7.66
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive, including imaging guidance, unilateral; placement of transarticular and/or intra-articular device(s) that engage bone with intrinsic fixation (e.g., screw[s], flange[s], blade[s]) piercing the lateral cortex of the sacrum and	11.00

	the medial cortex of the ilium (with or without piercing the lateral cortex of the ilium), including use of osteopromotive material and/or obtaining bone graft, when performed	

Proposal
At the May 2025 CPT Editorial Panel meeting, CPT codes 27278 and 27279 were revised to more clearly differentiate minimally invasive SI joint arthrodesis techniques based on whether the implanted device involves cortical piercing. The revised code descriptors were subsequently reviewed at the September 2025 RUC meeting.

CMS proposes to adopt the RUC-recommended work RVUs and direct PE inputs for both codes without refinement.

ACR Perspective and Comment
ACR supports CMS's proposal to adopt the RUC-recommended work RVUs and PE inputs for CPT codes 27278 and 27279.

Treatment of Incompetent Veins (CPT codes 36470, 36471, 36465, 36466, 36473, and 36474)

CPT Code	Descriptor	Proposed CY 2027 Work RVU
36465	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (e.g., great saphenous vein, accessory saphenous vein)	2.29
36466	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (e.g., great saphenous vein, accessory saphenous vein), same leg	2.62
36470	Injection of sclerosant; single incompetent vein (other than telangiectasia)	0.73
36471	Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg	1.18
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	3.41
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites	1.71

Proposal
In April 2025, the Relativity Assessment Workgroup (RAW) flagged CPT code 36465 for review due to Medicare utilization exceeding 10,000 services and increasing by more than 100% between 2018 and 2023. The RUC subsequently reviewed CPT code 36465 and its related

sclerosant and mechanochemical ablation codes (36466, 36470, 36471, 36473, and 36474) at the January 2026 meeting.

CMS proposes to adopt the RUC-recommended work RVUs for five of the six codes in this family. For CPT code 36466, however, CMS disagrees with maintaining the current work RVU of 2.93 given decreases in physician time and instead proposes a crosswalk to CPT code 57156, resulting in a proposed work RVU of 2.62.

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

ACR Perspective and Comment

ACR supports CMS's proposed work RVUs and PE inputs for CPT codes 36465, 36470, 36471, 36473, and 36474.

For CPT code 36466, ACR recommends maintaining the current work RVU of 2.93. The code descriptor has not changed, but the typical patient and corresponding vignette were updated to reflect current practice. The current survey reported five fewer minutes of intra-service time; however, the specialty societies explained that the previous vignette contained internal inconsistencies that may have affected how respondents assessed the service and limited the usefulness of a direct comparison.

The prior vignette identified insufficiency in the great and small saphenous veins, but the procedure description referenced treatment of the great and anterior accessory saphenous veins. Since physicians would not typically treat a vein without documented reflux, respondents may have been uncertain which veins they were intended to value. As a result, the prior survey findings are not directly comparable to the current survey data. Therefore, the reduction in service time alone does not justify a lower valuation, and the work RVU of 2.93 should be maintained.

Moreover, CPT code 57156 is not an appropriate crosswalk for CPT code 36466. Placement of a vaginal radiation afterloading apparatus is not clinically comparable to venous ablation and does not involve the same level of physician work, procedural intensity, technical skill, or clinical risk. Unlike CPT code 57156, CPT code 36466 requires intravascular treatment and carries risks such as hemorrhage, deep vein thrombosis, and pulmonary embolism. ACR supports maintaining the current work RVU of 2.93 for CPT code 36466, consistent with the RUC recommendation.

<u>Prostate Biopsy Services (CPT codes 55705, 55707, 55708, 55709, 55710, 55711, 55712, 55714, and 55715)</u>

CPT Code	Descriptor	Proposed CY 2027 Work RVU
55705	Biopsy, prostate, any approach, non-imaging guided	1.88
55707	Biopsy, prostate, transrectal, including imaging guidance, regional	2.63

55708	Biopsy, prostate, transrectal, including imaging guidance, regional and fusion-targeted lesion(s)	3.39
55709	Biopsy, prostate, transperineal, including imaging guidance, regional	3.23
55710	Biopsy, prostate, transperineal, including imaging guidance, regional and of fusion-targeted lesion(s)	3.81
55711	Biopsy, prostate, transrectal or transperineal, including imaging guidance, fusion-targeted lesion(s) without regional; first targeted lesion	2.37
5XX14	Biopsy, prostate, transrectal or transperineal, including imaging guidance, fusion-targeted lesion(s) without regional; each additional targeted lesion (List separately in addition to code for primary procedure)	0.68
55714	Biopsy, prostate, including imaging guidance, in-bore CT- or MRI-guided; first targeted lesion	3.62
55715	Biopsy, prostate, including imaging guidance, in-bore CT- or MRI-guided; each additional targeted lesion (List separately in addition to code for primary procedure)	1.80

Proposal
This prostate biopsy family of codes was identified through the April 2022 RAW review and restructured by CPT for 2027. CMS proposes to adopt the RUC-recommended work RVUs for eight of the nine codes but disagrees with the recommendation for CPT code 5XX14. Based on a crosswalk to CPT code 93567 *(Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supravalvular aortography (List separately in addition to code for primary procedure)),* CMS proposes 0.68 RVUs (instead of 0.80 RVUs) to maintain relativity with similarly timed services.

CMS proposes to accept the RUC-recommended direct PE inputs for all nine codes without refinement.

ACR Perspective and Comment
ACR supports CMS's proposed work RVUs and PE inputs for codes 55705, 55707, 55708, 55709, 55710, 55711, 55714, and 55715.

CMS proposes a work RVU of 0.68 for add-on code 5XX14 based on concerns that the reported service time results in a higher intensity than comparable services, ACR, however, believes that CMS's proposal understates the work involved. CPT code 5XX14 appropriately captures the physician work required to identify, target, and biopsy each additional magnetic resonance imaging (MRI) fusion-guided lesion, including both imaging and tissue acquisition. CMS's proposal of 0.68 work RVU values CPT code 5XX14 nearly the same as CPT code 76872 *(Ultrasound, transrectal;))*, which has 0.65 RVU. CPT code 76872 is an imaging code, while the work of CPT code 5XX14 involves both imaging and biopsy work. As a result, a work RVU of 0.68 for CPT code 5XX14 would create a rank order anomaly with the code family.

The RUC also noted that intensity comparisons between codes with short procedure times can be misleading and may not accurately reflect the complexity of the service. For these reasons, ACR continues to support the RUC-recommended work RVU of 0.80.

Percutaneous Lumbar Decompression (CPT code 62287)

CPT Code	Descriptor	Proposed CY 2027 Work RVU
62287	Decompression, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle-based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar	6.23

Proposal
CPT code 62287 was initially recommended for deletion but was ultimately retained after additional utilization review and stakeholder feedback. CMS disagrees with the RUC-recommended 7.06 work RVU. CMS instead proposes 6.23 RVUs for CPT code 62287 based on a crosswalk to CPT code 46707 *(Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS]))*, citing reduced physician work time without evidence of increased intensity.

CMS proposes to accept the RUC-recommended direct PE inputs without refinement.

ACR Perspective and Comment
CMS proposes a work RVU of 6.23 for CPT code 62287 based on a crosswalk to CPT code 46707. ACR does not believe this comparator accurately reflects the complexity, technical skill, and risk associated with an image-guided spinal procedure. CPT code 62287 is a complex procedure involving an anatomic region surrounded by vasculature and nerves and requiring precision, while CPT code 46707 pertains to repair of an anal fistula, which is a more superficial procedure.

ACR disagrees that the reduction in procedure time alone justifies a lower value, as the physician work remains unchanged. Although the same amount of work is now performed more efficiently (in a shorter amount of time), the procedure now requires greater intensity, mental effort, and judgment, which supports the 7.06 work RVU. CMS's proposed value of 6.23 work RVU is also well below the survey 25th percentile and does not maintain relativity within the code family. Given the intensity of the service and its relativity to comparable spinal procedures, ACR continues to support a work RVU of 7.06 for CPT code 62287.

