AMERICAN ASSOCIATION of PHYSICISTS IN MEDICINE

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; CY 2026 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Proposed Rule; CMS-1832-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 16, 2025 *Federal Register* notice regarding proposed changes to the Medicare Physician Fee Schedule (MPFS).

Use of HOPPS Data for MPFS Rate Setting of 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 radiation 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 insure 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.

In the proposed rule, CMS notes that the costs for furnishing radiation treatment delivery services in non-facility settings (freestanding radiation therapy centers) include capital-intensive and specialized resources that are difficult to compare to the kinds of resources involved in furnishing most other kinds of services in other non-facility settings. For example, the sum of the current prices for the equipment inputs used in the PE calculations for radiation treatment delivery services (i.e., $3,000,966 for ER089 (IMRT accelerator) and $773,104 for ER056 (radiation treatment vault)) is well over twice the price of the next most expensive piece of equipment ($1,559,013 for EL008 (room, MR) used in furnishing other types of services in other non-facility settings. Furthermore, other inputs for capital equipment over $1 million are utilized in a wide array of services for multiple specialties, while the equipment inputs for radiation treatment delivery services are more specialized in that they are used in a small number of services and predominantly in radiation oncology.

CMS states that the resources involved in furnishing radiation treatment delivery and superficial radiation treatment delivery services seem to be primarily driven by capital costs that aren't as likely to vary greatly between facilities like hospitals and freestanding radiation therapy centers, and because the billing codes for the services (both old and new) are already stratified into professional and technical services, these services have obvious characteristics that make use of Hospital Outpatient Prospective Payment System (HOPPS) data particularly appropriate. Additionally, use of routinely updated, auditable, and standardized cost data from hospital cost reports that is currently used in setting rates under the HOPPS offers the possibility of long-term stable rates that many interested parties have long sought and that may be helpful in maintaining access to care for capital-intensive services.

Effective January 1, 2026, CMS is proposing to use the relationship between the relative weights of the HOPPS Ambulatory Payment Classifications (APCs) to which the codes in these families are assigned to value the practice expense portion of the Radiation Treatment Delivery code families.

The AAPM agrees that utilizing the HOPPS data to set rates for some radiation oncology services may lead to more stable payment rates and price transparency.

Specifically, CMS is proposing to utilize the relationship between the proposed HOPPS APC relative weights for APCs 5621 *Level 1 Radiation Therapy*, 5622 *Level 2 Radiation Therapy* and 5623 *Level 3 Radiation Therapy* to crosswalk the valuation of practice expense-only CPT codes 77402, 77407, and 77412 when paid under the MPFS.

It is important to note that in the 2026 Hospital Outpatient Prospective Payment System proposed rule, CMS assigns the revised Radiation Treatment Delivery codes 77407 and 77412 to APC 5622 *Level 2 Radiation Therapy,* which is different than the MPFS proposal noted above. We believe that the Agency did not consider the revised CPT code descriptors that will include additional services. 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.

CMS believes that the relationship between the HOPPS APC relative weights more accurately reflects the relative resource costs associated with furnishing these services. While the AAPM agrees with the proposed methodology for establishing non-facility practice expense RVUs for CPT codes 77402, 77407 and 77412, it is imperative that CMS appropriately align the revised Radiation Treatment Delivery codes with the relative weights of the corresponding APCs.

Based on the relative weights, cost data and clinical similarities, the AAPM recommends the following CY 2026 HOPPS APC assignments for the revised Radiation Treatment Delivery codes (see table below):

- **CPT 77402 *Radiation treatment delivery; Level 1* assigned to APC 5622 *Level 2 Radiation Therapy*.**
- **CPT 77407 *Radiation treatment delivery; Level 2* assigned to APC 5623 *Level 3 Radiation Therapy*.**
- **CPT 77412 *Radiation treatment delivery; Level 3* assigned to APC 5623 *Level 3 Radiation Therapy*.**

CPT Code	Current Long Descriptor	2026 Long Descriptor	CMS Proposed 2026 APC Crosswalk	AAPM Recommended 2026 APC Crosswalk
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	5623	5623

Although the CPT code numbers are the same for the remaining 3 CPT codes in the new treatment delivery family, they represent completely different services. 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.

Work RVU Efficiency Adjustment

CMS notes that the Agency relies on survey data primarily provided by the AMA RUC to estimate practitioner time, work intensity, and practice expense, which are often reflected in the valuation of codes paid under the MPFS. CMS states that only a small portion of the total codes are considered for revaluation annually, and the Agency relies primarily on subjective information from surveys that have low response rates, with respondents who may have inherent conflicts of interest. CMS has expressed concern about not accounting for efficiencies gained in work RVUs for non-time based services included in codes describing procedures, radiology services and diagnostic tests states that are likely overinflated.

CMS is proposing to apply an efficiency adjustment to the work RVU and corresponding intra-service portion of physician time of non-time-based services that they expect to accrue gains in efficiency over time. This would periodically apply to all codes except time-based codes, such as evaluation and management (E/M) services, care management services, behavioral health services, services on the Medicare telehealth list, and maternity codes with a global period of MMM.

Specifically, CMS is proposing to use a sum of the past five years of the Medicare Economic Index (MEI) productivity adjustment percentage to calculate this efficiency adjustment, which results in a proposed efficiency adjustment of -2.5% for CY 2026.

