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Society of Interventional Radiology
The vision to heal

September 10, 2026

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
US Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Submitted electronically via: http://www.regulations.gov

Re: CMS-1848-P – Medicare and Medicaid Programs; CY 2027 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program; (July 14, 2026)

Dear Administrator Oz,
The Society of Interventional Radiology (SIR) is a professional medical association representing over 8,000 practicing interventional radiology physicians, trainees, medical students, scientists, and clinical associates. SIR's members range from medical students and residents to university faculty and private practice physicians. Our Society is dedicated to improving lives through image-guided therapies. Therefore, SIR appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) CY 2027 Revisions to Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment Policies proposed rule.

Conversion Factor

In the CY 2027 proposal, CMS will continue with two separate conversion factors (CFs). One CF will apply to services furnished by qualifying Alternative Payment Model (APM) participants, known as the qualifying APM conversion factor. The other CF will apply to all other services referred to as the non-qualifying APM conversion factor. For CY 2027, the qualifying APM CF is projected to decrease by $0.40 (1.19%), while the non-qualifying APM CF is expected to decrease by $0.56 (1.68%).

Impact: Interventional radiologists (IRs) currently face significant barriers to meaningful participation in APM tracks. Most existing APMs, including the predominant Accountable Care Organization (ACO) models, are heavily centered on primary care and do not adequately reflect the specialized, procedural nature of IR services performed across nearly every organ system. As a result, these models often fail to provide viable or relevant pathways for IRs to engage. Even when IRs are nominally included in an APM, their ability to contribute meaningfully is often constrained by limited involvement in care coordination, limited integration into performance metrics, and exclusion from shared savings distributions. However**,** IRs routinely improve patient outcomes and reduce overall costs through minimally invasive, image-guided procedures that serve as effective alternatives to more invasive and often more expensive treatments. These procedures frequently reduce the need for prolonged inpatient hospitalization, shorten hospital lengths of stay, and decrease downstream healthcare utilization, generating meaningful cost savings for patients and the healthcare system. Moreover, IRs

often perform procedures when other specialists have run out of options, meaning the specialty does not wholly own any single disease but participates in moments of urgency across many different disease states. Without dedicated models or modifications to existing frameworks that prioritize specialties that have exclusive ownership of a disease state, IRs remain structurally disadvantaged in the transition to value-based care. Finally, limited funding and stakeholder engagement are significant barriers to exploring innovative ways for IRs to participate in APMs.

SIR's recommendations: We strongly encourage CMS to broaden its efforts to create APM opportunities that are relevant to specialty care, ensuring that IRs can actively participate, qualify for the higher MACRA payment update, and benefit from shared savings and future APM bonus payments. Additionally, we urge CMS to collaborate with Congress on a long-term solution to the persistent issues affecting the Physician Fee Schedule (PFS), particularly the absence of a meaningful payment update that reflects actual practice costs.

Efficiency Adjustment

Beginning in CY 2026, CMS implemented a 2.5% efficiency adjustment to physician work RVUs and intra-service physician time for all non-time-based services paid under the Medicare Physician Fee Schedule (MPFS). For CY 2027, CMS proposes continuing to apply this adjustment to all non-time-based services. In addition, CMS proposes applying an efficiency adjustment to the handful of newly established or revised non-time-based services for CY 2027 whose valuation as part of the RUC process overlapped CMS's initial proposal for adjustments. The documented RUC-recommended values for these codes do not reflect any efficiency adjustments and may appear contradictory.

Impact: Applying a uniform 2.5% reduction across all non-time-based services continues to distort the relative value system. The policy undermines established relativity among services by reducing physician work irrespective of the actual clinical intensity, complexity, or risk associated with a procedure. Because higher-work RVU services experience larger absolute reductions, the policy could create rank-order anomalies and progressively erode the relativity that strengthens the physician fee schedule.

For IR, increased procedural efficiency does not necessarily translate into reduced physician workload. Advances in technology, imaging guidance, and operator experience often allow IRs to treat older, sicker, and more medically complex patients who previously would not have been procedural candidates. Physician work valuations are based on clinical vignettes describing a typical patient and do not fully capture the additional intensity and decision-making associated with atypical or high-acuity patients frequently encountered in practice. As a result, reducing work values based solely on presumed efficiency gains may fail to recognize the increasing complexity of the patients being treated.

SIR's recommendations: SIR urges CMS to discontinue the application of the physician work efficiency adjustment for non-time-based services. While CMS has expressed concerns about the valuation of physician work and the current process's ability to recognize efficiency gains over time, the Agency has not demonstrated that a uniform reduction accurately reflects changes in physician time, intensity, complexity, or risk across diverse specialties and services.

Physician experience, technical skill, and clinical judgment should be recognized and appropriately valued, not presumed to decline solely because a service has become more familiar or technologically advanced.

Site of Service Payment Differential

CMS continues the implementation of the site-of-service payment differential established for CY 2026, which reduces physician practice expense (PE) RVUs in the facility setting to account for indirect practice expenses that CMS believes are already covered by facility payments. While CMS acknowledges stakeholder concerns that the

policy may not accurately reflect the overhead costs incurred by independent physician groups practicing in hospitals and other facility settings, the agency has not proposed substantive modifications for CY 2027. Instead, CMS is seeking additional stakeholder input regarding physician employment arrangements, indirect practice expense allocations, the potential use of a new HCPCS modifier to identify employed physicians, and alternative approaches for allocating practice expenses across sites of care. CMS also released specialty-specific utilization data demonstrating that the policy's impact varies considerably with physician practice patterns and the proportion of services furnished in facility settings.

