American College of Radiology

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

The Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2025 Medicare Physician Fee Schedule (MPFS) final rule on Friday, November 1, 2024. In this rule, CMS describes changes to payment provisions and to policies for the Medicare Shared Saving Program, Medicare Prescription Drug Inflation Rebate Program and Medicare Overpayments. There is no formal comment period associated with the final rule.

Conversion Factor and CMS Overall Impact Estimates

CMS finalized the CY 2025 conversion factor at $32.3465 compared to the 2024 conversion factor of $33.2875. This was calculated by removing the 1.25 percent provided by the Consolidated Appropriations Act of 2023 that applied to services furnished from January 1, 2024, through March 8, 2024, and the 2.93 percent payment increase provided by the Consolidated Appropriations Act of 2024 that replaced the previous 1.25 percent increase and applied to services furnished from March 9, 2024, through December 31, 2024. CMS then applied a positive 0.02 percent budget neutrality adjustment.

CMS estimates an overall impact of the MPFS changes to radiology, nuclear medicine and radiation oncology to be 0 percent, while interventional radiology will see an aggregate decrease of 2 percent under the finalized fee schedule. Note that these impacts consider relative value unit (RVU) changes only and do not take into account the decrease to the conversion factor.

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

CMS is finalizing its proposals to use its statutory authority to update and expand coverage for colorectal cancer screening with the following changes:

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

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

CMS states in the rule, "We expect that clinicians who order CTC for CRC screening will educate their patients on risks and context of radiation exposure and potential extracolonic findings. A shared decision-making tool is not mandated but may be helpful for clinicians and patients to weigh their options for CRC screening.". In accordance with the Affordable Care Act, CTC will require no Part B coinsurance nor deductible when furnished as a CRC screening procedure.

CMS finalized the following timetables for CTC screening coverage:

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

In addition to adding coverage of CTC, CMS finalized its proposal to remove coverage of double contrast barium enema, stating that in the U.S., CTC has largely replaced double contrast barium enema as a radiographic option for colorectal cancer screening. CMS stated that in consultation with stakeholder organizations, it determined that barium enema procedures no longer meet modern clinical standards and are no longer recommended in clinical guidelines. Barium enema was no longer included in the USPSTF 2016 and 2021 recommendations for colorectal cancer screening. The ACR supported this proposal in our comments.

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

The ACR requested in our comment letter that CMS also consider a follow-up colonoscopy following a screening CTC to be a screening service exempt from patient cost-sharing. CMS responded by saying, "We disagree with commenters that requested a further expansion of a complete colorectal cancer screening to include CTC. CTC is a visualization procedure along with colonoscopy and flexible sigmoidoscopy whereas stool-based and blood-based CRC screening tests are non-visualization tests. CTC provides visualization of the contours of the whole colon and demonstrates mucosal surface abnormalities consistent with polyps and tumors. These tests are unlike noninvasive modalities such as stool-based and blood-based CRC screening, which present a binary positive/negative result with variable specificity and may result (in the case of a positive test) in the need for a visualization study to confirm the derived

suspicion of adenoma or cancer. The follow-on colonoscopy represents an extension of screening in a patient who has converted from average risk to increased risk as a result of the positive test. In the case of CTC, visualization of the colonic mucosal contour, as well as the remainder of the colonic wall and surrounding structures, has already been achieved and the determination of a suspicious finding has been made. Polyps over the size threshold prompt a referral for diagnostic/therapeutic colonoscopy for the purpose of polypectomy. Therefore, the follow-up screening colonoscopy after a positive non-visualization test is necessary to confirm the presence of polyps and/or cancer. A follow-up colonoscopy after an abnormal finding from a CTC would be considered a diagnostic colonoscopy to biopsy or remove visualized polyps and/or cancer.".

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

The Deficit Reduction Act of 2005 requires that the technical component of imaging services be paid at the lesser of the Physician Fee Schedule (PFS) or OPPS payment amount. Imaging services are defined as "imaging and computer-assisted imaging services, including X-ray, ultrasound (including echocardiography), nuclear medicine (including PET), magnetic resonance imaging (MRI), computed tomography (CT), and fluoroscopy, but excluding diagnostic and screening mammography."

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

The proposed technical component reimbursement rate for screening CTC under the PFS was $528 based on the published relative value units (RVUs) and the proposed conversion factor. The proposed TC reimbursement rate for the OPPS was $106.30.

