September 12, 2025

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1832-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1832-P; Medicare Program; 2026 Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment and Coverage Policies

Dear Administrator Oz:

The American Society of Nuclear Cardiology (ASNC) appreciates the opportunity to provide comments on the CY 2025 Medicare Physician Fee Schedule (PFS) proposed rule (CMS-1832-P) as published in the *Federal Register* on July 16, 2025.

ASNC is a greater than 5,700-member professional medical society, which provides a variety of continuing medical education programs related to the role of nuclear cardiology in patient-centered cardiovascular imaging, develops standards and guidelines for training and practice, promotes accreditation and certification within the nuclear cardiology field, and is a major advocate for furthering research and excellence in nuclear cardiology.

Specifically, ASNC offers comment on the following:

- Medicare CY 2026 Conversion Factor and G2211 Correction
- Efficiency Adjustment
- Indirect Practice Expense Site-of-Service Differential

We are deeply concerned that CMS' proposed policies, if finalized, will significantly reduce access to critical cardiovascular imaging services, threatening patient care and accelerating practice consolidation.

MEDICARE CY 2026 CONVERSION FACTOR AND G2211 CORRECTION

As proposed, the conversion factors would be impacted by three factors: 1) small permanent updates to the baseline beginning January 1, 2026, as required under the *Medicare Access and*

CHIP Reauthorization Act (MACRA); 2) a one-year 2.5 percent update enacted in H.R. 1 [P.L. 119-21]; and 3) a positive 0.55 percent budget neutrality adjustment.

While ASNC is grateful Congress provided a positive 2.5 percent adjustment for 2026, it masks the significant redistributive effect of CMS' proposals to implement an efficiency adjustment and changes to the practice expense (PE) methodology for services provided in the facility setting. ASNC offers comment on both proposals below.

ASNC continues to strongly advocate for permanent baseline updates to the conversion factors that account for the growth in physician practice costs, a position shared by the Medicare Payment Advisory Commission (MedPAC) again in its June 2025 report to Congress.[1] Specifically, MedPAC has recommended updates tied to the Medicare Economic Index (MEI) to maintain access to care for Medicare fee-for-service beneficiaries.

With regard to the conversation factor, HCPCS G2211 beginning in CY 2024 was implemented in a budget neutral manner and CMS estimated it would significantly increase Medicare spending. As a result, the budget neutrality adjustment in the 2024 Medicare PFS final rule resulted in a 2.18 percent cut to the 2024 conversion factor. The final estimate that CMS included in the CY 2024 Medicare PFS final rule was that G2211 would be billed with 38 percent of all office/outpatient E/M visits reported in 2024. However, an analysis conducted by the American Medical Association (AMA) shows the utilization of G2211 was 11.2 percent for 2024. Consequently, the 2024 budget neutrality adjustment cut was three times as large as it should have been, unnecessarily removing $1 billion from the Medicare fee schedule.

ASNC urges CMS to correct the utilization estimate for G2211 based on actual claims data from 2024 by making a prospective budget neutrality adjustment to the 2026 conversion factor in the forthcoming Medicare PFS final rule for 2026.

EFFICIENCY ADJUSTMENT

CMS' proposal to uniformly apply a 2.5 percent efficiency adjustment to the work RVUs for all non-time-based codes/services, as well as corresponding changes to the intraservice physician time, effective Jan. 1, 2026, assumes the same amount of physician work efficiency across a large group of services across a fixed period. **ASNC directs CMS to the thorough analysis and comments provided by the AMA RUC and underscores its opposition to CMS' proposed sweeping efficiency adjustment reduction for the following reasons:**

Disregards Appropriate Valuation and Disrupts Relativity
Work RVUs are designed to account for variable physician effort, time and intensity associated with different procedures. An across-the-board cut for thousands of services as proposed suggests

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[1] June 2025 Report to the Congress: Medicare and the Health Care Delivery System; Medicare Payment Advisory Commission. June 12, 2025. https://www.medpac.gov/document/june-2025-report-to-the-congress-medicare-and-the-health-care-delivery-system/

that individual review of services is unnecessary. CMS even proposes to apply the adjustment to codes the RUC and CMS have reviewed within the look-back period of five years, including codes being proposed for revaluation this year. CMS states this is necessary because of the reliance on survey data of recently resurveyed codes. We defer to the AMA RUC's extensive comments on the survey process and availability of extant data and timeliness of review of individual services.

Without individual review of services/codes, the variety and diversity of circumstances and factors among individual services and code families will not be recognized. Even CMS acknowledges in the proposed rule that "accruing efficiencies does not apply equally to all services, and that efficiencies gained over time may often apply more to services that take less time to perform." CMS' proposed across-the-board efficiency adjustment is undiscerning and contrary to CMS' own acknowledgement that any gained efficiencies over time are variable across services.