CMS continues to implement policies that redistribute reimbursement from procedure-based specialists to primary care providers. Specialties that bill more often for timed codes, such as family practice, clinical psychologists, clinical social workers, geriatrics, and psychiatry will experience an increase in RVUs; while specialties that bill more often for procedures, diagnostic imaging, and radiology services (such as radiation oncology, radiology, and some surgical specialties), would realize a decrease in RVUs. The current proposal results in an arbitrary reduction and does not reflect the resources required to provide radiation oncology services. This policy further exacerbates MPFS payment instability and will lead to additional cuts to radiation oncology services.

Currently, there is no annual update applied under the MPFS that accounts for inflation. Appling the work RVU efficiency adjustment based on the MEI is flawed and results in a reduction to radiation oncology physician payment while the cost to practice medicine continues to increase.

In addition, codes that have been recently revalued by the AMA RUC should be exempt from the efficiency adjustment as the valuation process would already incorporate work efficiency. This would include the revised Radiation Treatment Delivery codes 77402, 774074 and 77412.

The AAPM recommends that CMS not finalize the work RVU efficiency adjustment beginning in CY 2026 and reconsider an adjustment based on accurate and appropriate specialty-specific data.

Site of Service Differential

CMS is proposing significant updates to the PE methodology to better reflect current clinical practice. Specifically, CMS is proposing to recognize greater indirect costs for practitioners in office-based settings (e.g., freestanding radiation therapy centers) compared to facility settings (e.g., hospital outpatient departments).

For CY 2026, CMS is proposing a change to the methodology so that when work RVUs are used to allocate indirect PE to the facility RVUs, they are assigned at one-half the amount allocated to the non-facility PE RVUs for that same service. CMS notes that the purpose of this proposal is to address its concern for the potential of duplicative payment under the current practice expense methodology for allocating indirect costs for physicians practicing in the facility setting.

The current CMS proposal reduces the indirect practice expense RVUs for both hospital employed physicians, as well as private practice physicians performing procedures in a facility setting. The proposal does not differentiate between physicians who incur indirect expenses versus those that do not incur expenses. This proposal results in an arbitrary reduction in indirect practice expense RVUs for all services provided in the facility setting.

When private practice physicians perform a service in the facility setting, they incur indirect expenses (e.g., coding, billing, and scheduling). Physician practices would still have administrative staff, and their clinical staff often perform some work supporting services that are performed in the facility. These administrative costs are paid for through the physician's professional component claim. It is important to note that when physicians are directly employed by the hospital, hospitals often "charge" the physician related costs (e.g., administrative, coding, billing, rent) to the hospital department or unit.

It is imperative that CMS differentiate physicians that provide services in the facility setting and consider establishing a modifier to identify "hospital employed physicians". The proposed site of service differential reduction could be applied to indirect expenses of hospital employed physicians only and not penalize private practice physicians.

The AAPM recommends that CMS apply the proposed site of service indirect practice expense adjustment to hospital employed physicians only.

Multiple Procedure Payment Reduction (MPPR) and MR Exam Safety Procedure Codes

CMS applies the Multiple Procedure Payment Reduction (MPPR) policy for diagnostic radiology services under Medicare when multiple services are provided by the same physician to the same patient in the same session. Under the CMS guidelines, when multiple diagnostic imaging procedures are performed in a single session, most of the clinical labor activities and most supplies, with the exception of film, are not performed or furnished twice. Therefore, CMS applies a reduction in reimbursement for secondary and subsequent procedures because payment at 100% for secondary and subsequent procedures would result in duplicative reimbursement for clinical labor activities only performed once.

Magnetic Resonance (MR) Exam Safety Procedure codes 76014-76019 were implemented January 1, 2025 (see table below). Both the CPT Editorial Panel and the RUC recommended that CPT codes 76017, 76018 and 76019 be modifier -51 exempt and are indicated as such in the 2025 CPT coding manual. CPT code 76016 is appropriately included on the MPPR list.

CPT Code	CPT Descriptor
76014	MR safety implant and/or foreign body assessment; initial 15 minutes
76015	MR safety implant and/or foreign body assessment; each additional 30 minutes (add-on code)
76016	MR safety determination
76017	MR safety medical physics examination customization
76018	MR safety implant electronics preparation
76019	MR safety implant positioning and/or immobilization

The RUC discussed the MPPR issue at the January 2024 meeting and determined that there was no overlapping work and requested that these codes (i.e., 76017, 76018 and 76019) be modifier -51 exempt. These procedures can be performed with another procedure but may also be stand-alone procedures that are not always performed with other specified procedures. The value, time, and practice expense for these codes are separate from the work of other MR codes; there is also no overlap in pre-service work.

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

We believe that CMS erroneously assigned the MPPR policy to CPT codes 76017, 76018 and 76019.

The AAPM requests that CMS exempt MR Exam Safety Procedure codes 76017, 76018 and 76019 from the Multiple Procedure Payment Reduction policy effective January 1, 2026.

In addition, the AAPM recommends that the Multiple Procedure Indicator should be updated to "0" and the Diagnostic Imaging Family Indicator updated to "99" for CPT codes 76017, 76018 and 76019.

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.

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,

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