Impact: The site of service payment differential is designed to eliminate duplicate valuations of services and better balance payments between facility and non-facility settings for physicians. Between 2021 and 2025, global Hospital outpatient (OP) and ASC rates increased every year, with total increases of 14% for Hospital OP and 17% for ASC. In contrast, office-based lab (OBL) rates decreased 11% between 2021 and 2025. CY 2026 will mark the first increase in payments to OBLs in 5 years, driven by the Indirect PE policy. Still, office rates will remain below 2021 levels even after the implementation of the Indirect PE policy. Global Hospital OP and ASC rates will still increase by 2.4% (inclusive of the new Indirect PE policy). IRs that predominantly practice in the facility would see a 50% reduction in indirect PE RVUs. However, many IRs in a facility setting are not directly employed by the hospital but instead operate through independent practices that contract with the hospital to provide procedural services. These contracted IR groups incur substantial indirect costs, including expenses related to billing and coding, information technology, and other administrative functions.

SIR's recommendations: SIR urges CMS to recognize the diversity of IR practice models when evaluating the site of service payment differential. Many IRs provide services in facility settings while remaining employed by independent physician groups that continue to incur substantial indirect practice expenses, including scheduling, billing, coding, prior authorization, compliance, and care coordination activities. CMS should avoid broad assumptions that facility-based physicians incur minimal or no indirect practice expenses and should collect specialty-specific data before considering additional reductions to PE payments. SIR also recommends that CMS distinguish between hospital-employed physicians and independent physician practices furnishing services in facility settings. Any future modifications to the site of service payment differential, including consideration of a new HCPCS modifier, should be supported by reliable evidence demonstrating how indirect PEs vary across employment models and specialties. CMS should ensure that payment policies accurately reflect the resources required to furnish IR services, preserve beneficiary access, and avoid unintended incentives for physician practice consolidation.

Practice Expense

Indirect Practice Expense Methodology

CMS continues to express concerns about the current methodology for establishing practice expense (PE) RVUs, particularly its reliance on specialty survey data from the AMA's Physician Practice Information Survey (PPIS). The agency believes the existing approach is limited by outdated data, low survey response rates, inconsistent methodologies, and a lack of objective, auditable cost information. As part of a multiyear effort to modernize PE valuation, CMS proposes gradually eliminating specialty-level indirect practice expense adjustments based on historical PE/HR survey data and instead relying more heavily on service-level inputs and allocators. CMS would implement a two-year phase-in to remove the indirect practice cost index (IPCI) adjustment, applying a 5% cap to any increases or decreases in value, and establish a new PE stabilization mechanism designed to also limit significant year-to-year fluctuations and extreme volatility due to changes in valuations and allocation methodologies in PE RVUs. In addition, CMS proposes updates to specialty assignments for low-volume services and seeks to further standardize the process and timing for future specialty assignment reviews.

Impact: For IR, these proposals raise concerns about whether the PE methodology will continue to accurately capture the substantial indirect costs associated with providing IR services. IR practices often maintain

significant infrastructure to support patient evaluation, care coordination, multidisciplinary consultation, scheduling, prior authorization, compliance, coding, billing, and longitudinal follow-up. While the proposed stabilization factor may reduce annual payment volatility, it does not preserve the specialty-specific practice cost information currently reflected through the IPCI. As a result, PE payments may become less responsive to the unique resource requirements of IR and other procedure-based specialties.

More broadly, the cumulative impact of these PE proposals remains difficult to evaluate. CMS is proposing multiple interrelated changes simultaneously, making it challenging for stakeholders to isolate the effects of each policy and understand their combined impact on IR procedures and practices. Although CMS projected an overall positive payment impact for IR in CY 2027, those estimates reflect numerous concurrent policy changes and do not fully capture the impact of the proposed changes to the PE methodology alone. Additional service level and specialty-level analyses are needed to ensure that any reforms improve payment accuracy without creating unintended consequences for IR practices that continue to incur substantial indirect costs.

SIR's recommendations: SIR supports a Resource-Based Relative Value Scale (RBRVS) that is grounded in accurate, current, and specialty-specific data reflecting the resources required to furnish physician services. While we appreciate CMS's efforts to improve the accuracy of practice expense (PE) valuations and support ongoing updates to clinical labor, equipment, and supply pricing, we are concerned that the proposed changes to the indirect PE methodology replace established data-driven components with broad methodological adjustments that have not been sufficiently validated. CMS has not demonstrated that eliminating the Indirect Practice Cost Index (IPCI) will improve payment accuracy, nor has it identified a superior source of specialty-level practice cost information to replace it. Updated Physician Practice Information (PPI) Survey data were recently submitted to CMS and should be carefully evaluated before finalizing significant changes to the PE methodology.

Additionally, many IRs maintain private practices operating through an OBL but will also provide services to patients in the facility setting. When a physician in private practice furnishes a service or procedure in a facility setting, the physician practice continues to incur substantial administrative and practice-related expenses associated with furnishing that service. The practice remains responsible for functions such as coding and billing for the physician's professional claim, patient scheduling, and other administrative activities necessary to support the physician's services.

Accordingly, physician practices must continue to employ administrative personnel and maintain the infrastructure necessary to support these functions. In addition, practice-employed clinical staff often perform work that supports services ultimately furnished by the physician in a hospital or Ambulatory Surgical Center (ASC). These administrative and clinical personnel require office space that is separate from the hospital or ASC, as well as information technology and other operational resources. Physician practices also incur expenses for shared support functions, including human resources, legal services, compliance, and practice management.