MRA – Head, Neck (CPT codes 70544, 70545, 70546, 70547, 70548, 70549, 70XX4, 70XX5, and 70XX6)

CPT Code	Descriptor	Proposed CY 2027 Work RVU
70544	Magnetic resonance angiography, head, including image postprocessing; without contrast material(s)	1.17
70545	Magnetic resonance angiography, head, including image postprocessing; with contrast material(s)	1.17

70546	Magnetic resonance angiography, head, including image postprocessing; without contrast material(s), followed by contrast material(s) and further sequences	1.44
70547	Magnetic resonance angiography, neck, including image postprocessing; without contrast material(s)	1.17
70548	Magnetic resonance angiography, neck, including image postprocessing; with contrast material(s)	1.46
70549	Magnetic resonance angiography, neck, including image postprocessing; without contrast material(s), followed by contrast material(s) and further sequences	1.76
70XX4	Magnetic resonance angiography, head and neck, including image postprocessing; without contrast material(s)	1.77
70XX5	Magnetic resonance angiography, head and neck, including image postprocessing; with contrast material(s)	2.10
70XX6	Magnetic resonance angiography, head and neck; without contrast material(s) in one or both body regions, followed by contrast material(s) and further sequences in one or both body regions, including image postprocessing	2.23

Proposal
The MRA head and neck code family was first identified by the RAW in 2022 due to the increasing reporting of CPT codes 70544 and 70547 together. Following a two-year monitoring period during which the billing pattern persisted, the codes were reviewed again in 2024. In September 2025, the six existing MRA head and MRA neck codes were revised, and three new bundled codes for MRA head and neck were created.

CMS proposes to adopt the RUC-recommended work RVUs and direct PE inputs for all nine codes without refinement.

ACR Perspective and Comment
ACR supports CMS's proposal to adopt the RUC-recommended work RVUs and PE for these nine MRA head and neck services.

Computed Tomography-Upper Extremity with Contrast (CPT codes 73200, 73201, and 73202

CPT Code	Descriptor	Proposed CY 2027 Work RVU
73200	Computed tomography, upper extremity; without contrast material	1.00
73201	Computed tomography, upper extremity; with contrast material(s)	1.16
73202	Computed tomography, upper extremity; without contrast material, followed by contrast material(s) and further sections	1.24

Proposal
In April 2025, the RAW flagged CPT code 73201 for review due to high Medicare utilization identified through the CMS/Other source and 2023 Medicare utilization over 20,000 screen. As a result, the entire CT upper extremity family, including CPT codes 73200 and 73202, was surveyed for the January 2026 RUC meeting.

CMS proposes to adopt the RUC-recommended work RVUs and direct PE inputs for all three codes without refinement.

ACR Perspective and Comment
ACR supports CMS's proposal to adopt the RUC-recommended work RVUs and PE inputs for CPT codes 73200, 73201, and 73202.

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

CPT Code	Descriptor	Proposed CY 2027 Work RVU
77402	Radiation treatment delivery; Level 1 (e.g., single-electron field, multiple-electron fields, or 2D photons), including imaging guidance, when performed	0.00
77407	Radiation treatment delivery; Level 2, single-isocenter (e.g., 3D or IMRT) photons, including imaging guidance, when performed	0.00
77412	Radiation treatment delivery; Level 3, multiple isocenters with photon therapy (e.g., 2D, 3D, or IMRT) or a single-isocenter photon therapy (e.g., 3D or IMRT) with active motion management, or total skin electrons, or mixed electron/photon field(s), including imaging guidance, when performed	0.00

Proposal
In the CY 2026 PFS final rule, CMS finalized its proposal to use the relationship between the OPPS Ambulatory Payment Classifications (APC) relative weights for APCs 5621, 5622, and 5623 to value the PE-only radiation treatment delivery codes, 77402, 77407, and 77412. Since CY 2026, stakeholders have reported that CMS has overestimated the actual utilization of CPT code 77412.

Following review of early 2026 claims data showing that CPT 77412 accounted for only about 18% of utilization (instead of the estimated 35%), CMS proposes to refine the relativity within this family. For CY 2027, CMS has proposed revaluing the PE RVUs using the observed distribution of services, such that the PE and malpractice (MP) RVUs for these services represent the same share of total PE and MP RVUs as they did in CY 2025.

ACR Perspective and Comment
ACR strongly supports CMS's initiative to address long-standing valuation and coding distortions for radiation treatment delivery codes (CPT 77402, 77407, and 77412) and

appreciates basing payment policy on actual claims data rather than legacy utilization assumptions.

Because CMS calculates PE RVUs for these PE-only codes based on the relationship between OPPS APC relative weights (APCs 5621, 5622, and 5623), underlying hospital outpatient rate-setting anomalies are being imported directly into the PFS. Under the restructured code set, technique alone does not dictate code selection. Instead, billing is determined by clinical complexity, treatment area, number of targets, differential doses delivered, and patient-specific characteristics. Under Section 1848(c)(2)(B) of the Social Security Act, adjustments must maintain statutory budget neutrality. Correcting the utilization denominator for CPT 77412 from CMS's overstated 35% assumption down to the observed ~18% frees up RVUs within the radiation delivery service pool. This utilization correction provides the exact budgetary space needed within the existing radiation oncology PE allocation to properly recalibrate CPT 77407 without destabilizing the broader PFS budget neutrality equation.

While CMS adopted an OPPS-derived APC crosswalk as an administrative proxy to establish PE RVUs, CMS retains an independent statutory obligation under Title XVIII § 1848(c)(1)(B) of the Social Security Act to ensure PFS payments accurately reflect non-facility direct practice expenses. Relying on unrefined OPPS claims that blend legacy simple/intermediate delivery with modern multi-target Intensity-Modulated Radiation Therapy (IMRT) systematically depresses the recognized costs of freestanding linear accelerator capital, physics quality assurance, and specialized clinical labor and fails this statutory standard. Using an OPPS relative weight proxy does not relieve the agency of its duty to ensure non-facility direct PE inputs reflect actual freestanding delivery costs.

Historically, the deleted IMRT delivery codes (77385 and 77386) were assigned to APC 5623 (Level 3 Radiation Therapy) and reflect the true clinical complexity and practice expense profile now encompassed by revised code 77407. ACR joins colleagues across the radiation oncology community, including American Society for Radiation Oncology (ASTRO) and American Society for Radiation Oncology (ACRO), in emphasizing that CPT code 77407 requires reimbursement aligned with APC 5623-level resource intensity. To achieve this while maintaining clear distinctions across all three delivery tiers, CMS can readily adopt ACRO's mathematical recalibration crosswalk or implement the payment remedies advanced by ASTRO. Both approaches address the underlying cost-allocation anomalies inherited from legacy OPPS claims and preserve rational relativity across the code family.

ACR has conferred closely with our specialty colleagues at both ASTRO and ACRO, and all organizations agree that relying on unadjusted, legacy OPPS cost distributions will irreparably harm freestanding cancer centers. To provide CMS with actionable, consensus-driven solutions, ACR strongly urges the agency to adopt these specialty-developed recalibration remedies across both the OPPS and PFS rules to ensure final rates establish equitable, stable reimbursement for conventional photon delivery. Finally, CMS should utilize the most complete 2026 claims data available at the time of final rulemaking to support an accurate recalibration.

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

CPT Code	Descriptor	Proposed CY 2027 Work RVU
77520	Proton treatment delivery; simple, without compensation	0.00
77522	Proton treatment delivery; simple, with compensation	0.00
77523	Proton treatment delivery; intermediate	0.00
77525	Proton treatment delivery; complex	0.00

Proposal
For codes 77520, 77522, 77523, and 77525, payment is currently determined by local Medicare Administrative Contractors (MACs) rather than at the national level. Concerns have been raised about the geographic payment disparities in contractor pricing, however. As a result, interested parties have urged CMS to nationally price these services.