In our comment letter, ACR asked CMS to not apply the DRA cap to screening services such as CTC. The DRA excludes screening and diagnostic mammography from eligibility for the cap. It is unclear why Congress selected only these procedures for exclusion from the cap, but it seems likely they had a concern specifically about the impact of the cap on screening and diagnostic services to identify breast cancer. Given the prevalence of colon cancer and the relatively new availability of colon cancer screening with CTC, it seems plausible, if not likely, that if the DRA cap were to be enacted today, Congress would have excluded additional screening services from the cap.

CMS responded that it does not have the statutory authority to exclude services that are within the scope of the DRA's description of imaging services and finalized CTC's inclusion on the cap list.

In the OPPS proposed rule, CMS proposed to assign CPT code 74263 (Computed tomographic (CT) colonography, screening, including image postprocessing) APC 5522 (Level 2 Imaging without Contrast) with a reimbursement rate of $106.30. The ACR requested in our OPPS comment letter that screening CTC be re-assigned to APC 5524 Level 4 Imaging without Contrast with a proposed 2025 OPPS payment amount of $544.85, far more comparable to the

resource-based 2024 PFS payment of $566.22. In the OPPS final rule, CMS agreed that this newly covered screening test for colorectal cancer should be assigned to an APC where payment is more comparable to the purported resource costs, however, they assigned it to APC 5523 Level 3 Imaging without contrast at a payment rate of $241.72, rather than APC 5524.

Therefore, the technical component reimbursement rate for screening CTC in 2025 will be $241.72 in both the hospital outpatient and physician office settings. The final professional component RVU is 3.36 with a reimbursement rate of $108.68 using the current 2025 conversion factor of $32.3465. Note that the ACR is advocating with the American Medical Association and many other provider groups for an increase in the 2025 conversion factor. An increased conversion factor would increase the professional component reimbursement, but the technical component reimbursement rate would remain unchanged.

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

In 2023, CMS finalized the rebasing and revising of the Medicare Economic Index (MEI), with the purpose of reflecting current market conditions. However, this has not yet been implemented, as CMS received comments from stakeholders suggesting they delay until the AMA completes their physician practice information survey (PPIS).

In response to CMS's request for information over the years, some stakeholders indicated support for regular updates of the PPIS (every five years) while others disagreed, stating this could be a burdensome process for smaller practices. There was also a suggestion that CMS continue to consider an alternative to the PPIS altogether in case the AMA data is insufficient, with some supporting the 2017 US Census SAS data.

The AMA has recently concluded their PPI survey and is now performing data analysis.

Updates to Prices for Existing Direct PE Inputs

For CY 2025, CMS finalized the updated pricing for 18 supply and equipment items based on invoices received from stakeholders. These prices are reflected in Table 20.

CMS also increased the pricing of two supply items, *tubing set (SC083)* and *plasma separator (SD188)* for which they requested and received additional information and an updated invoice. CMS continues to accept invoices from commenters to guide their pricing of supplies and equipment.

Invoice Submission

Due to increases in invoice submission in recent years, CMS raised some concerns about distorted relativity across the fee schedule if only a small subset of supply or equipment items are being reviewed or updated, while the majority of the items are untouched. The Agency asked for feedback about whether a more comprehensive review, in coordination with clinical labor pricing updates, should be considered.

Many respondents supported more regular and comprehensive updates to the PE inputs, perhaps every five years, which could provide transparency to the process. There was a request to also maintain the four-year phase-in of future pricing updates. One commenter, however, cautioned that frequent updates could also amplify the impact of short-term market fluctuations and increase the administrative burden for CMS and health care providers.

Supply Pack Pricing Update

CMS has finalized the pricing of five supply packs and the creation of eight new supply codes. This effort was a result of information provided by a RUC workgroup which reviewed pricing discrepancies between the supply packs and the total of the individual items within the packs. As they did for with the supplies and equipment, CMS will be transitioning the pricing update over four years for the supply packs that are commonly used or have a large pricing difference; this effects three of the five supply packs.

Some commenters also raised questions about 15 additional supply packs that needed updating. CMS agreed with their concerns, but since many of these packs impact over 100 codes (some over 1,000 codes), CMS has reservations about pricing disruptions. CMS will address these in future rulemaking, should they be proposed.

Clinical Labor Pricing Update

CY 2025 is the final year of the clinical labor pricing update. CMS is implementing the pricing that they finalized in CY 2024, with the appropriate incremental increase for 2025.

CMS addressed comments that they received from stakeholders, stating that they consider the Bureau of Labor Statistics data to still be the most accurate source for pricing and that the four-year phase-in was implemented to avoid large swings in payment. Most of the comments received were consistent with prior years' comments, and CMS referred them to their previous rule language.