CMS also states in the rule that going forward it proposes that the public may submit nominations via the "Potentially Misvalued Codes" process if it is believed the efficiency adjustment will lead to inaccurate physician time and work RVUs for a particular code. The potentially misvalued codes process should not be used as the correction mechanism for CMS' broad and arbitrary application of an efficiency adjustment. The misvalued codes process is intended to review codes that may be over- or under-valued and should be relied upon, along with the established and transparent AMA RUC and survey processes, for appropriate and data-driven valuation of services.

Further, an across-the board adjustment will make it difficult, if not impossible to maintain appropriate relativity of new and revised codes. Maintaining relativity would be further complicated by application of the efficiency adjustment every three years as proposed.

Calculation of MEI is Not Transparent

CMS arrives at the 2.5 percent efficiency adjustment by tallying the last five years' private, nonfarm, productivity adjustments in the MEI. An adjustment of this magnitude demands full transparency by CMS in its calculations. CMS states the efficiency adjustment reflects the most recent historical estimate of the 10-year moving average growth of private non-farm business total factor productivity, as calculated by the U.S. Bureau of Labor Statistics (BLS). As articulated by the AMA RUC in its comments, the nonfarm productivity adjustment used for MEI for 2022-2026 is not listed in the CMS online tables related to the MEI nor in information available from the BLS. CMS should be fully transparent in its calculations and share data sources to validate the figures in Table 11 of the proposed rule.

CMS justifies, in part, the five-year look-back by inaccurately stating "many codes have never been revalued, and even for codes that have been revalued, there is, on average, more than 17 years since revaluation recommendations submitted by the RUC." CMS' statement is somewhat misleading because the RUC reviews higher volume services, on average, each 11 years.

It is also misleading and concerning for CMS to use MEI productivity to justify an efficiency adjustment when CMS and congressional lawmakers have ignored the MEI and left physicians without a real inflationary update for over two decades on top of sequestration, cuts to the conversion factor, penalties or no real return on practice investments for high performers in the Merit-based Incentive Payment System, and added regulatory burdens.

Three-year Efficiency Adjustment Updates

CMS is proposing to update and apply the proposed efficiency adjustment with a cadence of every three years. Recalculating and re-applying the efficiency adjustment will have a compounding effect. CMS states it is interested in comment as to whether efficiencies stop accruing for services after a predefined number of years. This is an important detail, but one that CMS seems unprepared to address until future rulemaking. CMS also does not address in the proposed rule any interactions between the proposed efficiency adjustment and proposed changes to the practice expense methodology. Conventional wisdom would dictate that if work values are reduced through application of an efficiency adjustment and if CMS' proposed methodology for reducing facility practice expense is based on the work RVU input, the facility practice expense for physician services will continue to decrease with future efficiency adjustments.

CMS is proposing a significant reduction to more than 7,000 physician services without having thought through all aspects of implementation. Physician payment changes with the level of consequence such that would be realized if CMS' proposed efficiency adjustment was finalized deserves a more iterative process of physician input rather than a 60-day comment period.

No Accounting for More Complex Patients

The diagnosis of and treatment planning for cardiovascular disease are becoming more challenging with complex patient presentations. Careful consideration of a patient's overall health and the implications for patient-centered test selection and performance is necessary when preparing for a diagnostic test, and interpretation of results must take into account individuals with multiple cardiac and noncardiac conditions that are increasing in our population, like presence of left bundle branch block, chronic obstructive pulmonary disease, obesity, deconditioning/frailty, chronic pain, and aortic stenosis. The presence of these and other comorbidities will determine image quality, the presence of perfusion artefacts, the selection of the stressor used in myocardial perfusion imaging, patient preparation, and other parameters, and they require careful consideration during scan interpretation and resulting treatment recommendations, which will complicate interpretation of nuclear studies. CMS assumes with its efficiency adjustment that physicians across the board have become more efficient without any consideration that the time and intensity of caring for a large swath of the Medicare population has become more complex, with, of the 68 million people who use Medicare, more than 95 percent having at least one chronic condition and almost half having four or more.[2]

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[2] Valenzano, CS. Tackling Chronic Disease: The Key to Cost-Effective Care; March 6, 2025. https://www.mathematica.org/blogs/tackling-chronic-disease-the-key-to-cost-effective-care#:~:text=Of the 68 million people,average rates of chronic conditions

Impact of AI Tools Ignored

CMS states it seeks comment on whether the introduction of new artificial intelligence (AI) has or will lead to otherwise unaccounted for efficiencies gained in specific services. This statement wrongly assumes that the use of AI-enabled tools and software results in physician work that requires less effort. AI tools often highlight or flag findings that require further physician review, confirmation or correlation with other studies. For example, the use of AI in imaging may produce significantly more images that a physician must review, including to avoid risk of liability. Research is also showing that continuous exposure to AI can also have a "deskilling" effect, reducing a physician's efficiency when AI is not in use.[3]

INDIRECT PRACTICE EXPENSE SITE-OF-SEVICE DIFFERENTIAL

For 2026, CMS proposes a significant change to the practice expense methodology which will recognize greater indirect costs for practitioners in office-based settings compared to facility settings. The proposal does this by inappropriately reducing without sufficient justification a key input for the indirect component of the facility practice expense RVU formula, the work RVU input, to 50 percent of the amount used for non-facility practice expense RVU computation.