CMS is proposing to calculate the PE RVUs for these services by:

- Using the total allowed charges paid by the MACs for these services to establish the pool of PE RVUs to allocate to the services in this family.
- Allocating PE RVUs to the individual services using the relationship between the APC relative weights for APCs 5625 (to which CPT codes 77522, 77523, and 77525 are assigned) and APC 5623 (to which CPT code 77520 is assigned) under the OPPS.

ACR Perspective and Comment
ACR appreciates CMS's efforts to develop a more consistent, transparent payment approach for proton beam treatment delivery services. Given the significant equipment, infrastructure, and staffing resources required to furnish proton therapy, ACR agrees that alternative valuation approaches may be appropriate when traditional practice expense methodologies do not fully reflect the costs of providing these services.

However, ACR is concerned that CMS has not provided sufficient information for stakeholders to fully evaluate the proposal. Without proposed RVUs or payment rates, it is difficult to assess whether the methodology would accurately reflect the resources required for proton beam therapy.

While ACR supports CMS's goal of establishing a more predictable national payment methodology, additional analysis and stakeholder input may be warranted before implementation. Any final approach should be transparent and ensure appropriate and stable reimbursement to facilitate continued patient access to these highly specialized cancer treatment services.

Potentially Misvalued Services Under the PFS

Proposal
For CY 2027, CMS received 15 nominations for potentially misvalued codes, with one of them pertaining to radiation oncology.

Image-guided Robotic Linear Accelerator Stereotactic Radiosurgery (HCPCS code G0339 and G0340)

CPT Code	Descriptor
G0339	Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment
G0340	Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment

During the September 2025 RAW meeting, the submitted action plan recommended deletion of HCPCS codes G0339 and G0340 because CPT code 77373 (*Stereotactic body radiation therapy, treatment delivery, per fraction to one or more lesions, including image guidance, entire course not to exceed five fractions*) was identified as an available code for reporting these services.

Medicare claims data showed that G0339 and G0340 continued to be used frequently, however, with approximately 3,000 and 12,000 claims, respectively, submitted in 2024. Based on this utilization, CMS believes the G-codes should be maintained to avoid disrupting current billing practices.

The RAW plans to review an action plan for these codes at the September 2026 RUC meeting. If the codes are not deleted for CY 2027, CMS welcomes additional information from the RUC regarding the most appropriate coding and payment methodology for these services.

ACR Perspective and Comment
While ACR initially recommended the deletion of CPT code G0339 and G0340, we agree with CMS's assertion that deleting the codes now could disrupt current billing and coding practices. Given that many radiation oncology procedures have been recently linked to OPPS rates, ACR recommends that CMS maintain the G-codes and use OPPS data to determine PE RVUs for stereotactic radiosurgery and stereotactic body radiation therapy services.

Current Procedural Terminology® (CPT®) Request for Information (RFI)

Proposal
CMS's CPT RFI seeks stakeholder feedback on the role of the CPT code set and the AMA RUC in Medicare physician payment policy. CMS is requesting input on potential challenges associated with the current CPT-based framework, including its impact on innovation, coding development, payment accuracy, primary care valuation, and administrative burden. The agency is also exploring whether alternative coding systems or valuation approaches could better support Medicare's goals of transparency, competition, prevention-focused care, and accurate resource-based payment. The RFI presents an opportunity for stakeholders to provide feedback on the strengths of the current CPT process, identify areas for improvement, and offer recommendations regarding future coding and payment methodologies.

ACR Perspective and Comment
ACR appreciates CMS's ongoing interest in evaluating the CPT coding system and the AMA RUC process. For many years, CPT has provided a standardized framework for reporting physician services and supporting accurate billing, data collection, quality measurement, and patient access to care.

ACR believes CPT remains the most effective mechanism for describing physician services. We have significant concerns about the operational and administrative challenges that would accompany the use of ICD-10-PCS for physician payment. In addition, the RUC survey process continues to provide the most practical and broadly applicable source of physician work and resource data across specialties, helping to preserve relativity and support accurate valuation of services. The CPT Editorial Panel and RUC bring together physicians and specialty societies with extensive clinical expertise to help ensure that new and evolving services are appropriately recognized and valued.

While there may be opportunities to enhance transparency and continue strengthening the data and methodologies used in the valuation process, the existing framework has provided a stable, consistent, and adaptable foundation that serves patients, physicians, and payers alike. We encourage careful evaluation of any proposed changes to ensure that the benefits of the current system are maintained and that transitions can occur smoothly for all stakeholders.

Request for Information on Duplicate Laboratory Testing, Imaging, and Result Sharing and Interoperability

Proposal
CMS issued this RFI to seek feedback about the inaccessibility of diagnostic imaging and lab test results within another system's electronic health record, which can result in duplicated tests. The agency "view[s] duplicate imaging and laboratory testing as one of several use cases in which the lack of clinical interoperability causes non-trivial beneficiary harm and program integrity concerns." CMS requests responses from clinicians, laboratories, imaging health care providers, health systems, payers, health information technology (IT) developers, and others about potential enforcement of frequency limitations and changes to payment policies, among other questions.

ACR Perspective and Comment
ACR strongly supports CMS's goal of reducing avoidable duplicate imaging and has long advocated for improved electronic exchange of diagnostic-quality images across healthcare systems. Through the ACR-led 2019 #DitchTheDisc campaign with the Radiological Society of North America (RSNA) and industry partners, the College has promoted standards-based electronic image exchange to improve access to prior examinations, reduce unnecessary repeat imaging and radiation exposure, and lower costs. ACR has also repeatedly urged the Department of Health and Human Services (HHS) and Congress to advance national image-sharing standards, interoperability requirements, and health IT certification policies that include imaging rather than focusing solely on electronic health record (EHR)-based clinical data. CMS should prioritize ensuring interoperability solutions before adopting payment edits or frequency limits

that could inadvertently penalize clinically necessary repeat imaging when prior examinations are unavailable at the point of care.

Changes to Primary Care and Care Management Due to Technology and Clinical Artificial Intelligence (AI)

Request for Information

CMS is exploring the use of artificial intelligence (AI) technology throughout primary care and indicates the agency would like to better understand that usage. CMS is seeking comments on how to develop a comprehensive and consistent approach to payment for technology-enabled care and poses specific questions for feedback. CMS requests information on clinical AI tools and new technologies that are being used in primary care settings.

ACR Perspective and Comment

As noted by CMS, many healthcare practices around the country use Clinical Decision Support (CDS) tools to make the most appropriate treatment decisions at the time of care. In the context of imaging, CDS systems communicate physician-developed Appropriate Use Criteria (AUC) information specific to a patient's clinical condition during the patient's workup. In addition, the CDS tool provides the ordering professional with real time feedback about whether an imaging order adheres to AUC and can also guide the clinician to a more appropriate imaging study (if imaging is actually needed). As a result, CDS tools can serve as an educational resource for providers and help promote movement towards value-based care.

A key facet of an imaging AUC program is its use of physician-developed, transparent, evidence-based criteria in CDS ordering systems to guide providers in determining a patient's imaging needs. By reducing unnecessary care and ensuring that the imaging services performed are warranted and appropriate, AUCs can also improve delays in access to care.