These costs remain real and necessary practice expenses even when the physician personally furnishes the underlying clinical service in a facility setting. Eliminating independent IR practices' ability to recoup indirect practice expenses at the professional claim level and instead shifting payment to the facility burdens these practices, limits their financial viability, and reduces access to care for many services.

SIR urges CMS to withdraw the proposed changes to the indirect PE methodology for CY 2027 and maintain the current methodology while evaluating the updated PPI Survey data. CMS should work with specialty societies, the AMA RUC, and other stakeholders to identify and evaluate appropriate specialty-level practice cost data sources before making significant changes to the PE methodology. Any future reforms should be supported by robust empirical evidence, transparent methodology, and detailed service- and specialty-level impact analyses that enable stakeholders to independently assess the individual and cumulative effects of proposed changes before implementation.

Specific Codes and Code Set Valuations

Fine Needle Aspiration (FNA) CPT® codes 10005 and 10006

At the request of an interested stakeholder, the AMA Relative Value Scale Update Committee (RUC) re-evaluated CPT® codes 10005 (Fine needle aspiration biopsy, including ultrasound guidance; first lesion) and 10006 (each additional lesion) during its January 2026 meeting after identifying the services as potentially misvalued.

Proposed: CMS proposes adopting the RUC-recommended physician work RVUs for both codes. The agency also accepted RUC's recommended direct practice expense (PE) inputs with one proposed modification. CMS proposes creating a new equipment item, ER130 (Fine Needle Aspiration portable ultrasound), with an invoice-supported value of $83,750.00, an increase from the portable ultrasound equipment (EQ250) reflected in the PE recommendations.

SIR's recommendations: SIR appreciates CMS accepting the RUC recommended work RVU for CPT® 10005 and 10006. SIR also appreciates the agency's recognition of the valuation of the US unit for these two codes and supports creating the new equipment item, ER130.

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

At the May 2025 CPT® Editorial Panel meeting, two new codes for reporting percutaneous intraosseous fiducial marker placement, 209X1 and 209X2, were created. These codes are not considered new technology, but codes to better define the work being performed for existing technology.

Proposed: CMS proposes adopting the RUC-recommended physician work RVUs and direct PE inputs without refinement.

SIR's recommendations: SIR appreciates CMS accepting the RUC-recommended work RVUs and PE direct inputs.

Sacroiliac Joint Arthrodesis (CPT® codes 27278 and 27279)

At the May 2025 CPT® Editorial Panel meeting, CPT® code 27278 was revised to include imaging guidance, placement of intra-articular structural bone graft, metal, and/or synthetic device(s) without cortical piercing; and CPT® code 27279 was revised to include placement of transarticular and/or intra-articular device(s) that engage bone with intrinsic fixation (eg, screw(s), flange(s), blade(s)) piercing the lateral cortex of the sacrum and the medial cortex of the ilium.

Proposed: CMS proposes adopting the RUC-recommended physician work RVUs and direct PE inputs without refinement.

SIR's recommendations: SIR appreciates CMS accepting the RUC-recommended work RVUs and PE direct inputs.

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

CMS identified CPT® code 36465 through its potentially misvalued code screen after Medicare utilization increased by more than 100% between 2018 and 2023, with annual volume exceeding 10,000 services. As a result, the RUC reviewed the entire family of CPT® codes describing sclerosant treatment of incompetent veins.

Proposed: CMS proposes to adopt the RUC-recommended physician work RVUs for five of the six codes in the family: 36465, 36470, 36471, 36473, and 36474. However, CMS does not agree with the RUC's recommendation for CPT® code 36466. The agency noted that the recommended intraservice time decreased from 35 minutes to 30 minutes, while the work RVU remained unchanged. CMS stated that maintaining the existing work RVU would require evidence of increased physician intensity, which it believes was not demonstrated. Instead, CMS proposes valuing CPT® code 36466 by crosswalking it to CPT® code 57156 (*Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy*), resulting in a proposed reduction in the physician work RVU from 2.93 to 2.62 (work RVU= 2.62, 29.25 minutes intra-service time, and 78.25 minutes total time). CMS proposed the RUC-recommended direct PE inputs for all CPT® codes in this family without refinement.

SIR's recommendations: CPT® code 36466 is now more intense because the great saphenous and anterior accessory saphenous veins are both anterior structures on the leg. Treatment of these two veins, as described in the prior vignette, does not require any repositioning of the patient or the leg. To access the great saphenous and anterior accessory saphenous veins, the ultrasound is kept in the same relative position with an ergonomically advantageous angle. With the new vignette, the more clinically appropriate treatment of the great saphenous and small saphenous veins means that treatment of the small saphenous vein is more intensive and takes more time. First, because the small saphenous vein is a posterior vessel in the calf, the leg must be repositioned either into an exaggerated frog-leg position or, sometimes, into the prone position during the procedure. Second, the small saphenous vein is smaller and technically is more challenging to access than the other superficial thigh veins. Finally, when the patient is placed in the frog-leg position, the ultrasound and access are usually upside down and backwards, making the mental effort to enter the vein much more difficult than with the great or small saphenous veins.

Additionally, CPT® code 36466 should not be crosswalked to CPT® code 57156 because this describes the work in placing a vaginal radiation afterloading apparatus. This has no clinical similarity to venous ablation. While a device is inserted into the vagina for the placement of radionuclide sources to deliver radiation, this in no way matches the intensity of a venous ablation. Typical complications associated with CPT® code 57156 are local and self-limited, while CPT® code 36466 involves intravascular work with risks of hemorrhage, deep vein thrombosis, and potentially even a life-threatening pulmonary embolism. The recognized risks are not present for CPT® code 57156, making it an inappropriate crosswalk. The typical patient and intensity have changed for this service; therefore, SIR urges CMS to accept its recommendation of 2.93 for CPT® code 36466.