In its June 2025 report to Congress, MedPAC presented different approaches to improving the valuation of services, including changing indirect practice expenses to better reflect costs of facility-based clinicians. MedPAC, however, urged policymakers to address the valuation of services *in tandem* with reforming fee schedule updates.[4] Practice consolidation and the migration of cardiologists from private practice to hospital employment have been driven largely by the lack of inflationary updates to physician payment, significant Medicare payment cuts to cardiology services and increasing administrative burden, including the unrestrained growth in prior authorization by Medicare Advantage plans.

We remind CMS that because of changes to clinical labor pricing inputs, nuclear cardiologists have faced four years (CY 2022-2025) of phased-in payment reductions. When CMS finalized new clinical labor pricing inputs, the rate per minute for a nuclear medicine technologist increased from $0.62 to $0.88, a 43 percent increase. Because nuclear cardiology is allocated a lower share of direct costs associated with clinical labor and uses high-cost supplies, the result was a significant decrease in payment for nuclear cardiology services, including a 12 percent cut to myocardial perfusion imaging. These cuts, arising from budget neutrality, were fundamentally unfair. While wages rose, CMS imposed a cut to preserve budget neutrality. These payment reductions coincided with reductions to the Medicare conversion factor, compounding the effect. These types of cuts are what drive practice acquisition and consolidation and are what make

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[3] Endoscopist deskilling risk after exposure to artificial intelligence in colonoscopy: a multicentre, observational study Budzyń, Krzysztof et al. The Lancet Gastroenterology & Hepatology; August 12, 2025. DOI: 10.1016/S2468-1253(25)00133-5

[4] June 2025 Report to the Congress: Medicare and the Health Care Delivery System; Medicare Payment Advisory Commission. June 12, 2025. https://www.medpac.gov/document/june-2025-report-to-the-congress-medicare-and-the-health-care-delivery-system/

employed practice models attractive to physicians. CMS' practice expense proposal follows a long history of Medicare payment reductions that have impacted cardiologists. It is perplexing to us that CMS would take yet another step that financially harms private practice cardiologists.

The application of CMS' indirect practice expense proposal to all physicians who provide services in the hospital outpatient or ambulatory surgery center settings is unnecessarily broad and does not reflect true resource costs incurred by physicians and practices for services provided in the facility setting. Therefore, we urge CMS to reconsider its proposal. Instead, **CMS' first priority should be to work with the physician community to accurately update practice expense per hour groupings and specialty data from the 2024 AMA Physician Practice Information Survey.**

Further, CMS' proposal makes no effort to properly identify physicians as being facility employed or in private practice. Even MedPAC noted in its June 2025 report that it would be "important to clearly and accurately define who is considered a hospital-affiliated clinician" when considering policies to reduce or eliminate indirect practice expense RVUs for facility services furnished by clinicians who are financially affiliated with a hospital.[5] Further, CMS must recognize the financial relationships between hospitals and hospital-owned practices vary significantly. In some cases, the hospital may not finance indirect practice expense for hospital-affiliated or hospital-employed clinicians.

CMS has presented its indirect practice expense proposal as simplistic and straight-forward, which is a misrepresentation of the complexity of physician practice and ownership arrangements. This proposal should not be finalized for CY 2026.

CONCLUSION

Further reductions in nuclear cardiology reimbursement will not only harm physicians but also delay timely diagnosis and management of cardiovascular disease in millions of Medicare beneficiaries. We urge CMS to reconsider these proposals and work collaboratively with the physician community to ensure that Medicare beneficiaries retain timely access to high-quality, evidence-based cardiovascular imaging.

Thank you for the opportunity to comment on the CY2026 PFS proposed rule and issues of importance to nuclear cardiologists. Any questions or requests for additional information should be directed to Georgia Lawrence, ASNC's Director of Regulatory Affairs at glawrence@asnc.org.

Sincerely,

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[5] June 2025 Report to the Congress: Medicare and the Health Care Delivery System; Medicare Payment Advisory Commission. June 12, 2025. https://www.medpac.gov/document/june-2025-report-to-the-congress-medicare-and-the-health-care-delivery-system/

Panithaya Chareonthaitawee, MD
President, American Society of Nuclear Cardiology