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

CMS continues to consider alternatives to their current PE methodology. They are aware of the AMA's PPI survey effort, which is expected to be complete by the end of CY 2024, after which the AMA will share the data with CMS. However, CMS believes it is important that they consider alternatives to improve the stability and accuracy of the PE methodology and are working with the RAND Corporation to develop these alternatives. This will include the analysis of updated PPIS data.

CMS believes that establishing a cycle to update supply and equipment inputs will help to promote stability and predictability. The Agency shared that they received diverse perspectives on their request for feedback on how to establish a mechanism that would account for inflation

and deflation in costs and how economies of scale should or should not factor into future adjustments to their methodology.

Many commenters also expressed their concern that CMS's current methodology does not accommodate newer technologies such as Software as a Medical Device (SaMD) and artificial intelligence (AI) and urged CMS to collaborate with medical associations and stakeholders on this topic.

CY 2025 Identification and Review of Potentially Misvalued Services

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

CPT code 27279 ***(Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device)*** had been re-nominated as potentially misvalued based on the absence of separate direct PE inputs for this 090 day global code in the non-facility setting. Due to lack of consensus in the medical community on whether this service may be safely and effectively performed in the non-facility/office setting, CMS is not nominating CPT code 27279 as potentially misvalued

CPT codes 10021 ***(Fine needle aspiration biopsy, without imaging guidance; first lesion)***, **10004** ***(Fine needle aspiration biopsy, without imaging guidance; each additional lesion (List separately in addition to code for primary procedure))***, **10005** ***(Fine needle aspiration biopsy, including ultrasound guidance; first lesion)***, **and 10006** ***(Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion (List separately in addition to code for primary procedure))*** have been nominated several times in recent years, with CMS concluding that this family is not misvalued. The nominator requested that CMS adopt the RUC-recommended RVUs for this family. Many commenters agreed with CMS that this family is not misvalued and did not support a resurvey of these codes. CMS states that they will welcome any additional information on these codes, but believe that they are currently accurately valued.

Valuation of Specific Codes for CY 2025

MRI-Monitored Transurethral Ultrasound Ablation of Prostate
(CPT codes 51721, 55881, and 55882)

- **51721** *(Insertion of transurethral ablation transducers for delivery of thermal ultrasound for prostate tissue ablation, including suprapubic tube placement during the same session and placement of an endorectal cooling device, when performed)*
- **55881***(Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation)*
- **55882** *(Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation; with insertion of transurethral ultrasound transducers for delivery of the thermal ultrasound,*

including suprapubic tube placement and placement of an endorectal cooling device, when performed)

For this new three-code family, CMS accepted the RUC-recommended values: CPT codes **51721** - wRVU 4.05, **55881** - wRVU 9.80, and **55882** - wRVU 11.50. CMS also finalized the PE inputs without refinement.

The Agency received some feedback from commenters who disagreed with the work RVUs and who expressed concern that the intra-service times collected by the RUC surveys were too low. However, many commenters were in support of the proposed work RVUs and indicated that these codes will be up for re-review in three years by the RUC, as they are on the New Technology list.

Percutaneous Radiofrequency Ablation of Thyroid
(CPT codes 60660 and 60661)

- **60660** *(Ablation of 1 or more thyroid nodule(s), one lobe or the isthmus, percutaneous, including imaging guidance, radiofrequency)*
- **60661** *(Ablation of 1 or more thyroid nodule(s), additional lobe, percutaneous, with imaging guidance, radiofrequency (List separately in addition to code for primary service)*

For this new two-code family, CMS accepted the RUC-recommended values: CPT codes **60660** - wRVU 5.75 and **60661** - wRVU 4.25. CMS also finalized the PE inputs without refinement.

The agency received support for their valuation of these codes. However, some commenters did share concerns about reimbursement challenges in the non-facility setting due to the high cost of the RF electrode. They feel that the high cost of the electrode could impact patient access to these services. CMS responded that they will consider invoices for the electrode if the commenters do not feel that the current pricing is appropriate.