Percutaneous Lumbar Decompression (CPT® code 62287)

CPT® code 62287 was initially recommended for deletion at the January 2025 RUC meeting due to declining utilization. However, after updated utilization data were presented at the May 2025 CPT® Editorial Panel meeting, the neurosurgery and radiology societies requested that the code be retained and resubmitted for survey. As a result, CPT® code 62287 was reviewed during the September 2025 RUC meeting after remaining in the code set.

Proposed: CMS does not agree with the RUC-recommended physician work RVU of 7.06 for CPT® code 62287. The agency determined that the survey reflected a decrease in physician work time that was not adequately incorporated into the RUC recommendation. Instead, CMS proposes a work RVU of 6.23, based on a crosswalk to CPT® code 46707 (Repair of anorectal fistula with plug). CMS also proposes adopting the RUC-recommended direct practice expense (PE) inputs without refinement.

SIR's recommendations: SIR disagrees with the CMS-recommended crosswalk to CPT® code 46707, as it is well below the survey 25th percentile and does not maintain relativity within the code family. The CMS crosswalk describes repair of an anal fistula, and the surveyed code describes a percutaneous diskectomy. The surveyed code is a more intense and complex procedure to perform given the surrounding spinal nerves and vascular anatomy. CPT® code 62287 requires a combination of technical precision, imaging interpretation, and procedural risk, representing a substantially greater intensity of physician work than the proposed crosswalk reflects. The complexity of the surveyed code physician work is not adequately represented by an anorectal procedure performed in a more superficial and directly accessible operative field. The procedure involves no direct visualization of the spine and depends entirely on image guidance and tactile feedback, with adjacent neural and vascular structures at immediate risk. Taken together, the technical precision, imaging interpretation, and procedural risk involved in CPT® code 62287 reflect a substantially greater intensity of physician work than the proposed crosswalk indicates.

Further, the CMS reference codes provided to support the crosswalk, 67912 and 24358, are less

intense/complex to perform. The RUC agreed with the specialty societies that the work to provide the surveyed code is intense/complex during the intra-service period, and therefore the RUC recommended a work RVU of 7.06, which places the code appropriately within the family. Specifically, the service has not changed substantially; the same physician work is being performed in 37 minutes as was in the 60 minutes of time, creating a greater level of complexity, mental effort, and judgment. This compression does not reduce the physician work involved; if anything, it increases the intensity/complexity, mental effort, and judgment required per unit time, since the same degree of anatomic precision and risk avoidance must be exercised more efficiently and without any reduction in margin for error. Valuation methodology should account for this shift in complexity rather than treat the reduced time alone as justification for a proportionally reduced work RVU.

The RUC-recommended value also maintains appropriate relativity with CPT® codes 62330 and 62331, which describe percutaneous image-guided lumbar decompression at the initial and additional levels, respectively. CPT® codes 62287 and 62330 share several defining characteristics: both require percutaneous lumbar spinal access performed without direct visualization of the operative field, both depend on continuous interpretation of fluoroscopic or other image guidance to confirm safe instrument positioning, both require specialized instrumentation designed for minimally invasive spinal access, and both involve decompression performed in immediate proximity to neural structures where a small deviation in trajectory can result in significant morbidity.

The two codes differ in their specific technical approach. CPT® code 62330 requires posterior access with removal of portions of the lamina and ligamentum flavum to achieve decompression. CPT® code 62287, by contrast, requires accurate posterolateral access through the annulus fibrosus and controlled removal of nucleus pulposus, all while avoiding the exiting nerve root, the traversing nerve root, the dorsal root ganglion, the thecal sac, and segmental vasculature that lie along or adjacent to the access corridor. This posterolateral trajectory affords a narrower and less forgiving working corridor than the posterior approach used in CPT® code 62330, and it requires the physician to navigate around a greater number of at-risk structures in immediate proximity to the point of entry.

The RUC maintains that the key reference codes appropriately bracketed the service. Specifically, the first key reference code, 22869, *Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level* (work RVU = 6.85, 43.88 minutes intra-service, 173.88 minutes total time), is a strong comparator. The top key reference code 22869 has similar intra-service time, total time, and postoperative work. Therefore, the codes should be valued similarly.

For additional support, the RUC referenced CPT® code 37718, *Ligation, division, and stripping, short saphenous vein* (work RVU = 6.95, 43.88 minutes intra-service time, and 176.88 minutes total time). The reference code has similar intra-service time, total time, and postoperative work. Therefore, the codes should be valued similarly. SIR urges CMS to finalize a work RVU of 7.06 for CPT® code 62287.

Evaluation and Management (E/M)

Visit Complexity Add-On (HCPCS code G2211)

CMS proposes deleting HCPCS code G2211 and replacing it with a new modifier (MOD1) beginning in CY 2027. The agency believes many of the activities represented by G2211 are already inherent in the underlying evaluation and management (E/M) service and that the longitudinal relationship between a practitioner and patient can be more appropriately identified through a modifier rather than a separately payable add-on code. CMS states that the proposed change would reduce administrative burden by eliminating the need to report a separate line-item charge while still recognizing the visit complexity associated with ongoing, relationship-based care.

