August 12, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1832-P
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-1832-P

Dear Dr. Oz,

The American Society of Neuroradiology (ASNR) represents over 6,000 physicians specializing in the field of Neuroradiology. As the preeminent society concerned with diagnostic imaging and image-guided intervention of diseases of the brain, spine, and head and neck, we appreciate the opportunity to comment on the Medicare and Medicaid Programs; CY 2026 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 Proposed Rule.

In this comment letter, we address the following:

- Endovascular therapy with imaging (CPT Codes 61624, 61626, 75894, 75898)
- Cerebral perfusion & CT angiography-head & neck (CPT Codes 70496, 70498, 70XX2, 70XX3)
- A/V usage for direct supervision
- Efficiency Adjustment

Endovascular therapy with imaging (CPT Codes 61624, 61626, 75894, 75898)
In the April 2024 RUC meeting, surveyed data was provided for endovascular therapy with imaging (CPT Codes 61624, 61626, 75894, 75898) for CY 2026. the RUC-recommended a work RVU of 20.00 for CPT code 61624, an RVU of 15.31 for CPT code 61626, an RVU of 2.25 for CPT code 75894, and an RVU of 1.85 for CPT code 75898. We agree with the proposed RUC recommended work RVU of 2.25 for CPT code 75894 and work RVU of 1.85 for CPT code 75898. The surveys for these were of sufficient quality and met the thresholds needed to have good data, with this survey process being the standard approach for determining RVUs.
For CPT code 61624, we do not agree with the proposed crosswalk of CPT codes 49622 (Repair of parastomal hernia, any approach (that is, open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; incarcerated or strangulated) leading to a work RVU of 17.06 instead of the RUC proposed 20.00. Comparison of the times between current surveyed times to work RVU, and the old RUC database times for

61624 is not appropriate because this code was not previously surveyed. The times within the database were not based on current valuation methodology of valuation with survey. The work intensity of code 61624 is more intense than the proposed crosswalk of 49622. 61624 is performed in patients with an intracranial aneurysm after presenting with subarachnoid hemorrhage. During the procedure of coiling of the aneurysm, rupture of the aneurysm or stroke during the procedure could lead to devastating neurologic complications and makes this much more intense than an abdominal hernia repair. The survey value of 61624 is supported by the current existing code including 61635 which has an intraservice time of 150 minutes and total wRVU of 24.28 but has more total time. The procedure is similar intensity in patient presenting with abnormality of a vessel, in this case stenosis, requiring intervention, stenting.

Similarly, we do not agree with the proposed value for CPT code 61626, with the proposed crosswalk of CPT 49594 (Repair of anterior abdominal hernia[s] [that is, epigastric, incisional, ventral, umbilical, spigelian], any approach [that is, open, laparoscopic, robotic], initial, including implantation of mesh or other prosthesis when performed, total length of defect[s]; 3 cm to 10 cm, incarcerated or strangulated). Comparison of the current surveyed times to the RUC database times, which were not validated through survey and commensurate changes in time to work RVU should not be justification for crosswalk. In addition, the work of 61626 is much more intense than the proposed crosswalk of 49594. The typical work associated with this code is in patient present with epistaxis requiring embolization of an external branch of the carotid artery. Although this is not an intracranial procedure, the common carotid artery is accessed and there is potential for neurologic complication, such as a stroke, when the cervical arteries are accessed given the common pathway to the brain. Patients who are presenting with epistaxis are also typically on anticoagulation with other comorbidities which add to the complexity of the procedure with potential for bleeding. The valuation is supported by the key reference service CPT code 37244 Vascular embolization or occlusion, inclusive of all radiologic supervision and interpretation, intraprocedural road mapping and imaging guidance necessary which has less intraservice time and less wRVU. The IWPUT is within similar range of service.

Regarding direct PE inputs refinements we agree with the proposed refinements for CPT code 61626 including clinical staff time for the CA011 activity 'Provide education/obtain consent' going to the standard of 2 minutes, an increase of 3 minutes to the equipment time for the angiography room (EL011), and that the equipment time for the professional PACS workstation (ED053) should be half of the physician preservice time plus the full physician intraservice time leading to 152 minutes. We however are suggesting that while the medical supply quantity of the SD172 (guidewire, cerebral (Bentson)) supply from 1 to 0 should instead be replaced with SD089 (guidewire, hydrophobic) supply of 1.