A 2020 observational study of over 200,000 providers and more than 7 million imaging requisitions across 288 United States healthcare institutions showed that increasing provider exposure to AUC via a CDS tool is associated with improved appropriateness scores for advanced imaging requisitions.[1]

With increasing radiologist shortages, reports of delays in interpretation due to capacity constraints are increasingly common in recent years. A March 2026 study from the Harvey L. Neiman Health Policy Institute found that the time between an imaging scan and its interpretation for office/hospital outpatient imaging increased 113% between 2014 and 2023.[2] A follow-up study in August 2026 showed a continuation of this trend. Extending the Medicare claims analysis through 2024 with data released this year, the authors found that turnaround

[1] Chepelev LL, Wang X, Gold B, et al. **Improved Appropriateness of Advanced Diagnostic Imaging After Implementation of Clinical Decision Support Mechanism.** *Journal of Digital Imaging. 2021;34(2):397-403.*

[2] Christensen EW, Drake AR, Rula EY, et al. **National Turnaround Time Trends for Medicare Fee-for-Service Beneficiaries, 2014-2023.** *Journal of the American College of Radiology.* 2026;23(7):1244-1252. DOI: 10.1016/j.jacr.2026.02.038.

times increased 177% over the 2014-2024 period with 92% of that increase occurring in the 2022-2024 period.[3]

Utilizing CDS systems integrated with AUC reduces inappropriate imaging, improves health outcomes, supports decision making, fosters an educational environment for providers, and results in cost savings. ACR has long been a proponent of optimizing patient care to ensure patients get the right imaging at the right time - even if that means no imaging is needed. To that end, we supported section 218 of the Protecting Access to Medicare Act of 2014 (PAMA), which requires ordering clinicians to consult AUC (a type of physician-developed clinical practice guideline) via a clinical decision support mechanism (CDSM) prior to ordering advanced diagnostic imaging services (ADIS) in Medicare Part B.

CMS made substantial operational and regulatory progress toward implementing the PAMA AUC program and built program infrastructure via notice-and-comment rulemaking between 2015 and 2020. The major components of the program, such as defining the scope of imaging subject to AUC, delineating and approving "Provider-Led Entities" (PLEs) to develop AUC content, and qualifying multiple CDSMs that integrated AUC into electronic ordering systems and EHRs were established. Although most of the substantive policy design was completed, in the CY 2024 Medicare Physician Fee Schedule (PFS) Final Rule, CMS placed an indefinite pause on implementation of the AUC program due to difficulties implementing the real-time claims processing component. In the same final rule, CMS acknowledged the value of the program both to the patient and Medicare via savings, supported statutory change to enable full implementation, and reserved the related regulations for future use.

Technology has far surpassed what was readily available in 2014, and ACR believes CMS should leverage the existing regulations currently reserved for future use and modernize the AUC program. Given the major hurdle preventing full implementation was the "real- time claims processing" obligation, this component should be replaced with an ordering provider's attestation of "conferring/reviewing" qualified AUC. CMS estimates that the utilization of AUC could lead to potential annual savings of $700 million annually to the Medicare program.

Updating and modernizing the AUC program are consistent with the Trump administration's focus on eliminating waste, fraud, and abuse by reducing unnecessary volume and associated costs while ensuring Medicare beneficiaries receive the benefit of advances in technology in the healthcare delivery system. The changes outlined above will ensure the AUC program can evolve with technology and improve patient care for generations to come.

[3] Drake, Alexandra R., Yuan, Cindy X., Wald, Christoph, Nicola, Gregory N., Johnson, Michele H., Rula, Elizabeth Y., and Christensen, Eric W. **"National Turnaround Time Trends for Medicare Fee-for-Service Beneficiaries: Updated Through 2024."** *Journal of the American College of Radiology*. Published online August 4, 2026. Article number S1546-1440(26)00333-9. DOI: **10.1016/j.jacr.2026.06.015**.

Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs)

Proposal
CMS proposes to include ACR's Qualified Clinical Data Registry (QCDR) measure, ACRad 34: *Overall Percent of CT Exams for which Dose Length Product is at or below the Size-Specific Dose Reference Level in the Diagnostic Radiology* MVP for the 2027 performance year.

ACR Perspective and Comments
ACR applauds CMS's proposal to include ACRad 34 in the Diagnostic Radiology MVP for 2027 MIPS reporting. This measure addresses a fundamental aspect of radiology quality and patient safety by assessing whether CT examinations are performed at radiation doses at or below established size-specific diagnostic reference levels. Since radiologists are directly responsible for CT protocol development, dose optimization, and imaging quality oversight, the measure is clinically meaningful, appropriately attributable to the specialty, and aligned with CMS's goals of advancing patient safety and reducing unwarranted variation in care.

ACR also supports the measure's inclusion because it may be implemented through existing radiology quality infrastructure, minimizing reporting burden while promoting meaningful performance improvement. In anticipation of broader adoption, ACR worked throughout 2026 to make ACRad 34 available for licensing by several QCDRs. While the measure was previously reportable only through ACR's registry, beginning in 2027, additional QCDRs are expected to implement the measure using licensed specifications that include the size brackets and diagnostic reference levels necessary to calculate performance.

Proposal
CMS proposes a new Improvement Activity, IA_AHW_XX, *Clinician Use of Artificial Intelligence (AI) to Improve Patient Care*, beginning with the CY 2027 performance period. The activity would recognize clinicians who establish policies and processes to evaluate, implement, and monitor AI-enabled tools used in clinical practice or who participate in developing and refining AI-enabled resources. Qualifying uses may include AI-assisted clinical decision support, documentation with clinician review, workflow support, and other applications intended to improve the quality, safety, efficiency, or coordination of patient care.

ACR Perspective and Comments
ACR supports this proposed Improvement Activity and strongly urges CMS to include IA_AHW_XX in the Diagnostic Radiology MVP. AI is already integrated into many radiology workflows, including image acquisition and reconstruction, worklist prioritization, detection and characterization of findings, clinical decision support, reporting, communication of actionable findings, and quality assurance. Because radiologists directly evaluate, implement, monitor, and improve these tools, the activity is clinically relevant and attributable to diagnostic radiology practice.

Including IA_AHW_XX would provide radiology practices with a meaningful Improvement Activity option that reflects current clinical practice while encouraging responsible AI governance. CMS should permit participation through documented policies and processes for pre-deployment evaluation; validation for the intended clinical setting and patient population;

clinician oversight; ongoing monitoring of performance and safety; review of workflow and patient-care impacts; and mechanisms to identify and address errors, bias, or unintended consequences. The activity should remain flexible enough to apply across practice sizes, settings, and AI use cases and should not require a practice to purchase or deploy a particular product. **Accordingly, ACR requests that CMS finalize IA_AHW_XX and add it to the Improvement Activities inventory for the Diagnostic Radiology MVP beginning with the 2027 performance year.**

Proposal

CMS proposes to adopt MVPs as the primary MIPS reporting path and retire traditional MIPS reporting beginning with the CY 2029 performance period/2031 MIPS payment year. Under the proposal, CY 2028 would be the final year clinicians could report through traditional MIPS, after which most MIPS-eligible clinicians would be expected to participate through an MVP. CMS describes this transition as part of its effort to move away from broad, menu-based reporting and toward more focused specialty- and condition-based pathways that organize quality measures, cost measures, Improvement Activities, and Promoting Interoperability requirements into cohesive reporting options.

In addition to CMS's proposals to include three new MVPs for the 2027 MIPS performance year (1. Diabetic Disease MVP, 2. Hypertension MVP, and 3. Hospitalist MVP), the agency also proposes to introduce the following measures to the Diagnostic Radiology MVP, under a new Nuclear Medicine clinical grouping:

- Q282*: Dementia: Functional Status Assessment*: This MIPS quality measure focuses on the importance of ensuring that patients diagnosed with dementia receive a comprehensive functional assessment annually.
- Q286*: Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia*: This MIPS quality measure aims to address safety concerns in patients diagnosed with dementia by ensuring that appropriate screening and follow-up actions are conducted.
- Q288: *Dementia: Education and Support of Caregivers for Patients with Dementia:* This MIPS quality measure focuses on the importance of providing education and support to caregivers of patients with dementia.
- Q386: *Amyotrophic Lateral Sclerosis (ALS) Patient Care Preferences*: This MIPS quality measure focuses on the importance of addressing end-of-life care preferences for patients diagnosed with ALS.

