



September 11, 2025

Mehmet Oz, M.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare Program; Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System; Proposed Rule; CMS-1834-P

Dear Administrator Oz,

The American Association of Physicists in Medicine (AAPM)¹ is pleased to submit comments to the Centers for Medicare and Medicaid Services (CMS) in response to the July 17, 2025 *Federal Register* notice regarding proposed changes to the Hospital Outpatient Prospective Payment System (HOPPS) and Ambulatory Surgical Center (ASC) Payment System.

Radiation Treatment Delivery Codes 77402, 77407 and 77412

At the September 2024 CPT Editorial Panel meeting, the Panel approved the revision of Radiation Treatment Delivery codes 77402, 77407 and 77412 to establish a technique -agnostic family of codes, which bundled all image guidance and active motion management. In addition, the Panel proposed deletion of IMRT treatment delivery codes 77385 simple and 77386 complex; and 77014 CT guidance for placement of radiation fields, which will be consolidated in the revised Radiation Treatment Delivery codes. The related guidelines and tables were updated to reflect the consolidated services for radiation oncology treatment delivery.

Under the new coding structure, radiation treatment delivery with conventional X-ray or electron beams is assigned levels of complexity based on the number of treatment sites and the complexity of the treatment delivery. The technique (3D, IMRT or VMAT) does not automatically contribute to complexity level. The complexity of treatment delivery varies depending on the area being treated, the number of targets identified and differential doses delivered.

¹ The American Association of Physicists in Medicine (AAPM) is the premier organization in medical physics, a broadly-based scientific and professional discipline encompassing physics principles and applications in biology and medicine whose mission is to advance the science, education and professional practice of medical physics. Medical physicists contribute to the effectiveness of radiological imaging procedures by assuring radiation safety and helping to develop improved imaging techniques (e.g., mammography CT, MR, ultrasound). They contribute to development of therapeutic techniques (e.g., prostate implants, stereotactic radiosurgery), collaborate with radiation oncologists to design treatment plans, and monitor equipment and procedures to ensure that cancer patients receive the prescribed dose of radiation to the correct location. Medical physicists are responsible for ensuring that imaging and treatment facilities meet the rules and regulations of the U.S. Nuclear Regulatory Commission (NRC) and various State regulatory agencies. AAPM represents over 9,000 medical physicists.

CMS proposes to maintain the current APC assignments for the revised Radiation Treatment Delivery codes 77402, 77407 and 77412 effective January 1, 2026 despite significant revisions to these CPT codes (see table below).

CPT Code	Current Long Descriptor	2026 Long Descriptor	CMS Proposed 2026 APC Assignment	AAPM Recommended 2026 APC Assignment
77402	Radiation treatment delivery, ≥ 1 MeV; simple	Radiation treatment delivery; Level 1 (for example, single electron field, multiple electron fields, or 2D photons), including imaging guidance, when performed	5621	5622
77407	Radiation treatment delivery, ≥ 1 MeV; intermediate	Radiation treatment delivery; Level 2, single isocenter (eg, 3D or IMRT), photons, including imaging guidance, when performed	5622	5623
77412	Radiation treatment delivery, ≥ 1 MeV; complex	Radiation treatment delivery; Level 3, multiple isocenters with photon therapy (for example, 2D, 3D, or IMRT) OR a single isocenter photon therapy (eg, 3D or IMRT) with active motion management, OR total skin electrons, OR mixed electron/photon field(s), including imaging guidance, when performed	5622	5623

We believe that the Agency did not consider the additional services included in the revised CPT code descriptors. The proposed APC assignments for CPT 77402 *Radiation treatment delivery; Level 1*; CPT 77407 *Radiation treatment delivery; Level 2* and 77412 *Radiation treatment delivery; Level 3* and their payment do not reflect the facility costs associated with these procedures.