Magnetic Resonance Examination Safety Procedures
(CPT codes 76014, 76015, 76016, 76017, 76018, and 76019)

- **76014** *(MR safety implant and/or foreign body assessment by trained clinical staff, including identification and verification of implant components from appropriate sources (e.g., surgical reports, imaging reports, medical device databases, device vendors, review of prior imaging), analyzing current MR conditional status of individual components and systems, and consulting published professional guidance with written report; initial 15 minutes)*
- **76015** *(MR safety implant and/or foreign body assessment by trained clinical staff, including identification and verification of implant components from appropriate sources (e.g., surgical reports, imaging reports, medical device databases, device vendors, review of prior imaging), analyzing current MR conditional status of individual components and*

systems, and consulting published professional guidance with written report; each additional 30 minutes (List separately in addition to code for primary procedure)

- **76016** *(MR safety determination by a physician or other qualified health care professional responsible for the safety of the MR procedure, including review of implant MR conditions for indicated MR exam, analysis of risk versus clinical benefit of performing MR exam, and determination of MR equipment, accessory equipment, and expertise required to perform examination with written report)*
- **76017***(MR safety medical physics examination customization, planning and performance monitoring by medical physicist or MR safety expert, with review and analysis by physician or qualified health care professional to prioritize and select views and imaging sequences, to tailor MR acquisition specific to restrictive requirements or artifacts associated with MR conditional implants or to mitigate risk of non-conditional implants or foreign bodies with written report)*
- **76018** *(MR safety implant electronics preparation under supervision of physician or other qualified health care professional, including MR-specific programming of pulse generator and/or transmitter to verify device integrity, protection of device internal circuitry from MR electromagnetic fields, and protection of patient from risks of unintended stimulation or heating while in the MR room with written report)*
- **76019** *(MR safety implant positioning and/or immobilization under supervision of physician or qualified health care professional, including application of physical protections to secure implanted medical device from MR-induced translational or vibrational forces, magnetically induced functional changes, and/or prevention of radiofrequency burns from inadvertent tissue contact while in the MR room with written report)*

For this new six-code family, CMS accepted the RUC-recommended values: CPT codes **76016** - wRVU 0.60, **76017** - wRVU 0.76, **76018** - wRVU 0.75, and **76019** - wRVU 0.60. **70614** and **76015** are PE-only codes.

CMS had proposed several PE refinements for these codes but reconsidered some of their refinements following stakeholder feedback. These are detailed below.

- For CPT codes 76014, 76015, 76016, 76018, and 76019, CMS proposed refining the clinical labor time for the CA034 activity (*Document procedure (nonPACS) (e.g. mandated reporting, registry logs, EEG file, etc.)*) from 2 minutes to 1 minute. However, based on comments they received, the Agency agreed that the full 2 minutes was necessary for the MR technologist to provide the detailed evaluation and written report.
- For CPT code 76015, CMS proposed to reduce the clinical labor time for CA021 (*Perform procedure/service---NOT directly related to physician work time*) from 27 minutes to 14 minutes, citing the 7 minutes in CPT code 76014, which is the parent code. However, many commenters responded, informing CMS that there is significantly more work involved in 76015 than 76014. CMS has finalized a 7-minute increase from the proposed 14 minutes to 21 minutes. This results in a slight increase for the Technologist PACS workstation (ED050) from the proposed 32 minutes to 39 minutes.

- For CPT code 76017, commenters agreed with CMS that the RUC-recommended 13 minutes of time for the Professional PACS Workstation (ED053) listed as a Facility PE input is an error and can be removed.
- For CPT code 76018 and 76019, stakeholders agreed with CMS that it is appropriate to reduce the clinical labor time for CA024 (*Clean room/equipment by clinical staff*) from 2 minutes to 1 minute since only the new equipment, EQ412 (*Vitals monitoring system (MR Conditional)*), is being cleaned and not the entire room. This refinement also results in a reduction to the equipment times for EL008 (*room, MR*) and EQ412 for both of these codes.
- For CPT code 76019, CMS will maintain supply item SL082 (*impression material, dental putty (per bite block)*) after stakeholder feedback that the item was incorrectly listed in the PE SOR, but is appropriate for the procedure.
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Ultrasound Elastography (CPT codes 76981, 76982, and 76983)

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

For this three-code family, CMS accepted the RUC-recommended values: CPT codes **76981** - wRVU 0.59, **76982** - wRVU 0.59, and **76983** - wRVU 0.47. CMS also finalized the PE inputs without refinement.

CT Guidance Needle Placement (CPT code 77012)

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

For this code, CMS accepted the RUC-recommended value: **77012** - wRVU 1.50. CMS is also finalizing their CT room (EL007) time for this code at 9 minutes despite comments from stakeholders that the convention the Agency applied to support the 9 minutes pertains to only RS&I codes in angiographic rooms.