CMS also proposes changing how the additional payment is calculated. Rather than assigning a fixed payment amount, as is currently done for G2211, CMS would value the modifier as 16% of the associated E/M service payment. The agency believes this percentage-based approach better preserves relativity across E/M visit levels by ensuring that lower-level visits with the modifier do not receive higher total payment than higher-level E/M services.

Impact: For IR, the proposal could change how Medicare recognizes and reimburses the ongoing resources associated with longitudinal patient management. CMS's approach assumes that the additional complexity of serving as the continuing focal point for a patient's care increases in proportion to the level of the underlying E/M service. However, for many IRs, the work associated with longitudinal care, including patient surveillance, care coordination, treatment planning, and management of complex vascular and oncologic conditions, may not necessarily vary in direct proportion to the complexity level of an individual E/M encounter. As a result, the proposed methodology could redistribute payment across E/M visit levels without demonstrating that such changes more accurately reflect the ongoing physician work and resources associated with relationship-based care. Additionally, the proposal does not address longstanding concerns about the budget-neutrality adjustment associated with the original G2211 utilization assumptions, which continue to affect physician reimbursement despite lower-than-expected utilization.

SIR's recommendations: SIR urges CMS to maintain the existing G2211 add-on code and associated RVUs until sufficient evidence demonstrates that a percentage-based modifier more accurately captures the complexity of longitudinal, relationship-based care. CMS has not established that the ongoing work associated with managing a patient's serious or complex condition varies in proportion to the level of a single E/M encounter and therefore has not justified replacing a fixed add-on payment with a percentage-based adjustment.

In addition, SIR strongly urges CMS to use actual claims experience to reassess and recalibrate the utilization assumptions underlying G2211. The agency's original projections substantially overstated utilization, resulting in a budget neutrality adjustment that continues to reduce the conversion factor despite lower-than-expected use of the code. CMS should correct this miscalculation and ensure that future payment policies are based on real-world utilization data rather than projected assumptions.

Payments Using Modifier -25

CMS proposes applying a Multiple Procedure Payment Reduction (MPPR)-like policy to office and outpatient evaluation and management (E/M) services reported with modifier 25 when furnished on the same date as a procedure with a 0-, 10-, or 90-day global period. Under the proposal, the highest-valued service, either the procedure or the E/M visit, would be paid 100% of the assigned value, while the remaining service would be reduced by 50%. CMS believes this approach better accounts for overlapping physician work when separately identifiable E/M services are provided on the same day as a procedure. The agency is seeking stakeholder feedback on whether a 50% reduction is appropriate or whether a smaller reduction, such as 25%, would more accurately reflect any overlap in services. CMS also expressed concerns that providers could alter scheduling patterns to avoid payment reductions and is evaluating whether additional policies may be needed to discourage inappropriate billing practices.

Impact: IRs provide separately identifiable E/M services on the same day as procedures, including determining procedural appropriateness, evaluating new symptoms, managing complications, or developing treatment plans for patients with complex vascular, oncologic, and other chronic conditions. The proposed policy would reduce payment for these E/M services despite their distinct clinical purpose and medical necessity. As a result, IR practices that provide comprehensive clinical evaluation in addition to procedural care could experience reimbursement reductions when modifier 25 is appropriately reported. The proposal may also reduce efficiency for both physicians and Medicare beneficiaries by encouraging separate visits for evaluation and treatment.

SIR's recommendations: SIR strongly opposes automatic payment reductions for appropriately reported E/M services billed with modifier 25. IRs provide separately identifiable E/M services on the same day as a procedure, including evaluating new symptoms, assessing procedural candidacy, developing treatment plans, and determining whether a procedure is appropriate or should be deferred. These services represent distinct physician work and medical decision-making that should not be presumed duplicative simply because they occur on the same day as a procedure. SIR is concerned that the proposal could discourage efficient, patient-centered care by creating financial incentives to separate evaluation and treatment into multiple visits, potentially increasing patient burden, delaying care, and adding administrative complexity.

SIR supports appropriate documentation and coding compliance and encourages CMS to address concerns regarding the improper use of modifier 25 through provider education, targeted review, and existing valuation processes, rather than an across-the-board payment reduction that would apply to medically necessary and appropriately billed services.

SIR is also concerned that CMS has not demonstrated that separately identifiable E/M services reported with modifier 25 routinely contain duplicative resources warranting a payment reduction, nor has it identified the specific overlap it seeks to address. CMS already possesses established mechanisms to evaluate and address overlap through code-specific valuation reviews and the misvalued code process. If CMS believes residual overlap exists for particular services, it should address those concerns through established processes rather than applying a uniform payment reduction across all specialties and procedures. CMS should also explain what evidence or circumstances justify revisiting a policy similar to one it previously declined to finalize. As noted in a 2023 letter to Cigna from the AMA and more than 100 physician organizations opposing similar modifier 25 payment policies, appropriate payment for both services supports timely diagnosis, streamlined treatment, and high-value care.

Teaching Physicians' Billing for Services Involving Residents or Teaching Physicians with Virtual Presence

CMS proposes expanding the teaching physician exception for evaluation and management (E/M) services furnished in qualifying primary care centers. Under current policy, residents may provide certain lower- and mid-level office/outpatient E/M services without the teaching physician's physical presence when specific supervision requirements are met. For CY 2027, CMS proposes removing the regulatory limitation restricting the exception to lower- and mid-level complexity visits, allowing all levels of office and outpatient E/M services to be furnished by residents under direct supervision when clinically appropriate. CMS also proposes corresponding regulatory changes to clarify that Medicare payment may be made for these services when all requirements of the teaching physician exception are satisfied.