Currently, both IMRT treatment delivery codes 77385 simple and 77386 complex are assigned to APC 5623 *Level 3 Radiation Therapy*. The geometric mean costs of CPT 77385 and 77386 need to be included in revised Radiation Treatment Delivery codes 77407 and 77412. In addition, the technical component of image guidance and active motion management has been bundled into the revised Radiation Treatment Delivery codes. The 2026 APC assignments need to be updated to reflect the coding changes for the Radiation Treatment Delivery code family (i.e., 77402, 77407, 77412) and reflect the new coding schema.

The AAPM recommends that CMS reassign CPT 77402 *Radiation treatment delivery; Level 1* to APC 5622 *Level 2 Radiation Therapy*.

The AAPM recommends that CMS reassign CPT 77407 *Radiation treatment delivery; Level 2* to APC 5623 *Level 3 Radiation Therapy*.

The AAPM recommends that CMS reassign CPT 77412 *Radiation treatment delivery; Level 3* to APC 5623 *Level 3 Radiation Therapy*.

For HOPPS rate setting purposes, CMS should treat 77402, 77407 and 77412 as new codes. These codes should be assigned to their respective APC with no associated data and use the existing codes for rate setting. It is critical that CMS use existing data for CPT codes 77385 and 77386 in APC 5623 for 2026 rate setting; and existing data for CPT code 77412 in APC 5622 for 2026 rate setting.

In addition, **after Medicare utilization data becomes available for the newly revised treatment delivery codes, the AAPM recommends that CMS consider using the HOPPS geometric mean of each individual CPT code to establish practice expense RVUs for radiation oncology codes, instead of the APC relative weight.** This revised methodology may provide additional accuracy for the services.

Hospital Outpatient Quality Reporting Program

For the Hospital Outpatient Quality Reporting (OQR) Program measure set, CMS adopted the *Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults* eQCM for voluntary reporting that begins with the CY 2025 reporting period, and mandatory reporting that begins with the CY 2027 reporting period/CY 2029 payment determination.

For 67 years, the AAPM is and has been a leading scientific and professional organization for continual improvements and assurance of the highest quality imaging and dose-image optimization for the safety and benefit of patient care. Based on our broad expertise and deep track record, the AAPM remains concerned regarding this quality measure as currently developed.

We agree with the Agency's proposal to maintain indefinite voluntary reporting of this measure due to continued feedback expressing concerns about the complex interfaces necessary to develop, maintain, and report the Excessive Radiation eQCM, including the financial burden and operational feasibility needed to translate CT radiology data into standardized eQCM-consumable data used by the measure.

The AAPM strongly supports the CMS proposal to make this quality measure voluntary in Calendar Year 2027 and subsequent years and not implementing a mandatory hospital outpatient reporting requirement.

Payment Adjustment Policy for Radioisotopes Derived from Non-Highly Enriched Uranium Sources

In the CY 2025 HOPPS final rule, CMS finalized a proposal to incentivize domestic production of Mo-99 by establishing a new add-on payment of \$10 per dose of Tc-99m derived from domestically produced Mo-99 starting on January 1, 2026. In this CY 2026 HOPPS proposed rule, CMS proposes that at least fifty percent of the Mo-99 used in the Tc-99m generator that produced a dose of Tc-99m must have been domestically produced for the dose to qualify for the add-on payment.

The AAPM supports the modified CMS proposal for a \$10 add-on payment for radiopharmaceuticals that use Tc-99M derived from at least fifty percent domestically produced Mo-99.

Low Volume APC Policy

Beginning in 2022, CMS established a Low Volume APC policy that designates clinical APCs, brachytherapy APCs, and New Technology APCs with fewer than 100 single claims that can be used for rate setting purposes in the claims year used for rate setting for the prospective year (the CY 2024 claims year for this CY 2026 proposed rule) as Low Volume APCs. We agree with CMS that low utilization of services can lead to wide variation in payment rates from year to year, especially as it relates to brachytherapy sources and new procedures and services. Under the Low Volume APC policy, the payment rates for these APCs would be set at the highest amount among the geometric mean, median, or arithmetic mean, calculated using up to four years of data.