Transcranial Doppler Studies (CPT codes 93886, 93888, 93892, 93893, 93896, 93897, 93898, and 93890)

- **93886** ***(****Transcranial Doppler study of the intracranial arteries; complete study)*
- **93888** (*Transcranial Doppler study of the intracranial arteries; limited study)*
- **93892** *(*T*ranscranial Doppler study of the intracranial arteries; emboli detection without intravenous microbubble injection)*
- **93893** *(Transcranial Doppler study of the intracranial arteries; venous-arterial shunt detection with intravenous microbubble injection)*
- **93896** *(Vasoreactivity study performed with transcranial Doppler study of intracranial arteries, complete)*

- **93897** *(Emboli detection without intravenous microbubble injection performed with transcranial Doppler study of intracranial arteries, complete)*
- **93898** *(Venous-arterial shunt detection with intravenous microbubble injection performed with transcranial Doppler study of intracranial arteries, complete)*
- **93890** *(Transcranial Doppler study of the intracranial arteries; vasoreactivity study)*

For this seven-code family, CMS accepted the RUC-recommended values: CPT codes **93886** – wRVU 0.90, **93888 -** wRVU of 0.73, **93892 -** wRVU of 1.15, **93893** w RVU of 1.15, **93896** - wRVU 0.81, **93897** - wRVU 0.73, and **93898** - wRVU of 0.85. CMS also finalized the PE inputs without refinement.

CMS received some comments that disagreed with the times for the vascular ultrasound room (EL016) and the technologist PACS workstation (ED050). The commenters felt that the PACS time was overcounted and the ultrasound room time was undercounted, based on their own membership study. CMS responded that the equipment times were based on standard equipment time formulas and are in support of the RUC-recommended times.

Drugs and Biological Products Paid Under Medicare Part B

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

In rulemaking over the last few years, CMS finalized many policies to implement section 90004 of the Infrastructure Investment and Jobs Act, which established a refund for discarded amounts of certain single-dose container or single-use package drugs under Part B. CMS is finalizing clarifications to several policies implemented in the CY 2023 and CY 2024 PFS final rules, including: exclusions of drugs, for which payment has been made under Part B for fewer than 18 months, from the definition of refundable single-dose container or single-use package drug, and identifying single-dose containers. CMS is also finalizing a requirement that the JW modifier must be used if a billing supplier is not administering a drug, but there are amounts discarded during the preparation process before supplying the drug to the patient. Finally, CMS is finalizing that skin substitutes will not be included in the identification of refundable drugs for the calendar quarters in 2025.

Payment for Radiopharmaceuticals in the Physician Office

In an effort to provide clarity on which methodologies are available to Medicare Administrative Contractors (MACs) for pricing of radiopharmaceuticals in the physician office setting, CMS is finalizing a clarification that, for radiopharmaceuticals furnished in a setting other than a hospital outpatient department, MACs shall determine payment limits for radiopharmaceuticals based on any methodology used to determine payment limits for radiopharmaceuticals in place on or prior to November 2003. Such a methodology may include, but is not limited to, the use of invoice-based pricing.

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

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

In the March 31, 2020 COVID-19 IFC, CMS changed the definition of "direct supervision" during the public health emergency (PHE) for COVID-19 as it pertains to supervision of diagnostic tests, physicians' services, and some hospital outpatient services, to allow the supervising professional to be immediately available through virtual presence using two-way, real-time audio/video technology, instead of requiring their physical presence. CMS has previously extended flexibility through rulemaking. CMS has expressed concern about an abrupt transition to the pre-PHE policy that defines direct supervision to require the physical presence of the supervising practitioner.

The ACR provided comments supporting CMS's extension of this policy. CMS is extending this flexibility for all services on a temporary basis only. CMS will continue to define direct supervision to permit the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2025. CMS will consider the most appropriate way to balance patient safety concerns with the interest of supporting access that CMS may address in future rulemaking. CMS noted that most commentors requested that CMS make this flexibility permanent. CMS may address the most appropriate way to balance patient safety concerns with the interest of supporting access in future rulemaking.

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

In the CY 2024 PFS PR, CMS solicited comments on extending or permanently establishing the virtual presence flexibility for certain services valued under the PFS that are typically performed in their entirety by auxiliary personnel as defined at § 410.26(a)(1). CMS believes these services are low risk by their nature, do not often demand in-person supervision, are typically furnished entirely by the supervised personnel, and allowing virtual presence for direct supervision of these services would balance patient safety concerns with the interest of supporting access and preserving workforce capacity.