Impact: This proposed expansion of the teaching physician would provide greater flexibility for teaching programs by allowing residents to furnish all levels of office and outpatient E/M services under existing supervision requirements when clinically appropriate. For interventional radiology training programs, this change may improve efficiency in resident clinics, expand opportunities for resident participation in patient evaluation and longitudinal care, and reduce administrative barriers associated with current supervision requirements. The proposal could also support workforce development by providing residents with additional experience managing increasingly complex patients in outpatient settings while maintaining oversight by teaching physicians. Overall, the change may enhance access to care and improve the educational experience for IR trainees without altering payment rates for the underlying E/M services.

SIR's recommendations: SIR supports CMS's proposal to expand the teaching physician exception to allow residents to participate in all levels of office and outpatient E/M services under appropriate teaching physician supervision. Interventional radiology increasingly involves the evaluation and management of patients with

complex vascular, oncologic, and chronic conditions, and resident involvement in higher-level E/M visits is essential to developing the clinical judgment, medical decision-making, and longitudinal patient management skills required for independent practice. Allowing residents to participate in level 4 and level 5 visits when clinically appropriate will better align Medicare policy with modern graduate medical education and the clinical role of interventional radiologists.

Global Surgical Packages

CMS continues to evaluate the accuracy of 10-day and 90-day global surgical packages and is seeking input on whether additional postoperative visit reporting is needed to support future valuation changes. Based on prior claims-based data collection using CPT® code 99024, CMS found that postoperative visits occur less frequently than assumed when many global services were originally valued, particularly for 10-day global procedures. For CY 2027, CMS is not proposing additional mandatory reporting requirements but is requesting stakeholder feedback on broader reporting of CPT® code 99024 and alternative data sources that could better inform future refinements to global surgical package valuations. CMS also released supplemental analyses comparing current work RVUs for selected global procedures with projected values if postoperative visits included in the global package were reduced or removed, suggesting that some services may be overvalued relative to observed postoperative care patterns.

Impact: CMS's analysis suggests that some global surgical services may be overvalued because postoperative visits are reported less often than expected under CPT® code 99024. While CMS is not currently proposing valuation changes, the agency is signaling continued interest in using postoperative visit data to inform future refinements to global packages. For IR, this could have significant implications for procedures assigned 10-day or 90-day global periods if CMS concludes that fewer postoperative visits occur than were assumed during valuation. However, variations in CPT® code 99024 reporting may not accurately reflect the full scope of postoperative care furnished by IRs, particularly when follow-up care is delivered through alternative care models, multidisciplinary teams, or documentation workflows that do not consistently result in claims reported under 99024. Given the diversity of IR practice settings and postoperative management patterns, reliance on incomplete reporting data could lead to future valuation changes that do not accurately reflect the resources required to deliver global services.

SIR's recommendations: SIR urges CMS to exercise caution when evaluating global surgical package valuations based on postoperative visit reporting data. While SIR supports efforts to improve the accuracy of physician payment, CPT® code 99024 reporting data may not fully capture the scope of postoperative care furnished by IRs. Underreporting of postoperative visits should not be interpreted as evidence that follow-up care was not provided, particularly given the variation in documentation practices, care delivery models, and reporting patterns across specialties and practice settings.

SIR is particularly concerned that reliance on incomplete or inconsistently reported 99024 data could lead to inappropriate reductions in valuations for procedures with 10-day and 90-day global periods. Interventional radiology practice patterns vary substantially by procedure type, patient population, and site of service, and postoperative care is often delivered through a combination of clinic visits, imaging review, multidisciplinary care coordination, and other follow-up activities that may not be fully reflected in claims reporting alone. Accordingly, SIR encourages CMS to consider alternative data sources and work collaboratively with specialty societies before pursuing future changes to global package valuations. Any refinements should be supported by comprehensive, accurate data that reflects the full range of postoperative services furnished to Medicare beneficiaries.

Vascular Embolization or Occlusion Procedure with Use of a Pressure-Generating Catheter (HCPCS code G0577)

CMS proposes a valuation methodology for HCPCS code G0577, effective July 1, 2026, to recognize the additional resources associated with vascular embolization procedures performed using pressure-generating catheter technology in the office-based setting. As a counterpart to the existing C-codes (C9797 and C8004), which are payable only under the OPPS and ASC payment systems, G0577 is only payable under the MPFS payment system. For CY 2027, CMS proposes to establish physician work RVUs for G0577 by directly crosswalking the physician work and time from CPT® code 37243, while developing practice expense RVUs based on the payment relationship between CPT® code 37243 and HCPCS code C9797 under the OPPS. CMS is also seeking stakeholder feedback on whether an office-based equivalent should be established for HCPCS code C8004, which currently lacks a reporting mechanism in the office-based lab (OBL) setting.

Impact: The proposed valuation of HCPCS code G0577 would establish a mechanism to recognize the additional resources associated with vascular embolization procedures performed with pressure-generating catheter technology in the office-based setting. This is particularly significant for interventional radiology, as many emerging technologies rely on high-cost disposable supplies that may not be adequately recognized under the current practice expense methodology. By creating a separate code for this technology, CMS acknowledges that the costs associated with innovative devices can exceed those contemplated in traditional procedure valuations.

However, the proposal also highlights a broader challenge for office-based interventional radiology services. As new high-cost technologies enter the market, incorporating the cost of expensive disposable supplies directly into MPFS payments can create reimbursement distortions and budget-neutrality pressures that affect physician payments. The absence of a comparable office-based payment mechanism for technologies such as those currently described by HCPCS code C8004 may also limit beneficiary access to innovative therapies in the office-based lab setting and create reimbursement inconsistencies across sites of care.