The AAPM supports continuation of the Low Volume APC policy.

Comprehensive APC Methodologies for Surgical Insertion Codes for Brachytherapy

CMS continues to utilize the Comprehensive Ambulatory Payment Classifications (C-APC) payment methodology in CY 2026. Under the C-APC policy, CMS provides a single payment for all services on the claim regardless of the span of the date(s) of service. Conceptually, the C-APC is designed so there is a single primary service on the claim, identified by the status indicator (SI) of “J1”. All adjunctive services provided to support the delivery of the primary service are included on the claim.

Since the inception of the Comprehensive APC methodology, the AAPM has commented on concerns around the claims data used for rate setting due to significant variations in clinical practice and billing patterns across the hospitals that submit these claims. We met with CMS staff in February 2018 and in our 2019, 2020, 2021, 2022 and 2023 HOPPS proposed rule comment letters, the AAPM proposed a modified C-APC methodology for the surgical codes related to brachytherapy that mirrors the current CMS payment policy for single-session cranial stereotactic radiosurgery codes 77371 and 77372, which allows separate payment for specified preparation and planning codes. To date, the Agency has not addressed these concerns and the impact on Medicare beneficiary access to brachytherapy in the hospital outpatient setting is evident.

While the AAPM supports policies that promote efficiency and the provision of high-quality care, we have long expressed concern that the C-APC methodology lacks the appropriate charge capture mechanisms to accurately reflect the services associated with the C-APC.

The AAPM remains concerned that the rates associated with C-APCs do not accurately or fully reflect the services and costs associated with the primary procedure. Given the complexity of coding, serial billing for cancer care, and potentially different sites of service for the initial surgical device insertion and subsequent treatment delivery or other supportive services, the AAPM continues to oppose the current comprehensive APC payment methodology for cancer care. **We urge the Agency to explore alternatives to the C-APC methodology so that it appropriately values this life saving service.**

The current Comprehensive APC payment methodology for brachytherapy does not accurately reflect the true cost of providing the procedures.

The AAPM recommends that CMS discontinue the Comprehensive APC payment policy in 2026 for all brachytherapy insertion codes. CMS should revert to status indicator “T” for CPT codes 19296, 19298, 19499, 20555, 31643, 41019, 43241, 55874 55875, 55920, 57155 and 58346.

Alternatively, CMS could continue to pay for “J1” brachytherapy insertion codes under the C-APC payment methodology but exclude and make separate payment for designated preparation and planning services in addition to the C-APC payment (see Attachment A).

Software as a Service

Algorithm-driven services that assist practitioners in making clinical assessments can include clinical decision support software, clinical risk modeling, and computer aided detection (CAD). CMS refers to these technologies as software as a service (SaaS). For CY 2026, CMS is seeking comments on alternative and consistent payment methods for SaaS under the HOPPS to consider for future rulemaking.

We recognize that many of the current examples of SaaS involve diagnostic imaging and appreciate that the Agency recognizes the importance of separate and distinct payments, sometimes through add-on payments, for these services. The AAPM has concerns regarding the CMS packaging methodology that does not recognize component coding or the complexity of some services.

Machine learning applications (e.g., artificial intelligence) in healthcare can add significant value to the healthcare system by providing tools to help physicians provide better care for their patients. The number of artificial intelligence (AI) tools cleared by the FDA is escalating, and the vast majority are related to diagnostic imaging. To prevent an overwhelming number of potential AI codes, a limited number of CPT codes should be created with broad descriptor language that is inclusive of many clinical scenarios. The current method of creating a new code for each instance where a new AI-use case develops is not sustainable, is unnecessary given similarities in underlying technology, and is administratively burdensome.

In 2021, the AMA CPT Editorial Panel issued guidance for classifying various artificial intelligence/augmented intelligence (AI) applications. The guidance divides the work associated with the use of AI enabled medical services and/or procedures into one of three categories: assistive, augmentative, or autonomous.