ACR Perspective and Comments

ACR appreciates CMS's continued efforts to make MIPS participation more clinically meaningful through MVPs and recognizes the importance of developing specialty-specific pathways that better reflect the care radiologists deliver. However, the proposed timeline to sunset traditional MIPS heightens the importance of ensuring that all radiology practices, including diagnostic radiology, interventional radiology, nuclear medicine, breast imaging, and other subspecialized practices, have meaningful and feasible MVP participation options before traditional MIPS is retired.

ACR, therefore, urges CMS not to finalize the sunset of traditional MIPS until it can demonstrate that MVPs offer meaningful, specialty-relevant, and operationally feasible reporting options for the full range of radiology clinicians and practices.

Radiology is highly subspecialized. Barriers remain when MVP measures do not align with clinicians' scope of practice, cost measures are not attributable, or non-patient-facing clinicians lack control over interoperability requirements. CMS should **maintain traditional MIPS until radiology MVPs include adequate specialty- and subspecialty-specific measures, appropriate Improvement Activities, and clear approaches for the Cost and Promoting Interoperability categories reweighting.**

ACR supports continued collaboration with CMS to refine the Diagnostic Radiology MVP to include measures that accurately reflect the contributions of radiologists and nuclear medicine physicians to patient care. However, **ACR is concerned that including MIPS Quality Measures Q282, Q286, Q288, and Q386 in the Diagnostic Radiology MVP's Nuclear Medicine clinical grouping demonstrates a misunderstanding of diagnostic radiology's role in dementia and ALS management. These measures do not align with radiology practice and should not be included in the scope of practice for diagnostic radiologists and nuclear medicine physicians.**

These measures focus on longitudinal patient management activities such as functional assessment, safety screening, and caregiver education - responsibilities primarily managed by neurologists, geriatricians, primary care physicians, and multidisciplinary teams. Diagnostic radiologists and nuclear medicine physicians primarily perform and interpret imaging studies and have little meaningful control over these aspects of patient care. Including these measures risks inappropriate attribution and requires radiologists to report on activities outside their clinical responsibilities.

In addition, expecting QCDRs that support the Diagnostic Radiology MVP to also support these additional measures is inappropriate. These measures are not aligned with radiology workflows or data capture and would impose unnecessary operational burden without advancing the purpose of a radiology-focused MVP.

CMS has consistently emphasized the importance of selecting quality measures that are meaningful, clinically relevant, and attributable to the clinicians being evaluated. In this context, ACR requests clarification on how participants in the Diagnostic Radiology MVP, including those selecting the nuclear medicine clinical grouping, would satisfy the numerator requirements for these measures and meaningfully affect performance outcomes. If CMS is unable to demonstrate a clear and direct alignment between the measure requirements and the clinical activities routinely performed by Diagnostic Radiology MVP participants, ACR suggests replacing these measures with imaging-focused alternatives that assess activities within radiologists' and nuclear medicine physicians' control.

For the 2026 performance period, the ACR National Radiology Data Registry QCDR supports 12 CMS-approved QCDR measures, as well as applicable MIPS quality measures. However, the available measure inventory provides limited coverage of services specific to the Diagnostic

Radiology MVP's Nuclear Medicine clinical grouping. Additional measure options should address aspects of services that radiologists and diagnostic nuclear medicine physicians perform or directly influence, including: appropriate patient preparation and protocol selection; radiopharmaceutical administration and documentation; image acquisition quality and technical adequacy; optimization of administered activity and patient radiation exposure; timely interpretation; standardized documentation of clinically significant findings; comparison with relevant prior imaging; closed-loop communication and follow-up of urgent, actionable, or incidental findings; diagnostic concordance with pathology or other reference standards; avoidance of preventable repeat imaging; and appropriate use of diagnostic nuclear medicine and molecular imaging studies.

Measures in the Nuclear Medicine clinical grouping should address imaging and be clinically meaningful, attributable to their applicability to the participating clinician, feasible to capture through routine reporting or registry workflows, and applicable across relevant practice settings. Participating clinicians should select measures based on their patient population, scope of practice, case volume, examination mix, and reporting workflow.

MIPS Value Pathways (MVPs) Scoring Methodology Request for Information

Request for Information
CMS seeks comments on future refinements to the MVP scoring methodology as MVPs become the primary MIPS reporting pathway. Specifically, CMS requests feedback on whether clinicians and groups reporting the same MVP should be compared to one another more directly, including whether normalization or other comparative scoring approaches should be applied at the final score level or within individual performance categories.

CMS also requests comment on whether any changes to MVP scoring should be implemented beginning with the CY 2029 performance period, when traditional MIPS would be sunset under the proposal, or whether CMS should test or phase in scoring changes in advance of that transition. The agency indicates that it is considering these issues to better align MVP scoring with the goal of producing comparable information for patients and clinicians while preserving a fair and meaningful basis for MIPS payment adjustments.

ACR Perspective and Comments
ACR appreciates CMS's consideration of improving the fairness, transparency, and comparability of MVP scoring as MVPs become the primary MIPS reporting pathway. We support the principle that clinician performance should be compared only against clinicians and groups reporting the same MVP, rather than across unrelated reporting pathways or clinically dissimilar measure sets. However, it is necessary that CMS implement any same-MVP comparison methodology carefully to ensure that improved comparability does not come at the expense of fairness for clinicians practicing in smaller, rural, non-patient-facing, or highly subspecialized settings.

ACR recommends that CMS conduct detailed specialty-specific modeling and publicly share the results before proposing or finalizing any MVP scoring methodology that normalizes, benchmarks, or otherwise compares performance among clinicians and groups

reporting the same MVP. Such modeling should evaluate whether same-MVP comparisons remain reliable when MVP participation is limited, when reporting cohorts are small, or when participants within a single MVP represent substantially different subspecialty practice patterns.

This analysis should account for the number and distribution of clinicians reporting each MVP, the availability and reliability of measure benchmarks, the degree of sub-specialization within each MVP, and the impact of reweighted performance categories. These issues are particularly important for radiology MVPs because diagnostic radiology, interventional radiology, nuclear medicine, breast imaging, and other radiology subspecialties may vary significantly in available measures, case volumes, reporting workflows, and participation in MIPS performance categories.

ACR is concerned that applying normalization or direct comparison within an MVP without appropriate guardrails could unintentionally disadvantage clinicians practicing in smaller or more specialized reporting cohorts, especially when available measures do not capture the full scope of services provided or when certain performance categories are reweighted because they are not applicable to non-patient-facing clinicians. To protect against these unintended consequences, **CMS should consider safeguards such as minimum cohort-size thresholds before applying normalization; suppression or alternative scoring when same-MVP comparison groups are too small to produce reliable results; continued application of small-practice, rural-practice, and non-patient-facing flexibilities; case-volume protections for measures with low denominator counts; transparent appeal or review processes when clinicians believe they are being compared against an inappropriate cohort; and clear advance notice of how reweighted categories will affect MVP final scores.** A scoring methodology intended to improve comparability should not create instability in scores, reduce predictability for practices, or penalize clinicians because an MVP is not sufficiently tailored to their specialty or subspecialty.

Before implementing any new MVP scoring methodology, CMS should provide specialty-specific examples, impact analyses, and opportunities for stakeholder review. ACR also encourages CMS to test any same-MVP comparison methodology through a phased approach before tying it to payment adjustments, particularly if traditional MIPS is sunset and MVPs become the primary reporting pathway for clinicians outside of advanced payment models (APMs). This testing should include radiology-specific scenarios that demonstrate how diagnostic radiology, interventional radiology, nuclear medicine, breast imaging, and other subspecialized practices would be scored when reporting under the same or related MVP structures.

Proposals Directly Applicable to Third-Party Intermediaries (e.g., QCDRs and Qualified Registries)

Proposal

CMS proposes several updates to requirements for third-party intermediaries, including QCDRs and qualified registries (QRs) that support MIPS data submission. These proposals address additional transparency obligations related to qualified posting requirements, including information about services offered and associated costs, as well as a continued emphasis on

ensuring that intermediaries provide accurate, timely, and reliable data-submission support for clinicians and groups participating in MIPS.