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

Medicare Shared Savings Program

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

Summary of Shared Savings Program Proposals

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

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

Eligibility Requirements and Application Procedures

CMS finalized changes in eligibility requirements and application procedures. To better align program policies with CMS's goal of increasing the number of beneficiaries in an accountable care relationship with a health care provider, CMS will sunset the requirement that CMS terminates the participation agreement if the ACO's population is not at least 5,000 by the end of the performance year specified by CMS in its request for a Corrective Action Plan (CAP) while continuing to require ACOs to meet the minimum threshold of 5,000 assigned beneficiaries to begin a new agreement.

ACOs must still meet the requirement of 5,000 assigned beneficiaries to begin a new agreement period in the Shared Savings Program, but we will allow ACOs that fall below 5,000 assigned beneficiaries during the agreement period until time of renewal to return to the 5,000-beneficiary threshold.

Updates to the Quality Payment Program (QPP)

Advanced APM Proposals

For the Advanced APM track, if an eligible clinician participates in an Advanced APM and achieves Qualifying APM Participant (QP) or Partial QP status, they are excluded from the MIPS reporting requirements and payment adjustment (though eligible clinicians who are Partial QPs may elect to be subject to the MIPS reporting requirements and payment adjustment).

Eligible clinicians who are QPs for the CY 2024 performance year receive a 1.88 percent APM Incentive Payment in the 2026 payment year. Beginning with the CY 2024 performance year (payment year 2026), QPs will also receive a higher PFS payment rate (calculated using the differentially higher "qualifying APM conversion factor") than non-QPs. QPs will continue to be excluded from MIPS reporting and payment adjustments for the applicable year. As required under statute, starting with payment year 2025 (based on 2023 eligibility), Qualifying Participants (QPs) in Advanced APMs will receive a lump-sum APM Incentive Payment equal to 3.5% payment of their estimated aggregate paid amounts for covered professional services furnished during CY 2024 (down from 5%). In payment year 2026 (based on 2024 eligibility), this incentive payment drops to 1.88%. Also beginning in payment year 2026, CMS will apply two separate PFS conversion factor updates—one for QPs (0.75) and one for all non-QP eligible clinicians (0.25). Also under statute, the thresholds to achieve QP status beginning in the 2025 QP performance period will increase to 75% (from 50%) for the payment amount method, and 50% (from 35%) for the patient count method.

Advanced APMs

CMS had proposed to amend the 6th criterion to use claims for all covered professional services to identify attribution-eligible beneficiaries for all Advanced APMs, beginning with performance year 2025. The sixth criterion identifies beneficiaries who have received certain services from an eligible clinician who is associated with an APM Entity for any period during the QP

Performance Period. By no longer specifying a claim for E/M services as the default attribution basis in the sixth criterion, instead making the default attribution based on covered professional services, CMS aimed to eliminate the need to create unique attribution bases that are tied to a specific Advanced APM's attribution methodology. CMS had solicited comment on this proposal to revise the sixth criterion of the definition of "attribution-eligible beneficiary" at § 414.1305 to include a beneficiary who has at least one claim for a covered professional service furnished by an eligible clinician who is on the Participation List for the APM Entity (or by the individual eligible clinician, as applicable) at any determination date during the QP Performance Period. CMS is not finalizing the proposed change to the definition of "attribution-eligible beneficiary." CMS did not finalize the proposal to amend the 6th criterion of our definition to use claims for all covered professional services to identify attribution-eligible beneficiaries for all Advanced APMs.

APM Performance Pathway

CMS will establish the APP Plus quality measure set beginning in the CY 2025 performance period/2027 MIPS payment year. The APP Plus quality measure set will incrementally grow to be comprised of 11 measures, consisting of the six measures in the existing APP quality measure set and five new measures from the Adult Universal Foundation measure set. These 11 measures will be incrementally incorporated into the APP Plus quality measure set over performance year 2025 through performance year 2028, or the performance year that is one year after eCQM specifications become available for Quality IDs: 487 (Screening for Social Drivers of Health) and 493 (Adult Immunization Status), whichever is later.

MIPS Value Pathways (MVPs)

In the proposed rule, CMS introduced two new Requests for Information (RFI), *Building upon the MIPS Value Pathways (MVPs) Framework to Improve Ambulatory Specialty Care* and *Transforming the Quality Payment Program*, focusing on the full implementation of MVPs into MIPS and the eventual sunsetting of traditional MIPS. **In the final rule, CMS thanked its commenters for their feedback on both RFIs and agreed to consider the recommendations for future rulemaking.**

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

CMS raised concerns and sought comments regarding Medicare beneficiaries' health care, which is increasingly fragmented because they see more specialists with greater frequency over several visits, while primary care provider encounters remain consistent. The RFI explained that an ambulatory specialty care MVP would address the quality-of-care coordination and support care continuity for these beneficiaries.