The AAPM supports the CPT Editorial Panel's current efforts to simplify the AI code set to a handful of broad codes. It is our belief that many of the Category III CPT codes already approved should be folded into these new AI codes being established. Having only a few well-crafted codes will allow for a more appropriate determination of costs and better-defined relationships with codes for professional services and imaging acquisition.

The AAPM encourages CMS to pursue future software as a service code development and valuation through the American Medical Association (AMA) CPT/RUC process, which allows for transparency and dialogue with involved stakeholders.

AI, SaaS, and Software as a Medical Device (SaMD) should not be viewed as “operating in the background” simultaneously for patients. Some types of AI, SaaS, and SaMD should be paid separately because of the added value they provide for a specific patient’s condition, while other types may not need to be paid separately. Furthermore, AI, SaaS, and SaMD may be unique to a specific service and patient diagnosis, warranting an approach to value practice expense on a case-by-case basis.

The AMA AI taxonomy could serve as a starting point for establishing a comprehensive framework for how AI and SaaS can be covered across Medicare’s benefit categories if patients are to benefit from the wide variety of digital advances in health care delivery and providers are to be encouraged to incorporate these advances into their practices. This framework should include principles that apply across Medicare’s benefit categories.

Payment strategies for SaaS procedures across settings of care will need to account for the different costs associated with each setting. CMS should consider solutions that can be applied consistently across all services in a benefit category that would provide appropriate coverage and reimbursement for new technology across all payment systems.

Ancillary Services under the Ambulatory Surgical Center Payment System

The Ambulatory Surgical Center payment system aligns ASC rates with the ambulatory payment classification (APC) groups that are used to pay for services in hospital outpatient departments. The August 2007 ASC final rule established a policy to make separate ASC payments for ancillary services, for which separate payment is made under the HOPPS, when they are provided integral to ASC covered surgical procedures.

It appears that there may be some radiology and radiation oncology related ancillary codes that do not have coverage and payment under the ASC payment system but are separately paid under the HOPPS.

Magnetic Resonance Exam Safety Procedures (CPT 76014-76019):

Magnetic Resonance (MR) Exam Safety Procedure codes were implemented January 1, 2025 (see table below). CPT codes 76014, 76016, 76017, 76018 and 76019 have separate payment under the HOPPS and should be covered and paid separately under the ASC payment system. CPT code 76015 is an add-on code and should be packaged under the ASC with status indicator N1. These codes are not included in Addendum BB of the 2026 ASC proposed rule.

CPT Code	CPT Descriptor	Proposed 2026 APC Assignment
76014	MR safety implant and/or foreign body assessment; initial 15 minutes	5731 Level 1 Minor Procedures
76015	MR safety implant and/or foreign body assessment; each additional 30 minutes (add-on code)	
76016	MR safety determination	5521 Level 1 Imaging without Contrast
76017	MR safety medical physics examination customization	5523 Level 3 Imaging without Contrast
76018	MR safety implant electronics preparation	5742 Level 2 Electronic Analysis of Devices
76019	MR safety implant positioning and/or immobilization	5733 Level 3 Minor Procedures

The AAPM recommends that CMS provide coverage and separate payment for MR Exam Safety codes 76014, 76016, 76017, 76018 and 76019 under the ASC payment system effective January 1, 2026.

Quantitative MRI Brain Analysis (HCPCS 0865T & 0866T):

Category III codes 0865T and 0866T Quantitative MRI brain analysis with and without diagnostic MRI have separate payment under the HOPPS and should be covered and paid separately under the ASC payment system. These codes are not included in Addendum BB of the 2026 ASC proposed rule.

CPT Code	CPT Descriptor	Proposed 2026 APC Assignment
0865T	Quantitative MRI brain analysis without diagnostic MRI	5523 Level 3 Imaging Without Contrast
0866T	Quantitative MRI brain analysis with diagnostic MRI	5523 Level 3 Imaging Without Contrast

The AAPM recommends that CMS provide coverage and separate payment for Quantitative MRI Brain Analysis codes 0865T and 0866T under the ASC payment system effective January 1, 2026.