CMS frames these proposals as part of its broader effort to improve oversight, usability, and public-facing information about third-party intermediaries. The proposed changes would affect how QCDRs and qualified registries describe their services, make information available to potential users, and demonstrate compliance with CMS requirements during the self-nomination and participation process.

CMS proposes to add language to QCDR requirements to clarify that performance feedback reports must be provided based on the level of data submitted (individual, group, virtual group, etc.).

ACR Perspective and Comments

ACR appreciates and supports CMS's interest in promoting transparency and accountability among third-party intermediaries, like QCDRs and QRs, that support MIPS participation. Clear information about available services can help clinicians and groups better understand their reporting options and make informed decisions about the tools and support needed for successful participation. However, CMS should ensure that any new posting or disclosure requirements are appropriately tailored and do not impose unnecessary administrative burden on QCDRs and qualified registries, particularly those operated by specialty societies.

CMS should recognize important operational differences among QCDRs. Specialty society-led QCDRs, such as ACR's National Radiology Data Registry, are often designed to support specialty-specific quality improvement, measure development, benchmarking, and clinical reporting infrastructure for a defined clinician community as a primary function of the registry and are not maintained solely to support MIPS participation. Other QCDR entities may operate more like commercial reporting vendors that broadly market standardized MIPS submission services. CMS should ensure that qualified posting requirements are flexible enough to account for these different models.

Without clear definitions and guardrails, requiring public posting of detailed service offerings and associated costs could create confusion for clinicians and unintended consequences if CMS applies the same expectations across QCDRs with different operational models. For specialty society-led QCDRs, costs and services associated with registry participation may vary depending on membership status, registry participation model, measure availability, data submission method, technical integration needs, institutional arrangements, or evolving program capabilities. ACR recommends that CMS avoid requiring QCDRs to publicly post proprietary, competitively sensitive, or operationally complex information that may vary by participant, evolve during the performance year, or become misleading if presented without context.

If CMS finalizes additional posting requirements, it should permit registries to provide general descriptions of service models, cost ranges, and explanatory context rather than mandating rigid cost schedules or fixed service descriptions that may not apply uniformly across participants. This flexibility is particularly important because QCDRs may need to adjust pricing during the year, implement new reporting services and methods, add reporting capabilities, expand support

for a new MVP, add new QCDR measures, or develop new implementation tools as CMS policies, specialty needs, and participant workflows evolve. CMS should clarify how publicly posted cost and service information may be updated after the qualified list is posted so that public-facing information remains current, accurate, and useful to clinicians.

Requiring QCDRs and qualified registries to finalize fees, forecast operational costs, and define service offerings according to CMS's qualified posting timeline may also create administrative burden because registry budgeting, vendor contracting, technology development, and measure implementation activities often occur on different schedules. ACR strongly urges CMS not to impose posting requirements that would effectively force specialty societies with QCDRs or QRs to align their organizations' budgeting, service development, measure implementation, or technology timelines to CMS's qualified posting schedule. These operational timelines should remain owned and managed by the specific specialty society so that registry services can evolve in response to specialty needs, participant workflows, measure development priorities, quality improvement opportunities, and organizational budgetary schedules.

ACR urges CMS to ensure that any new transparency requirements support, rather than discourage, continued participation by specialty societies in the QCDR program. Specialty society QCDRs play an important role in developing clinically meaningful measures, supporting specialty-specific reporting infrastructure, and promoting quality improvement in areas where traditional MIPS measures may not adequately capture clinician contributions. Additional requirements should be proportionate, clearly defined, and flexible enough to account for the different models through which QCDRs and qualified registries operate.

Although ACR agrees that performance feedback reports are more useful if they display scores at the group and individual level, ACR does not agree with the proposal to require performance reports to be specific to the participation level. Our primary concern is that many clinicians either do not know the level at which they intend to report or do not inform the QCDR of this information until very late in the year. While we believe QCDRs should do their best to display scores at both the group and individual level, CMS's proposal seems to be based on the expectation that QCDRs ascertain this information early in the performance year. Based on our own direct experience with registry users, ACR does not believe this is feasible.

Fast Healthcare Interoperability Resources® (FHIR)-Based Digital Quality Measurement in the Quality Payment Program and Other CMS Quality Programs - Request for Information

ACR supports CMS's goal of modernizing quality measurement through interoperable, reusable data and reduced reporting burden. ACR recommends a phased, evidence-based transition, preserving current reporting pathways until FHIR-based workflows are operationally ready and have been tested to ensure complete, accurate, and comparable results across all stakeholders.

ACR's Key Recommendations on FHIR-Based Digital Quality Measurement

- Make FHIR reporting mandatory only after readiness criteria are met, such as stable specifications, available data, successful end-to-end testing, and demonstrated data quality.

- Preserve existing reporting pathways until FHIR-based reporting is operationally ready and practical for each measure and participant.
- Protect specialty and QCDR measures when required data are not consistently available through mature FHIR standards or varied source systems.
- Test the full reporting workflow across source systems, intermediaries, and CMS before using FHIR-based results for scoring, payment, or public reporting.
- Provide clear implementation guidance, testing tools, technical assistance, sufficient lead time, and appropriate protections when technology limitations are outside a clinician's control.

Transition Approach and Design

ACR supports a phased transition introducing FHIR-based reporting alongside existing options. FHIR-based reporting should not be mandatory for any measure until all specifications, data elements, workflows, and processes have been thoroughly tested for accuracy and comparability. This transition period should include robust pilot testing, a minimum of two years for validation, and clear exception pathways for measures not reliably supported via FHIR.

Before retiring existing options, CMS should publish readiness criteria, ensure successful end-to-end testing that is broad-based across practice and measure types, provide adequate lead time, and protect clinicians from penalties due to technology limitations beyond their control. Scoring implications from multiple reporting options should also be addressed.

Factors Affecting Technological Readiness for FHIR-Based Reporting

FHIR-based digital quality measures (dQMs) can support more interoperable, reusable, and automated quality measurement workflows. For radiology, however, readiness cannot be determined solely by the availability of the diagnostic imaging report in the EHR. Although the diagnostic radiology report is the radiologist's principal interpretive work product, many radiology quality measures also require the imaging order and clinical indication, acquisition and procedural parameters, radiation dose information, image- or series-level findings, follow-up recommendations, and data derived directly from images. These elements may reside across the EHR, Radiology Information System (RIS), Picture Archiving and Communication System (PACS), vendor-neutral archive, reporting system, imaging modality, registry, and other specialty systems rather than in a single FHIR-accessible repository. Additionally, many radiology quality-measure data elements are documented in narrative, free-text reports rather than standardized structured fields. Until those concepts are captured consistently as discrete data, quality reporting may continue to require manual abstraction or validated extraction technologies, including natural language processing or other advanced methods.

FHIR's representation of diagnostic imaging capabilities has expanded beyond Release 4, but adoption across production systems remains uneven. Availability has not advanced uniformly. In FHIR R5, ImagingStudy remains a Trial Use resource at FHIR Maturity Model level 4, while ImagingSelection was introduced to represent selected Digital Imaging and Communications in Medicine (DICOM) instances, frames, or image regions and link image evidence to resources such as Observation. The current FHIR R6 ballot designates ImagingStudy and ImagingSelection as normative, but R6 remains a ballot specification rather than the current published production release. Many regulated and production implementations therefore remain based on FHIR R4,

creating a practical gap between newer imaging capabilities and those consistently available in deployed systems.

This distinction matters because an ImagingStudy resource describes the availability and organization of a DICOM study but does not contain the DICOM instances themselves. FHIR can represent selected study metadata and the information needed to locate imaging content, while DICOM and DICOMweb provide the complete imaging metadata and payload. Retrieval of instances, frames, bulk data, or pixel data generally requires a DICOM Web Access to DICOM Objects - RESTful Services (WADO-RS) server or another storage mechanism. Study-, series-, and instance-level queries generally rely on Query based on ID for DICOM Objects - RESTful Services (QIDO-RS). FHIR and DICOMweb should therefore be treated as complementary components of a radiology quality measurement workflow.