In response to the RFI, ACR praised CMS on its goal to improve the complexities and nonviability of the traditional MIPS program and its desire to construct a program rewarding integration of specialty care across a patient's journey, emphasizing improved coordination and

collaboration between primary and specialty care physicians at the point of referral. ACR noted that the radiology community values its part in care coordination and cross-specialty collaboration, as well as its vital role in episodic and longitudinal integrated primary-specialty care and active engagement in managing population health, like cancer screening programs and appropriate evidence-based follow-up recommendations for actionable incidental findings used with tracking and preventive care management tools.

ACR strongly recommended against CMS's proposal to mandate participation in the model for relevant specialty care providers when applicable MVPs are available because previously required or proposed mandatory Advanced Payment Models (APMs) generated concerns regarding the ability to ensure fair or predictable payment, excessive payment cuts, lack of proven track record of net savings, or cost savings over treatment quality and substantial administrative burdens for those participating in these models. Instead, ACR urged CMS to extensively test the proposed model and its incorporated MVPs and provide significant time for specialty implementation.

Because the proposed model incorporates MVPs, non-patient-facing specialties, like diagnostic radiology, will depend on CMS adopting alternative participation approaches given their current barriers to participating in all MVP performance categories, specifically the Cost category. ACR agreed to explore alternatives like those described in the Transforming the Quality Payment Program RFI (summarized below), in which CMS agreed to examine the flexibilities within the Medicare Access and CHIP Reauthorization Act (MACRA) to "consider and apply alternative measures or activities that fulfill the goals of the applicable performance category."

ACR agreed that CMS should align the proposed model's health IT and data sharing requirements and leverage advances in Federal interoperability policy. We also explained that given the frequency of patients moving between distinct health institutions (by choice and in critical care situations), EHR systems must store reference data to enable the care continuum across systems to provide access to imaging before arrival, which may be crucial for patient outcomes.

RFI: Transforming the Quality Payment Program
ACR was encouraged by the *Transforming the Quality Payment Program RFI's* proposals for making MVP participation available to non-patient-facing specialties lacking MVPs. However, in response to its request for feedback on clinician readiness for MVP reporting, MIPS policies for sunsetting traditional MIPS in the CY 2029 performance period/2031 MIPS payment year, and what "meaningful MIPS participation" would look like for clinicians who, in the future, with the sunset of traditional MIPS, may not have an applicable MVP, the ACR described its uncertainty about MIPS-eligible radiologists' future engagement in future radiology-focused MVPs. ACR highlighted that patients and radiology practices would benefit no more than they are already under MVP participation. While quality measures and improvement activities are available for radiologist reporting, MVPs lack cost and promoting interoperability (PI) measures. ACR anticipates that future MVP participation and scoring would function like traditional MIPS, for which the Cost and PI categories are re-weighted to the Quality and Improvement Activity (IA) categories, given their non-patient-facing status and further underscored that radiology is

highly sub-specialized and would likely leave portions of radiology-eligible clinicians unqualified to use future MVPs due to their subspecialty.

MVP Scoring

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

MIPS Category Weighting

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

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

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

Clinicians will have until November 1 of the year before the applicable MIPS payment year to make this appeal to CMS. In other words, if a clinician intends to request this type of reweighting for the 2024 MIPS performance year, they will have until November 1, 2025, to submit their request to CMS.

MIPS Performance Threshold and Incentive Payments

The MIPS performance threshold is the value that determines whether MIPS participants will receive a positive, negative, or neutral payment adjustment during the associated MIPS payment year. Beginning with the 2022 performance years, CMS was statutorily required to set the MIPS performance threshold based on the mean or median value derived from a previous year's scoring data. Using the mean from 2017 MIPS scoring data, CMS set the performance threshold at 75 points in 2022 and has remained at 75 points through the 2024 performance year. For the 2025 performance period, CMS has finalized the proposal to maintain a 75-point performance threshold.

CMS finalized the minimum and maximum payment adjustment of +/- 9% for performance years 2020 and beyond. No changes have been made to the MIPS adjustment.