SIR's recommendations: SIR appreciates CMS's proposal to recognize the additional resources associated with pressure-generating catheter technology through HCPCS code G0577 and encourages the agency to establish an office-based equivalent for HCPCS code C8004 to ensure appropriate reimbursement for innovative technologies furnished in the OBL setting.

However, SIR continues to support the long-standing AMA and RUC recommendation that high-cost disposable supplies be separately identified and reimbursed outside of the Medicare Physician Fee Schedule. As the number and cost of innovative IR technologies continue to grow, incorporating these expenses directly into physician payment rates creates budget-neutrality pressures that can unintentionally erode reimbursement for physicians' work. SIR urges CMS and Congress to develop a separate, transparent payment pathway for high-cost disposable items that is regularly updated and accurately reflects acquisition costs. Such an approach would better support innovation, promote site-of-service neutrality, maintain beneficiaries' access to advanced therapies, and ensure that physicians' compensation is not diminished by the cost of expensive technology.

Quality Payment Program (QPP)

Sunsetting Traditional MIPS and Full MVP Implementation

CMS proposes to sunset the traditional MIPS reporting option after the CY 2028 performance period. Beginning with the CY 2029 performance period, MVPs would become the only MIPS reporting option for MIPS-eligible clinicians who do not participate in a MIPS Alternative Payment Model. Clinicians participating in a MIPS APM would continue to have the option to report through the APM Performance Pathway (APP)/APP Plus. CMS also proposes to permit virtual groups to report MVPs beginning with the CY 2029 performance period.

Impact: SIR remains concerned that a mandatory transition to MVPs may occur before the MVP framework

includes a sufficient number of clinically relevant measures and cost measures for interventional radiologists. IR practice is highly diverse, encompassing a broad range of disease states, patient populations, procedures, and practice settings, including inpatient, outpatient, academic, community, private practice, urban, suburban, and rural settings. A single mandatory pathway may not accurately reflect this variation, particularly when many available measures apply only to narrow procedural or subspecialty populations. Requiring all clinicians to transition to MVPs without first resolving measure gaps could increase reporting burden, create inequitable scoring, and limit meaningful participation.

In addition, sunsetting traditional MIPS could effectively eliminate clinically meaningful quality measures that are not selected for inclusion in an MVP, despite substantial investments by specialty societies and measure stewards in their development, testing, implementation, and maintenance. Eliminating these measures could reduce meaningful reporting options for specialists and discourage future investment in specialty-specific quality measure development.

SIR Recommendations:

- CMS should not finalize a mandatory sunset of traditional MIPS until each specialty has an MVP with sufficient, broadly applicable quality measures, improvement activities, and clinically appropriate cost measures.
- CMS should maintain traditional MIPS as an available reporting pathway alongside MVPs, or establish clear readiness criteria and a formal delay mechanism for specialties whose MVPs do not yet support meaningful participation.
- CMS should provide additional funding, technical assistance, and streamlined pathways to support the development, testing, implementation, and ongoing stewardship of specialty-specific quality measures.

MIPS Value Pathways and the Interventional Radiology MVP

CMS proposes to modify all 27 existing MVPs for the CY 2027 performance period. The modifications would add MIPS core measure selections, expand certain clinical concepts, capture additional applicable specialties, address maintenance requests, and remove measures or activities that are proposed for removal from the broader MIPS inventory.

Impact: SIR appreciates CMS's continued maintenance of the MVP inventory but remains concerned that the IR MVP may not offer enough measures that are broadly applicable across the specialty. Measure choice is particularly important for IR given the wide range of disease states, patient populations, and procedures treated across the specialty. If the IR MVP relies heavily on measures applicable only to selected disease states, procedures, or subspecialty services, many IRs may be unable to select a complete and meaningful measure set.

SIR is also concerned that substantial variation in the number of available quality measures across MVPs may create inequities between specialties. Clinicians participating in MVPs with larger measure inventories have greater flexibility to select measures that are applicable to their practice and have established benchmarks, while clinicians participating in MVPs with limited measure sets may have fewer opportunities to achieve comparable scores.

SIR Recommendations:

- CMS should continue to refine the IR MVP by adding quality measures and improvement activities that are broadly applicable to IR practice, including measures addressing care coordination, patient safety, shared decision-making, patient-reported outcomes, access, and practice-based quality improvement.

- CMS should retain flexibility for IR clinicians and groups to select measures that reflect their actual scope of practice and should avoid requiring measures that apply only to narrow procedural populations.
- CMS should work directly with SIR and other specialty stakeholders to identify measure gaps and develop specialty-specific and subspecialty-appropriate measures before full MVP implementation. CMS should seek meaningful input from relevant specialty societies when selecting, adding, or removing measures within an MVP rather than making these decisions without input from the clinical experts whose specialties are represented.

Interventional Radiology MVP Measure Set

Quality ID	Quality Measure	Measure Type
145	Radiology: Exposure Dose Indices Reported for Procedures Using Fluoroscopy	Process
374	Closing the Referral Loop: Receipt of Specialist Report	Process
413	Door to Puncture Time for Endovascular Stroke Treatment	Intermediate Outcome
420	Varicose Vein Treatment with Saphenous Ablation: Outcome Survey	Patient-Reported Outcome
421	Appropriate Assessment of Retrievable Inferior Vena Cava (IVC) Filters for Removal	Process
465	Uterine Artery Embolization Technique: Documentation of Angiographic Endpoints and Interrogation of Ovarian Arteries	Process
RCOIR12	Tunneled Hemodialysis Catheter Clinical Success Rate	Outcome
RCOIR13	Percutaneous Arteriovenous Fistula for Dialysis - Clinical Success Rate	Outcome
RPAQIR14	Arteriovenous Graft Thrombectomy Clinical Success Rate	Outcome
RPAQIR15	Arteriovenous Fistulae Thrombectomy Clinical Success Rate	Outcome

Note: The table above reflects the current quality measures available within the IR MVP.