Diagnostic Imaging Reference in United States Core Data for Interoperability (USCDI) v7 is consequently an important prerequisite for radiology quality measurement. The element is intended to provide the imaging endpoint, unique identifiers, and contextual information - including DICOMweb endpoints that support QIDO-RS, WADO-RS, or Web Access to DICOM Objects - Uniform Resource Identifier (WADO-URI) - needed to access a diagnostic imaging study. While inclusion in USCDI establishes a national interoperability expectation, it does not demonstrate that the element has been consistently profiled in US Core, implemented in certified products, deployed by providers, or validated in end-to-end quality measurement workflows.

Access to images and DICOM metadata is necessary for measures that depend on acquisition parameters, radiation-dose attributes, series characteristics, or calculations performed from pixel data. For example, CMS measure 1056 FHIR (Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Clinician Level)) requires CT pixel data to calculate CT global noise and size-adjusted dose. Those pixel data are not carried in the FHIR ImagingStudy resource. However, a FHIR imaging reference could enable an authorized application to locate and retrieve the corresponding content from the PACS or vendor-neutral archive.

CMS should confirm radiology-specific readiness criteria before establishing mandatory FHIR-based quality measurement dates. At a minimum, readiness should include: stable specifications for the required imaging resources; broad production implementation of the necessary FHIR imaging resources and search capabilities; implementation of Diagnostic Imaging Reference through applicable US Core and certification requirements; standards-based, authorized access to DICOM images and metadata; availability of all numerator, denominator, exclusion, risk-adjustment, and attribution data as standardized discrete elements; and successful end-to-end testing across EHRs, RIS, PACS, and vendor-neutral archives, modalities, registries, measure engines, and CMS submission systems.

Emerging Integrating the Healthcare Enterprise (IHE) Radiology profiles for integrated reporting, evidence selection, and AI-enabled workflows illustrate this maturity gap. The Integrated Reporting Applications profile is published on FHIR R5 and uses ImagingSelection and other FHIR resources to coordinate reporting applications, image displays, and AI tools. Imaging Diagnostic Report Phase II is also advancing a FHIR-based diagnostic-report

architecture. CMS's timelines should not assume that these R5- and R6-dependent capabilities are already available across R4-based production environments.

This detailed review of technological readiness factors impacting implementation of imaging-based dQMs is provided to illustrate and emphasize the complexity and immensity of effort that will be required to fully transition to FHIR-based digital quality measurement in the QPP.

Factors Affecting Operational and Practical Readiness for FHIR-Based Reporting

Technical interoperability is not the same as practical interoperability. The fact that a data element can be represented in FHIR does not establish that a radiology practice can reliably access, exchange, validate, and report that information across the systems and organizations where it furnishes services.

Therefore, ACR recommends that CMS permit practices and intermediaries to run FHIR-based reporting in parallel with established reporting methodologies during a voluntary testing period. During the voluntary testing period, discrepancies should be identified, investigated, and resolved without affecting MIPS scores, payment adjustments, or public reporting.

Radiologists frequently furnish services across hospitals, outpatient facilities, health systems, and other sites that use different EHRs, RIS, PACS, and reporting applications. Testing should therefore include multi-EHR and multi-vendor environments, varied client configurations, and data generated outside the radiologist's own technology. CMS should clarify whether registries will test directly with source-system vendors, through participating practices, or through a CMS-supported framework, and how responsibility will be allocated when an end-to-end test fails.

During the transition, clinicians may report the same or similar measures through different collection types. CMS should ensure that the choice or availability of a reporting method does not create an unintended scoring advantage or disadvantage. CMS should evaluate whether separate benchmarks, stratified comparisons, or other adjustments are needed when data capture, case finding, and measure calculation differ by method.

Radiologists often do not own or control the hospital and facility systems that contain the data required for quality reporting. Implementing FHIR-based reporting may therefore depend on cooperation from hospitals and other facilities for data access, interface development, patient matching, and ongoing maintenance. This operational dependency can create substantial cost, complexity, and variability across sites.

Registries and QCDRs play a vital role in the digital reporting ecosystem, serving as partners in aggregation, transformation, validation, and submission - especially for independent practices operating across diverse technology environments. However, this work depends on vendors reliably providing required data in formats that registries and reporting systems can use. Even if a registry is technically capable of receiving FHIR data, participating practices may still face barriers to obtaining complete data from their own source systems. True readiness can only be achieved by evaluating capabilities across the entire reporting chain, rather than focusing on a single participant.

For QCDRs, qualified registries, and reporting vendors, this transition is more than a change in file format. The shift to FHIR-based reporting may necessitate development of new Application Programming Interfaces (APIs), authentication and authorization processes, data mappings, ingestion pipelines, validation tools, measure engines, client support functions, and submission workflows. During this period, intermediaries often must maintain their current collection and submission methods while simultaneously developing and operating new FHIR-based environments. This dual responsibility increases operational complexity and requires careful planning.

To facilitate this transition, CMS can clarify the path forward by soliciting concrete implementation plans from vendors and intermediaries, including expected development time, cost, staffing, testing needs, supported FHIR versions, and capacity to serve diverse practices. At the same time, offering incentives, shared testing services, implementation grants, and other supports will help encourage vendor participation and reduce costs for clinicians. Clear expectations and available resources will contribute to smoother adoption and broader engagement.

Robust end-to-end testing is essential before FHIR-based measures impact scoring, public reporting, or payment. Effective testing should encompass all key steps, including source data extraction, exchange through intermediaries, calculation and aggregation of measures, submission, and CMS receipt. In addition, comparability testing across FHIR, Quality Reporting Document Architecture (QRDA), MIPS Clinical Quality Measure (CQM), QCDR, qualified registry, and other reporting methods is critical to ensure that different approaches yield materially equivalent results. Clearly defined processes for identifying and resolving discrepancies will help maintain trust in reported outcomes.

To support these efforts, CMS should provide a national testing environment, reference data sets, conformance tools, implementation playbooks, and a formal issue-resolution process. ACR encourages CMS to conduct voluntary pilots with specialty societies, QCDRs, vendors, and practices before establishing any mandatory compliance dates for radiology measures. Such pilots would allow stakeholders to identify gaps, gather feedback, and refine processes in a lower-risk setting.

Clear implementation guides, measure-specific data dictionaries, mapping guidance, sample payloads, test cases, validation tools, educational resources, and ongoing technical support are essential to successful adoption. These resources should be tailored to the needs of clinicians, practices, specialty societies, measure developers, QCDRs, qualified registries, EHR vendors, and other intermediaries, recognizing that each group has distinct responsibilities and dependencies within the reporting ecosystem. CMS should provide comment periods to solicit measure-specific feedback on all above-mentioned resources from each of the listed stakeholders.

Defining what constitutes a comprehensive FHIR submission, evaluating completeness, considering technology limitations, and offering hardship exceptions are all necessary to ensure fairness for clinicians. Special attention is warranted for smaller practices, rural and underserved providers, and organizations with limited technical staff, as they may benefit from shared

services, subsidized interfaces, extended timelines, simplified testing, and increased policy flexibility. When considering differentiated implementation schedules, it is essential to ensure that flexibility does not limit access to meaningful specialty measures or create inequitable scoring across provider types.

Finally, ACR recommends that CMS refrain from using FHIR-based results for payment or public reporting until specifications are stable, measure availability is adequate, data capture is reliable, and performance results are comparable. Certification or program requirements should align with the actual functionality needed for end-to-end quality reporting and be adopted only with sufficient advance notice through future rulemaking. These steps will help ensure an equitable and effective transition for all stakeholders.