Cerebral perfusion & CT angiography-head & neck (CPT Codes 70496, 70498, 70XX1, 70XX2, 70XX3)

In the September 2024 RUC meeting, surveyed data was presented for CPT code 70XX1 (Computed tomographic angiography (CTA), head and neck, with contrast material(s), including noncontrast images, when performed, and image postprocessing), CPT code 70XX2 (Computed

tomographic (CT) cerebral perfusion analysis with contrast material(s), including image postprocessing performed with concurrent CT or CT angiography of the same anatomy (List separately in addition to code for primary procedure)), and 70XX3 (Computed tomographic (CT) cerebral perfusion analysis with contrast material(s), including image postprocessing performed without concurrent CT or CT angiography of the same anatomy). Additionally, CPT code 70496 (Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing) and CPT code 70498 (Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing) were presented with updated survey data as part of the code family. We agree with the proposed acceptance of the RUC recommended work RVU of 2.50 for CPT code 70XX1, the work RVU of 0.77 for CPT code 70XX2, the work RVU of 1.00 for CPT code 70XX3, and the work RVU of 1.75 for both CPT codes 70496 and 70498. We also agree with the proposed acceptance of the RUC recommended direct PE inputs for CPT codes 70XX1, 70XX2, 70XX3, 70496, and 70498 without refinement.

A/V usage for direct supervision

We thank CMS for proposing to permanently include the use of audio/video real-time communication technology in the definition of direct supervision for diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests for services without a 010 or 090 global surgery indicator. With a significant radiologist and physician shortage, this innovative use of technology ensures access of all patients throughout the country, particularly in rural areas where shortages are exacerbated.

Efficiency Adjustment

The ASNR disagrees with the proposed efficiency adjustment to non-time-based work RVUs and associated intraservice time. The thought process that efficiencies automatically happen with all non-time-based work RVUs is too simplified. Current mechanisms exist for CMS and RUC to monitor efficiencies gained through the public nomination process and the Relativity Assessment Workgroup (RAW). Arbitrarily identifying only non-time based work RVU adjustments introduces significant distortions in the Relative Value Update Scale which has been supported by the CMS in prior rule making cycles. The AMA RUC process considers modifications in workflows through the survey valuation process.

Although introduction of technology such as the Picture Archive and Retrieval System (PACS) has improved workflows in radiology, this has not necessarily led to efficiencies in physician work. For example, the number of images acquired by CT scanners and MRI scanners have exponentially increased over the years. Image quality has continually improved with thinner slices available so that more images are now available to review in greater detail and in higher resolution than before. Newer and advanced MRI sequences have been added to standard imaging protocols that help to improve disease identification.[1,2,3]

The efficiency factor also introduces payment instability during significant workforce shortage of physicians and may exacerbate patient access to neuroradiologists in rural areas.[4]
The ASNR appreciates the opportunity to comment on this CMS Proposed Rule for the Physician Fee Schedule for CY 2026. Please feel free to contact us with any questions or comments. Rahul Bhala, MBA, MPH can be reached at rbhala@asnr.org.

Respectfully Submitted,

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President, 2025-2026
American Society of Neuroradiology

cc:
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1 Lindner T, Bolar DS, Achten E, Barkhof F, Bastos-Leite AJ, Detre JA, Golay X, Günther M, Wang DJJ, Haller S, Ingala S, Jäger HR, Jahng GH, Juttukonda MR, Keil VC, Kimura H, Ho ML, Lequin M, Lou X, Petr J, Pinter N, Pizzini FB, Smits M, Sokolska M, Zaharchuk G, Mutsaerts HJMM; on behalf of the ISMRM Perfusion Study Group. Current state and guidance on arterial spin labeling perfusion MRI in clinical neuroimaging. Magn Reson Med. 2023 May;89(5):2024-2047. doi: 10.1002/mrm.29572. Epub 2023 Jan 25. PMID: 36695294; PMCID: PMC10914350.
2 Touska P, Connor SEJ. Recent advances in MRI of the head and neck, skull base and cranial nerves: new and evolving sequences, analyses and clinical applications. Br J Radiol. 2019 Dec;92(1104):20190513. doi: 10.1259/bjr.20190513. Epub 2019 Sep 24. PMID: 31529977; PMCID: PMC6913354.

3 Eraky AM, Beck RT, Treffy RW, Aaronson DM, Hedayat H. Role of Advanced MR Imaging in Diagnosis of Neurological Malignancies: Current Status and Future Perspective. J Integr Neurosci. 2023 May 15;22(3):73. doi: 10.31083/j.jin2203073. PMID: 37258452.

4 Chen, James Y., Chen, Karen, Buch, Karen Hagiwara, Mari and Lexa, Frank. In Plain Sight, a Radiology Workforce Crisis in the Making – Gap Between Job Growth and the Radiology Training Pipeline American Journal of Neuroradiology Apr 2025, ajnr.A8764; DOI: 10.3174/ajnr.A8764