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

The adjusted benchmark for the selected measures will look like this:

Measure Achievement Points	Performance Rate
1 – 1.9	84 – 85.9%
2 – 2.9	86 – 87.9%
3 – 3.9	88 – 89.9%
4 – 4.9	90 – 91.9%
5 – 5.9	92 – 93.9%
6 – 6.9	94 – 95.9%
7 – 7.9	96 – 97.9%
8 – 8.9	98 – 98.9%
9 – 9.9	99 – 99.9%
10	100%

CMS originally proposed to exclude the 9th decile from this benchmark, but upon consideration of feedback received during the public comment period, it has finalized that the 9th decile will be included.

Quality Measures Proposed for Addition and Removal

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

#436: Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques
This measure is being removed as it is considered duplicative of the following newly added measure in the Diagnostic Radiology set:

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

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

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

Quality Data Completeness Requirements

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

Cost Performance Category

CMS finalized its proposal to add six episode-based cost measures beginning with the 2025 performance period for implementation at the group (TIN) and clinician (TIN/NPI) level with a 20-episode case minimum.

- Chronic Kidney Disease
- End-Stage Renal Disease
- Kidney Transplant Management

- Prostate Cancer
- Rheumatoid Arthritis
- Respiratory Infection Hospitalization

It also includes substantive updates to the *Cataract Removal with Intraocular Lens (IOL) Implantation (currently named Routine Cataract with Intraocular Lens [IOL] Implantation)* and the *Inpatient Percutaneous Coronary Intervention (PCI) (currently named ST-Elevation Myocardial Infarction [STEMI] Percutaneous Coronary Intervention [PCI])* episode-based cost measures.

CMS decided that the following five factors will be considered when removing a cost measure from MIPS.
Factor 1: It is not feasible to implement the measure specifications.
Factor 2: A measure steward can no longer maintain the cost measure.
Factor 3: The implementation costs or negative unintended consequences associated with a cost measure outweigh the benefits of its continued use in the MIPS cost performance category.
Factor 4: The measure specifications do not reflect current clinical practice or guidelines.
Factor 5: The availability of a more applicable measure that applies across settings or populations or is more proximal to desired patient outcomes for the particular topic.

CMS noted that it will consider the cost measure removal criteria in future years to determine whether the Total Per Capita Cost measure or any other measure should be proposed for removal.

CMS decided to modify the benchmark methodology for scoring cost measures beginning with the CY 2024 performance period and establish a new cost measure exclusion policy starting in the CY 2025 performance period. Under the new policy, if data used to calculate a score for a cost measure is impacted by significant changes (i.e., changes external to the care provided resulting in misleading or inaccurate measure calculation), like rapid or unprecedented changes to service utilization, the affected cost measure is excluded from the MIPS-eligible clinician's or group's cost performance category score.

Improvement Activities Performance Category

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

Under the simplified scoring finalized by CMS, all activities will be assigned the same weight. Regular MIPS clinicians must submit two activities for full category credit, while small, rural, and non-patient-facing clinicians only one.

Improvement Activities Finalized for Removal

Activity ID	Activity Name	Rationale for Removal
IA_EPA_1	Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record	CMS considers this activity to be obsolete due to high utilization of EHRs.
IA_PM_12	Population Empanelment	CMS considers this activity obsolete due to the wide acceptance of empanelment.
IA_CC_1	Implementation of Use of Specialist Reports Back to Referring Clinician or Group to Close Referral Loop	This activity is considered duplicative and is also highly utilized.
IA_CC_2	Implementation of Improvements that Contribute to More Timely Communication of Test Results	This activity is considered obsolete due to the wide adoption of EHRs and patient portals.
IA_ERP_4	Implementation of a Personal Protective Equipment (PPE) Plan	This activity is considered obsolete; since the COVID-19 pandemic, clinicians are well-prepared in PPE safety and this activity is unlikely to drive further improvements.
IA_ERP_5	Implementation of a Laboratory Preparedness Plan	This activity is considered obsolete; since the COVID-19 pandemic, clinicians are well-prepared in COVID-19-related patient safety and laboratory-preparedness enhancements have been made throughout patient care settings.
IA_BMH_8	Electronic Health Record Enhancements for BH Data Capture	There is now an alternative activity available (IA_BMH_7: Implementation of Integrated Patient Centered Behavioral Health Model) which has a stronger

		relationship to quality care or improvements.
IA_PSPA_27	Invasive Procedure or Surgery Anticoagulation Medication Management	This activity is considered duplicative of IA_CC_15: Perioperative-Surgical Home Care Coordination

CMS published Fact Sheets on the overall MPFS final rule, the Quality Payment Program, the Shared Savings Program and a Press Release.