Biology Guided Radiation Therapy (HCPCS G0562 & G0563):

HCPCS codes G0562 and G0563 for Biology Guided Radiation Therapy are assigned to New Technology APCs under the HOPPS and should be covered and paid separately under the ASC payment system. These codes are not included in Addendum BB of the 2026 ASC proposed rule.

CPT Code	CPT Descriptor	Proposed 2026 APC Assignment
G0562	Complex simulation with PET-CT	1514 New Technology-Level 14 (\$1,201-\$1,300)
G0563	SBRT with positron emission delivery	1525 New Technology-Level 25 (\$3,501-\$4,000)

The AAPM recommends that CMS provide coverage and separate payment for Biology Guided Radiation Therapy codes G0562 and G0563 under the ASC payment system effective January 1, 2026.

We thank you for this opportunity to submit our comments and request that CMS carefully consider these issues for the 2026 final rule. Should CMS staff have additional questions, please contact Wendy Smith Fuss, MPH at (561) 631-0677.

Sincerely,



M Mahesh, PhD, MS, FAAPM, FIOMP, FACR, FSCCT, FACMP
President, American Association of Physicists in Medicine



Michele S. Ferenci, PhD
Chair, Professional Economics Committee

ATTACHMENT A

The AAPM identified a list of twenty-eight (28) codes proposed for separate payment in addition to the C-APC payment for the brachytherapy insertion codes (CPT 19296, 19298, 19499, 20555, 31643, 41019, 43241, 55874, 55875, 55920, 57155, 58346) effective January 1, 2022 (see below). Not all planning and preparation codes would be utilized for each brachytherapy insertion procedure code listed above. This C-APC modified policy mirrors the current CMS payment policy for single-session cranial stereotactic radiosurgery codes 77371 and 77372, which allows separate payment for specified preparation and planning codes.

- 10035 Placement of soft tissue localization device (egg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including image guidance; first lesion
- 32553 Placement of interstitial devices for radiation therapy guidance (egg fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple
- 49411 Placement of interstitial devices for radiation therapy guidance (egg fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvis (except prostate), and/or retroperitoneum, single or multiple
- 55874 Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance
- 55876 Placement of interstitial device(s) for radiation therapy guidance, prostate, single or multiple
- 76000 Fluoroscopy, up to 1 hour physician or other qualified health care professional time
- 76872 Ultrasound, transrectal
- 76873 Ultrasound, transrectal; prostate volume study for brachytherapy treatment planning
- 77280 Therapeutic radiology simulation-aided field setting; simple
- 77285 Therapeutic radiology simulation-aided field setting; intermediate
- 77290 Therapeutic radiology simulation-aided field setting; complex
- 77295 3-dimensional radiotherapy plan, including dose-volume histograms
- 77300 Basic radiation dosimetry calculation
- 77301 Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications
- 77306 Teletherapy isodose plan; simple, include basic dosimetry calculation(s)
- 77307 Teletherapy isodose plan; complex, include basic dosimetry calculation(s)
- 77316 Brachytherapy isodose plan; simple, include basic dosimetry calculation(s)
- 77317 Brachytherapy isodose plan; intermediate, include basic dosimetry calculation(s)
- 77318 Brachytherapy isodose plan; complex, include basic dosimetry calculation(s)
- 77321 Special teletherapy port plan
- 77331 Special dosimetry, only when prescribed by treating physician
- 77332 Treatment devices; simple
- 77333 Treatment devices; intermediate
- 77334 Treatment devices; complex
- 77336 Continuing medical physics consultation
- 77338 Multi-leaf collimator devices for IMRT
- 77370 Special medical radiation physics consultation
- C9728 Placement of interstitial devices for radiation therapy/surgery guidance (e.g., fiducial markers, dosimeter), for other than the following sites (any approach); abdomen, pelvis, prostate, retroperitoneum, thorax, single or multiple