



American Society of Neuroradiology

September 4, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1848-P
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CY 2027 Payment Policies under the Medicare Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies (CMS-1848-P)

Dear Dr. Oz,

The American Society of Neuroradiology (ASNR) represents over 5,000 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 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 Proposed Rule.

In this comment letter, we address the following:

- Practice Expense (PE) RVU Methodology
- Percutaneous Lumbar Decompression (CPT Code 62287)
- MR angiogram of the head and neck (CPT codes 70544, 70545, 70546, 70547, 70548, 70549, 70XX4, 70XX5, and 70XX6))
- Current Procedural Terminology (CPT) Request for Information
- Duplicate Laboratory Testing, Imaging, and Result Sharing and Interoperability Request for Information

Practice Expense (PE) RVU Methodology

The ASNR supports a resource-based PE methodology grounded in accurate, current data, that reflect actual practice costs across settings. We are concerned that recent CMS proposals replace specific data inputs with broad methodological adjustments that lack a clear empirical basis and, in some cases, diverge from CMS-commissioned RAND analyses. Updated Physician Practice Information Survey data

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provided to CMS in January 2025 offer current specialty-level cost information, and CMS should rely on these data and RUC recommendations, particularly for low-volume services, before making fundamental changes to the PE and professional liability insurance methodologies. Additionally, ASNR recommends that CMS postpone implementation of the practice expense proposals until a future rulemaking cycle that includes granular specialty-level impact analysis for each proposed methodological change, work with the AMA to determine how 2024 PPI data can be used to reflect current physician practice costs and hours worked and continue using the 2006-based MEI cost shares for CY 2027 until the 2024 PPI data can be fully considered.

Percutaneous Lumbar Decompression (CPT Code 62287)

ASNR urges CMS to finalize the RUC-recommended work RVU of 7.06 for CPT code 62287. CMS's proposed crosswalk to CPT code 46707 undervalues the service because percutaneous lumbar decompression requires image-guided spinal access without direct visualization, precise navigation near neural and vascular structures, and substantial procedural judgment and risk management. Although the intra-service time has decreased, the same complex physician work must be performed more efficiently, increasing rather than reducing intensity. The RUC-recommended value also maintains appropriate relativity within the lumbar decompression code family and is supported by comparable reference services.

MR Angiogram of the Head and Neck (CPT codes 70544, 70545, 70546, 70547, 70548, 70549, 70XX4, 70XX5, and 70XX6)

The MRA head and neck code family was first identified by the RAW in 2022 due to the increasing rate of CPT codes 70544 and 70547 being reported together, with the pattern following a two-year monitoring period. This led to the September 2025 CPT code revisions to the six existing MRA head and MRA neck codes and the creation of three bundled codes for MRA head and neck. At the January 2026 RUC meeting, survey data was provided for MRA of the head and neck (CPT codes 70544, 70545, 70546, 70547, 70548, 70549, 70XX4, 70XX5, and 70XX6) for CY 2027. The RUC-recommended a work RVU of 1.17 for CPT codes 70544, 70545, 70547, a work RUV of 1.44, a work RVU of 70546, a work RUV of 1.46 for 70548, a work RVU of 1.76 for 70549. The RUC proposed a work RVU of 1.77 for 70XX4 1.77, a work RUV of 2.10 for 70XX5, and a work RVU of 2.23 for 70XX6. CMS proposes adopting the RUC-recommended work RVUs and direct PE inputs for all nine codes without refinement. The ASNR supports and appreciates this decision.

Current Procedural Terminology (CPT) Request for Information

CPT is a well vetted process in which all medical specialties, CMS, and vendors can participate to help recognize work done in medicine. This is an open meeting meaning anyone can attend and suggest a new code with enough level of evidence. Having CPT codes helps to establish a common language among physicians, payors, and insurers in both commercial and government. This is in a sense a way to have interoperability. Without it there could be multiple ways for payments to be deduced and would create an even more complex payment system which could benefit the payor and not the patient. It should also be noted that CPT codes are simply names for procedures performed by healthcare

professionals and do not represent coverage determination which is decided by payers. There is suggestion of the possibility of using ICD-10 codes instead of CPT codes. This would not account for differences in work performed regarding the individual patient and negatively effect ancillary specialties like radiology where ordering exams is beyond our control. Further payment to all respective parties in a patient's care would be rather difficult to sort out for a given disease entity.

Duplicate Laboratory Testing, Imaging, and Result Sharing and Interoperability Request for Information

While ASNR appreciates CMS trying to overall decrease unnecessary and duplicative imaging for our patients we worry that some of the proposed potential ways to reduce will only hurt diagnostic clinicians like neuroradiologists. For instance, payment denial or reduction does not stop these studies from being ordered and instead just penalizes those being asked to produce the work. Additionally, if CMS tries to limit how often a test or imaging can be performed this may hinder care by having too strict of guidelines to not consider variation in the individual patient's needs. This would equate into further decrease in autonomy for the ordering physician to be able to care for their patients.

We do believe interoperability may be beneficial for sharing images and do support replacement of physical media to digital based transfers however this may require significant investments for physician practices and cost analysis should be performed by CMS to see if viable option or if will need support.

Respectfully Submitted,



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President, 2026-2027
American Society of Neuroradiology

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