MIPS Core Measure Designation and Reporting Requirement

CMS proposes to remove the existing requirement to report at least one outcome measure, or a high-priority measure when an applicable outcome measure is unavailable. In its place, CMS proposes a new MIPS core measure designation for 78 measures. Clinicians reporting traditional MIPS would be required to report one MIPS core measure among their six quality measures, and clinicians reporting an MVP would be required to report one MIPS core measure among their four quality measures. Small practices would be exempt. When no applicable core measure is available, a clinician or group would be required to self-attest and report another measure in its place. Failure to report a core measure or complete the attestation process would result in zero points for one required measure.

Impact: SIR supports CMS' proposal to remove the existing requirement to report at least one outcome or high-priority measure. However, requiring clinicians to report a designated core measure could similarly restrict their ability to select measures that are most relevant to their practice, particularly for specialties such as IR where broadly applicable measures may be limited. SIR therefore supports CMS' proposed attestation process, which would provide important flexibility by allowing clinicians and groups without an available and applicable core

measure to report another quality measure in its place.

SIR Recommendations:

- CMS should ensure that every MVP includes at least one broadly applicable and clinically relevant core measure.
- SIR supports CMS' proposed attestation process for clinicians and groups when no available and applicable core measure exists, allowing them to report another quality measure in its place.
- CMS should consult with SIR and other relevant specialty societies before designating measures as core within the IR MVP to ensure that selected measures are clinically relevant, broadly applicable across IR practice, and feasible for clinicians, registries, and EHR vendors to report.

MVP Scoring Methodology

CMS seeks feedback on potential changes to the MVP scoring methodology, including whether scores should be normalized by comparing clinicians reporting the same MVP and whether a new methodology should be implemented in CY 2029 or piloted earlier.

Impact: SIR supports CMS' goal of improving scoring fairness but is concerned that comparing clinicians solely because they report the same MVP may not result in meaningful comparisons. IR encompasses diverse procedures, patient populations, and practice settings, and clinicians within the same MVP may report different quality measures. Any revised scoring methodology should account for these differences and remain fair, transparent, and predictable.

SIR Recommendations:

- CMS should not normalize scores based solely on participation in the same MVP without ensuring that clinicians and the measures they report are sufficiently comparable.
- CMS should account for differences in measure availability, benchmarks, patient populations, and practice settings that could advantage or disadvantage certain clinicians.
- CMS should simplify and align MIPS benchmarking and scoring methodologies to improve transparency and predictability.
- CMS should pilot any new MVP scoring methodology before tying it to payment adjustments and engage specialty societies in evaluating its impact across specialties and practice settings.

Data Completeness

CMS previously finalized that it intended to raise the quality measure data completeness requirement to 75% for the 2024 and 2025 performance periods and has now proposed to maintain this threshold through the 2027 and 2028 MIPS performance periods.

Impact: SIR recognizes the importance of data completeness to effectively assess a clinician's performance on quality measures and prevent selection bias as much as possible. SIR is committed to developing VIRTEX, its clinical data registry. SIR supports working with CMS to leverage platforms to enhance data completeness and ease the burden of reporting on clinicians. VIRTEX centers on quality improvement, efficient resource use, patient-reported outcomes, and enhanced technology to care for patients with specific medical conditions. VIRTEX will leverage clinical information from EHRs and other registries, in addition to claims data, to form a complete vision of patient care events. SIR is committed to improving patient outcomes and safety by setting and maintaining quality measures and standards of care.

SIR recommendations: SIR appreciates that CMS is maintaining the 75% level through 2028 and encourages

CMS to continue to maintain the 75% beyond 2028. Interventional radiologists (IRs) are uniquely positioned to work within a variety of clinical settings and places of service. An IR may provide care to the same patient at multiple in-patient and out-patient facilities, each with EHR and documentation systems that frequently are not interoperable. As a result, data completeness may be compromised. In addition, patients who are transferred from one facility to another may experience an incomplete transfer of data resulting from variations in EHR vendors and gaps in interoperability. SIR highlights that this requirement may not account for this variation in the type of practice settings that interventional radiologists often practice.

Performance Threshold

CMS previously finalized a MIPS performance threshold of 75 points for the 2027 performance period. The 75-point performance threshold will remain in place through the 2028 performance period.

Impact: Raising the performance threshold would increase administrative burden on physicians and place a financial strain on smaller and rural physician practices. The payment cuts associated with not meeting a higher performance threshold would compound the financial distress physicians are currently navigating, including high inflation, workforce shortages, as well as significant proposed cuts in overall Medicare physician reimbursement.

SIR Recommendations: SIR supports and appreciates CMS' proposal to maintain the threshold at 75 points for the 2027 performance period. SIR encourages CMS to maintain this level for subsequent years beyond 2027.

SIR appreciates the opportunity to comment on the CY 2027 MPFS proposed rule and to provide recommendations that support accurate physician payment, beneficiary access, and meaningful opportunities for interventional radiology participation in quality and value-based payment programs. If you have any questions, please contact SIR's Senior Manager of Health Policy and Economics, Ashley Maleki, at amaleki@sirweb.org or (703) 691-1855.

Sincerely,

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