General Solicitation of Comments

ACR recommends that CMS use a measure-by-measure readiness process rather than a single uniform deadline because readiness varies with the availability of structured, standardized data and the technological or operational feasibility of reporting each measure. CMS should identify candidate measures with mature digital specifications and broadly available structured data; conduct voluntary pilots; publish testing and comparability results; address identified gaps; provide at least one full performance year of stable specifications and production experience; and only then propose mandatory use through notice-and-comment rulemaking. Measures that rely heavily on narrative documentation or data elements not available through FHIR-enabled workflows should retain alternative reporting pathways until reliable digital reporting is demonstrated.

Before requiring FHIR-based reporting for a measure, CMS should also demonstrate that the necessary data are routinely captured, accessible to the reporting practice, supported by major vendors, and successfully tested across different real-world practice environments. The existence of a FHIR interface alone should not be treated as evidence that measure-specific data are complete, standardized, or reliable for automated reporting.

For specialty measures, CMS should work directly with specialty societies, QCDRs, clinicians, source-system vendors, and reporting intermediaries to determine whether the underlying clinical concepts can be captured consistently. The transition should reduce burden and cost rather than relocate burden and cost to practices, registries, or vendors through expensive custom extraction and mapping.

CMS should not establish a specialty-agnostic, single deadline for mandatory FHIR-based digital quality measurement. For radiology measures, the transition date should be conditioned on demonstrated availability of all required clinical, imaging, and workflow data; wide production implementation of the relevant FHIR imaging resources; standardized implementation of USCDI v7 Diagnostic Imaging Reference; authorized DICOMweb access to image metadata and pixel data when required; and successful multi-vendor end-to-end testing. Until these conditions are met, CMS should retain current reporting pathways and permit phased adoption by measure and specialty.

Conclusion
ACR appreciates CMS's continued engagement with stakeholders on FHIR-based digital quality reporting. ACR supports modernization that improves interoperability, reusability, automation, and reporting efficiency, but urges CMS to preserve flexibility, establish specialty-specific readiness criteria, protect clinicians from technology failures outside their control, and validate the complete radiology workflow - including FHIR-based clinical exchange and authorized DICOMweb access - before requiring FHIR-based reporting.

Merit-based Incentive Payment System Quality Performance Category

Proposal
CMS proposes replacing the "high priority" designation with a "core measure" designation for quality measures identified as particularly relevant to patients, consumers, and clinicians by the CMS Core Quality Measures Collaborative. CMS would also require clinicians to report at least one available core measure instead of the previously required single outcome measure. This change would also apply to MVPs.

If this proposed change is implemented, groups who are unable to submit a core measure must submit an attestation to CMS stating that no MIPS core measures were available or applicable for them to report. Small practices will be exempt from the requirement to submit a core measure and will not be obligated to submit the attestation to CMS.

ACR Perspective and Comments
ACR supports CMS's proposal to eliminate the "high priority" designation and to replace the outcome measure requirement with Core Measures. Historically, the high priority designation seems to have been applied somewhat arbitrarily. With so many measures removed from the program, it should be assumed that all those remaining would be considered "high priority." ACR strongly supports the proposal to replace the outcome measure requirement with Core Measures and strongly encourages CMS to engage with the relevant specialty society in determining what measures are considered "core". Radiologists have long struggled to find measures which could be considered to measure outcomes. For many years, the Diagnostic Radiology measure set has included only one outcome measure, and very few QCDR measures have been designated as outcome measures, making it difficult for radiologists to satisfy this reporting requirement.

ACR appreciates that the proposed Core Measures within the Diagnostic Radiology MIPS measure set and MVP are widely adopted and commonly reported by radiologists. However, all three measures are topped out and have been for many years. ACR therefore encourages CMS to work with relevant specialty societies to identify and introduce clinically meaningful, non-topped-out measures, including appropriate pathways for newer measures that do not yet have established benchmarks.

As CMS works with specialty societies to identify clinically meaningful, non-topped-out measures, ACR recommends that CMS consider ACRad 44: *Comprehensive Reporting of Coronary Artery Calcification on Chest Computed Tomography (CT)* for inclusion in the

Diagnostic Radiology MIPS measure set and MVP and for future designation as a core measure. ACRad 44 evaluates whether radiologists identify and report coronary artery calcification on applicable noncardiac chest CT examinations. This is an actionable incidental finding that can inform cardiovascular risk assessment and follow-up. The measure is clinically relevant to radiology, attributable to the interpreting radiologist, and offers a meaningful alternative to the currently proposed topped-out core measures. If the measure does not yet have an established benchmark, CMS should provide an appropriate implementation pathway that allows sufficient reporting experience and benchmark development before applying core-measure reporting requirements.

Proposal

CMS proposes the addition of a new MIPS electronic Clinical Quality Measure (eCQM), the *Rate of Timely Follow-up on Abnormal Screening Mammograms for Breast Cancer Detection,* to the Diagnostic Radiology specialty set beginning in performance year 2028. If approved as proposed, this measure's denominator would be "Female patients aged 40-75 years with an abnormal screening (Breast Imaging Reporting and Data System (BI-RADS) 0) or screening-to-diagnostic (BI-RADS 4, 5) mammogram during the measurement period," and the numerator would be "Patients in the denominator population who received timely diagnostic resolution defined as negative/benign/probably benign follow-up imaging (BI-RADS 1, 2, 3) or breast biopsy within 60 days after the date of their index abnormal screening." To allow groups and clinicians time to adapt their workflows to requirements, this new measure is being proposed with a one-year implementation delay, much like the previous radiology eCQM,.

ACR Perspective and Comments

ACR supports improving timely diagnostic resolution after abnormal screening mammogram but strongly cautions CMS against introducing this measure for clinician- or group-level MIPS reporting at this time. The measure was developed for facility- and system-level use, where accountability aligns with the coordinated scheduling, patient navigation, follow-up imaging, biopsy, pathology, and clinical results, and cross-team communication processes required.

Although subsequent testing reported acceptable reliability, validity, and technical feasibility at the clinician and group levels, clinician-level results were derived from National Provider Identifiers (NPIs) under a single Taxpayer Identification Number (TIN), and group-level results were based on only six groups within one hospital system. This limited testing does not establish that the measure will perform reliably across diverse practice types, workflows, vendors, and resource settings.

The measure may unfairly hold radiologists accountable for factors beyond their control, such as scheduling, patient-related delays, navigation barriers, limited workforce, or care provided by others. Additionally, BI-RADS results are often stored in unstructured reports, requiring technical solutions (like search algorithms or custom interfaces) that are not consistently available across EHR, radiology, and registry vendors. These issues could disproportionately burden small or rural practices and lead to inaccurate performance scores and payment adjustments.

Therefore, **ACR urges CMS not to finalize this measure for clinician- or group-level MIPS reporting for 2028. CMS should either keep the measure at the facility level or delay implementation until robust multi-TIN, varied practice type testing shows reliable performance and confirms that outcomes can be accurately attributed even when clinicians and groups do not control the entire care pathway.** Before implementation, CMS must ensure that eCQM data are available in standardized, interoperable formats; provide extraction tools and clear vendor guidance; and establish safeguards for follow-up care outside the reporting entity's control.

If CMS moves forward, ACR recommends using 2028 and beyond for voluntary, non-scored testing across varied TINs, practice types, and technology environments. CMS should release final specifications, standardized BI-RADS extraction tools, vendor guidance, test cases, attribution rules, and data-validation procedures early; set exclusions for circumstances outside clinicians' control; and offer technical assistance to resource-limited practices. Initial implementation should use confidential feedback (not payment or public reporting), and final rollout should depend on proven interoperability, data completeness, reliable attribution, and demonstrated lack of negative impact on access to breast imaging services.

Conclusion

ACR appreciates the opportunity to provide comments on the CY 2027 PFS proposed rule. We encourage CMS to continue to work with physicians and their professional societies through the rulemaking process to create and promote a stable and equitable payment and delivery system. 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 Kathryn Keysor (kkeysor@acr.org).

Respectfully submitted,

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